DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2022

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE ADMINISTRATOR

I am pleased to present the fiscal year (FY) 2022 Health Resources and Services Administration (HRSA) Budget. HRSA is the primary Federal agency for improving health outcomes and achieving health equity through access to quality services, a skilled health workforce, and innovative, high-value programs. The FY 2022 Budget provides $12.6 billion to build upon investments already made to respond to the COVID-19 pandemic and invest in programs that improve equitable access to health care for people that are medically underserved, geographically isolated, and economically vulnerable.

The FY 2022 Budget request:

- Supports the Health Center program, an essential source of high quality, value based primary health care services in underserved communities
- Invests critical resources to help address the opioid crisis and other substance use and mental health challenges, including funding to expand the behavioral health provider workforce
- Commits to end the HIV/AIDS epidemic by increasing access to treatment, expanding use of pre-exposure prophylaxis (also known as PrEP), and ensuring equitable access to services and supports
- Provides funding to increase the diversity of the healthcare workforce to ensure that clinicians reflect the communities and populations they serve and individuals from disadvantaged and underrepresented backgrounds have equitable access to careers in the health field
- Funds evidence-based interventions to address critical gaps in maternity care service delivery, improve maternal health outcomes, and reduce maternal mortality, including by ending race-based disparities
- Protects rural healthcare access by increasing funding for rural healthcare providers and rural residency programs

These investments are critical in order to protect the health and well-being of the American people, and achieve this Administration's health equity objectives.

Diana Espinosa
Acting Administrator

Organizational Chart

Health Resources and Services Administration

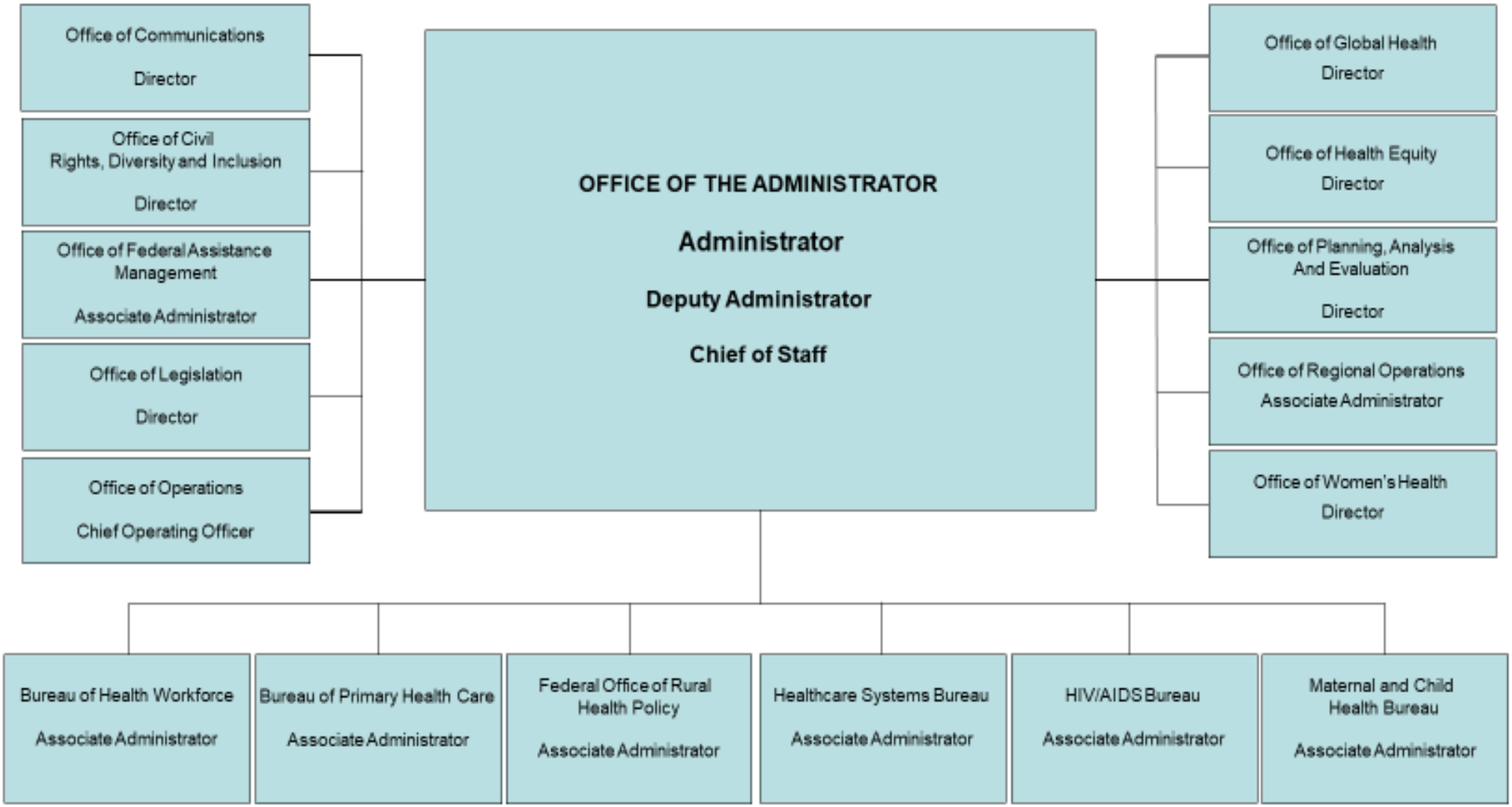

Table of Contents

Executive Summary

TAB

Introduction and Mission

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

HRSA supports programs and services that target, for example:

- Underserved persons who live in rural and poor urban neighborhoods where health care providers and services are scarce;
- Individuals who lack health insurance—many of whom are racial and ethnic minorities;
- African American infants who have 2.3 times the infant mortality rate as non-Hispanic white infants,[1] and African-American mothers have 3.2 times the pregnancy-related mortality rate as non-Hispanic white mothers;[2]
- The more than 1.2 million people living with HIV infection;[3]
- Persons affected by opioid use disorders and other substance use disorders; and
- The more than 118,000 individuals who are waiting for an organ transplant.[4]

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

[1] Ely DM, Driscoll AK. Infant mortality in the United States, 2017: Data from the period linked birth/infant death file. National Vital Statistics Reports, vol 68 no 10. Hyattsville, MD: National Center for Health Statistics. 2019. Accessed August 19, 2020.
[2] Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765. Accessed August 19, 2020.
[3] Centers for Disease Control and Prevention. Basics Statistics. Accessed April 6, 2021.
[4] Organ Procurement and Transplantation Network. Accessed April 6, 2021.

Overview of Budget Request

The FY 2022 President's program level request is $12.6[5] billion for the Health Resources and Services Administration (HRSA). This level is $496.5 million, or 4.1 percent above the FY 2021 enacted level. The Budget builds upon investments already made to respond to the COVID-19 pandemic and provides crucial targeted investments to protect the health and well-being of the American people, while accelerating efforts in the third year of the HHS-wide initiative to end the HIV/AIDS Epidemic (EHE), improving maternal health, advancing equity and reducing health disparities, ending the opioids epidemic, and prioritizing investments in rural communities to ensure access to quality health care.

Highlights of the major changes to programs are listed below:

Health Centers and Free Clinics: -$44.7 million; total program $5.6 billion[6] – The Budget provides resources for Health Centers to serve approximately 29.8 million patients in FY 2022. The Budget includes an increase of $50.0 million in discretionary funding to support awards for an additional 140 health centers, resulting in the total participation of approximately 440 health centers across the country to increase access to HIV prevention services, including Pre-Exposure Prophylaxis (PrEP). Health Centers funding also reflects a $94.7 million reduction through sequestration of direct spending pursuant to Balanced Budget and Emergency Deficit Control Act (BBEDCA).

HIV/AIDS: +$131.0 million; total program $2.6 billion – The request includes $190.0 million, an increase of $85.0 million, for the third year of the EHE, which will support evidence informed practices to link, engage, and retain people with HIV in care. The increased resources will support additional HIV care and treatment services in 47 jurisdictions. Approximately 50,000 clients will be served by this initiative through FY 2022. The Budget also provides an additional $46.0 million to Parts A, B, and C to support jurisdictions, states, and populations with the greatest need, especially racial and ethnic minority populations adversely affected by COVID-19 pandemic.

Health Workforce: +$131.5 million; total programs $1.8 billion[7]

- *National Health Service Corps (NHSC): +$47.3 million; total program $477.3 million*[8] The Budget supports scholarships and loan repayment to improve access to quality primary care, dental, and behavioral health in underserved urban, rural, and tribal areas. The request includes $180.0 million specifically for loan repayment for clinicians to provide opioid and substance use disorder treatment, and $5.0 million for Maternity Care Target areas to implement requirements contained in the Improving Access to Maternity Care Act. NHSC funding also reflects a $17.7 million reduction through sequestration of

[5] Reflects sequestration reduction from FY 2022 Enacted levels for Health Centers, National Health Service Corps (NHSC), Teaching Health Centers Graduate Medical Education (THCGME), Family to Family, and Maternal, Infant, and Early Childhood Home Visiting (MIECHV), resulting in a decrease of -$119.5 million in mandatory funding from FY 2021 Enacted mandatory level.
[6] Reflects sequestration reduction of -$94.7 million from FY 2021 Enacted for Health Centers.
[7] Reflects sequestration reduction of -$24.9 million from FY 2021 Enacted for NHSC and THCGME.
[8] Reflects post-sequestration funding level.

direct spending pursuant to Balanced Budget and Emergency Deficit Control Act (BBEDCA).

- *Health Professions Training for Diversity +$7.0 million; total program $97.1 million*
  The Budget provides an increase of $7.0 million for training for diversity programs. This includes increases for the following programs; Centers of Excellence, Scholarship for Disadvantaged, and the Health Careers Opportunity program. The additional funding will increase the diversity of the healthcare workforce and expand access to culturally competent care in medically underserved communities.

- *Nursing Workforce Diversity: +$3.5 million; total program $23.3 million*
  The request increases nursing education opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities who are underrepresented among registered nurses. The additional funding will support 29 continuing awards and 6 new awards, advancing the goal of increasing diversity of the healthcare workforce.

- *Behavioral Health Training Programs: +$75.0 million; total program $224.9 million*
  The Budget prioritizes investments in the behavioral health workforce to expand integrated behavioral health care and treatment services in underserved communities. This investment will expand the number of behavioral professionals and paraprofessionals entering the health workforce, advancing the goal of ending the opioid crisis.

- *Public Health and Preventative Medicine: +$1.0 million; total program $18.0 million*
  The request provides additional supplemental awards to Public Health and Preventive Medicine Training programs to address public health needs with a focus on increasing outreach to the underserved through rotations in rural health departments and Federally Qualified Health Centers in rural areas.

- *Geriatric program: +$3.8 million; total program $46.5 million*
  The Budget includes an increase of $3.8 million to award supplemental grants to nursing homes to assist with the recovery phase of the COVID-19 epidemic.

- *Loan Repayment/Faculty Fellowships +$1.1 million; total program $2.3 million*
  The investment provides an additional 19 awards to recruit and retain health profession graduates from disadvantaged backgrounds who serve as faculty at eligible health professions colleges.

Maternal and Child Health (MCH): +$124.8 million; total program $1.5 billion[9]

- *MCH Block Grant: +$110.0 million; total program $822.7 million*
  The request includes an increase of $81.0 million for Special Projects of Regional and National Significance, and an increase of $29.0 million for formula awards to states.

[9] Reflects post-sequestration funding level. Family-to-Family and MIECHV programs were also subject to sequestration in FY 2021.

Approximately, $77.3 million of the SPRANS increase promotes efforts to reduce maternal mortality and morbidity rates.

The Block Grant serves an estimated 60 million people, including 92 percent of pregnant women, 98 percent of infants, and 60 percent of children nationwide.

- *Autism and Other Developmental Disabilities: +$4.0 million; total program $57.3 million*
  The Budget increase supports an additional 5,000 children served, for a total of 125,000 children.

- *Emergency Medical Services for Children (EMSC): +$5.8 million; total program $28.1 million*
  The Budget provides additional funding to states to address critical gaps that remain for children's' access to high quality emergency and trauma care. The request also supports States building mental health capacity for children in emergency departments.

- *Screening and Treatment for Maternal Depression and Related Behavioral Disorders: +$5.0 million; total program $10.0 million*
  The request supports expanding services to an additional seven states in FY 2022, for a total of 14 states.

<u>Rural Health: +$70.7 million; total programs $400.2 million</u>

- *Rural Health Outreach: +$7.5 million; total program $90.0 million*
  The request includes $10.4 million, an increase of $5.0 million to support Rural Maternity and Obstetrics Management Strategies (RMOMS) grants to expand access and improve maternal health in rural communities. The additional $2.5 million provides funding for new awards to fund emerging public health needs.

- *Rural Hospital Flexibility Grants: +$1.9 million; total program $57.5 million*
  The Budget will expand activities for the state support of hospitals.

- *Rural Communities Opioid Response: +$55.0 million; total program $165 million*
  The Budget supports grants to provide substance use/opioid use disorder prevention, treatment, and recovery services to rural residents.

- *Telehealth: +$2.5 million; total program $36.5 million*
  The Budget supports the expansion of the Evidence-Based Telehealth Network Program with seven new awards in support of increasing access to healthcare services and improving health outcomes by using direct-to-consumer technologies.

- *Black Lung and Radiation Exposure Screening and Education programs; +$1.6 million; total programs $14.924 million*
  The Budget provides an increase of $1.6 million to ensure coal miners receive proper screenings, primary care and other services.

- *Rural Residency Planning and Development; +$2.2 million; total program $12.7 million* The request supports approximately 14 new Rural Residency Planning and Development awards to expand the number of rural residency training programs with the goal of increasing the number of physicians choosing to practice in rural areas.

340B Drug Pricing Program/Office of Pharmacy Affairs: +$7.0 million; total program $17.2 million The Budget includes an increase of $7.0 million to expand HRSA's program integrity efforts within the 340B Drug Pricing Program. The additional funding provides increase audit and oversight of the program including regulation support and systems support.

The Budget also includes 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.

Program Management: +$12.7 million; total program $168.0 million –The Budget supports program management activities that effectively and efficiently support HRSA's operations, including investments in information technology and cybersecurity. These investments are aligned with the President's Management Agenda.

Family Planning: +$53.5 million; total program $340.0 million
The Budget request provides funding for family planning methods and related health services, as well as related training, information, education, counseling, and research to improve family planning awareness and service delivery.

Vaccine Injury Compensation Program: +$5.0 million; total program $16.2 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 supports the additional costs of medical reviewers dedicated to evaluating the increased claims and reduce the current backlog of claims.

Countermeasure Injury Compensation Program; +$5.0 million, total program $5.0 million -
The request supports compensation to eligible individuals for injuries and deaths directly resulting from the use of covered countermeasures, including non-COVID-19 and COVID-19 claims. The funding also supports administrative costs associated with reviewing medical claims and determining compensation eligibility.

Overview of Performance

HRSA and its partners work to achieve the vision of "Healthy Communities, Healthy People." In pursuing this vision, HRSA's strategic goals are to improve access to quality health care and services, foster a health workforce able to address current and emerging needs, enhance population health and address health disparities though community partnerships, maximize the value and impact of HRSA programs, and optimize HRSA operations to enhance efficiency, effectiveness, innovation, and accountability. The Highlights section below groups key program performance measures by HRSA's goals and includes anticipated measure targets for fiscal year (FY) 2022. In collaboration with states, communities, and organizations, the performance examples below illustrate how HRSA will continue to improve health outcomes and address disparities through access to quality services, a skilled health workforce, and innovative, high-value programs for millions of Americans who are geographically isolated and economically or medically vulnerable.

Highlights

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

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

- In FY 2022, the Health Centers Program expects to support health centers' provision of affordable, accessible, quality, and cost efficient care to 29.8 million patients.

- HRSA expects to help states serve 63 percent of children through the Maternal and Child Health (MCH) Block Grant program in FY 2022, 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 to 5.4 per 1,000 in FY 2022 by supporting state MCH activities to improve the health of mothers, children, and families, particularly among low-income mothers and families or those with limited availability of care.

- In FY 2022, HRSA expects to serve 50,000 new clients under the *Ending the HIV Epidemic* initiative.

- By supporting the provision of HIV medications and related services to more than 280,000 persons in FY 2022 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 2022, the Ryan White HIV Emergency Relief Grants (Part A) and HIV Care Grants to States (Part B) are projected to support, respectively, 3.3 million visits and 2.7 million visits for health-related care.

- In FY 2022, 83% of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test are expected to be virally suppressed.

- To increase the number of patients from racially and ethnically diverse backgrounds able to find a suitably matched unrelated adult donor for their blood stem cell transplants, the C.W. Bill Young Cell Transplantation Program projects that it will have nearly four million adults on the donor registry in FY 2022 who self-identify as belonging to an underrepresented racial or ethnic group.

- The Organ Transplantation program projects that it will facilitate the transplantation of more than 32,600 deceased donor organs in FY 2022.

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

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

- In FY 2022, 11,000 healthcare providers will be deemed eligible for Federal Tort Claims Act malpractice coverage through the Free Clinics Medical Malpractice program. The program encourages providers to volunteer their time at sponsoring free clinics, thereby expanding the capacity of the healthcare safety net.

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

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

- In FY 2022, 430,000 unique individuals will receive direct services through Federal Office of Rural Health Policy Outreach grants, which improve rural health through community coalitions and evidence-based models by focusing on quality improvement, increasing health care access, coordination of care, and integration of services.

- The Graduate Psychology Education (GPE) Program will train 400 students in FY 2022 through innovative doctoral-level health psychology programs that foster an integrated and interprofessional approach to addressing access of behavioral health and substance use prevention and treatment services in high need areas through academic and community partnerships. The GPE Program is focused on providing specialized training to doctoral health psychology students, interns, and post-doctoral residents in the provision of Opioid Use Disorder and other Substance Use Disorder prevention and treatment services.

- In FY 2022, HRSA expects to have 148,721 cord blood units from underrepresented

racial and ethnic minorities available through the C.W. Bill Young Cell Transplantation Program, increasing the likelihood of finding suitably matched donors among these populations with a high rate of diversity in tissue types.

- The MCH Block Grant program expects the ratio of the Black infant mortality rate to the White infant mortality rate to decrease to 2.0 to 1 in FY 2022.

Performance Management

Performance management is central to the agency's overall management approach and performance-related information routinely is used to improve HRSA's operations and those of its grantees. HRSA's performance management process includes setting priorities and goals that are linked to HRSA's Strategic Plan, action planning and execution, regular monitoring and review with follow-up. HRSA's Strategic Plan includes three goals focused on health access, the health workforce, and population health, each of which gives direction to the agency as it administers its external programs (described above). HRSA's Strategic Plan also includes one goal focused on internal HRSA performance management that drives improved used of data and evidence to support decision-making. In accordance with the *Foundations for Evidence-Based Policymaking Act of 2018*, HRSA uses the results from its performance measurement as evidence to address pressing agency questions about program impacts and progress toward agency and department goals. Building an evidence-base on program impacts informs agency leadership decisions and policies.

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

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

These aspects of HRSA's performance management system promote accountability and transparency, support collaboration in problem solving and help drive performance improvement at the agency and among HRSA's grantees. Ultimately, HRSA holds itself to high standards to maximize program investment impacts and to improve health outcomes.

Budget Exhibits

TAB

All Purpose Table
Health Resources and Services Administration

(Dollars in Thousands)

	FY 2020		FY 2021		FY 2022	
	Final	FY 2020 Supplemental Funding /1,2,3,4	Enacted	FY 2021 Supplemental Funding/5	President's Budget	FY 2022 +/- FY 2021
PRIMARY CARE:						
Health Centers:						
Health Centers	1,505,522	700,000	1,562,772	-	1,612,772	+50,000
Health Centers Mandatory/7	4,000,000	1,320,000	4,000,000	7,600,000	3,905,348	-94,652
Health Center Tort Claims	120,000	-	120,000	-	120,000	-
Subtotal, Health Centers	***5,625,522***	***2,020,000***	***5,682,772***	***7,600,000***	***5,638,120***	***-44,652***
Free Clinics Medical Malpractice	1,000	-	1,000	-	1,000	-
Subtotal, Bureau of Primary Health Care (BPHC)	**5,626,522**	**2,020,000**	**5,683,772**	**7,600,000**	**5,639,120**	**-44,652**
Subtotal, Mandatory BPHC (non-add)	*4,000,000*	*1,320,000*	*4,000,000*	*7,600,000*	*3,905,348*	*-94,652*
Subtotal, Discretionary BPHC (non-add)	*1,626,522*	*700,000*	*1,683,772*	-	*1,733,772*	*+50,000*
HEALTH WORKFORCE:						
National Health Service Corps (NHSC):						
NHSC	120,000	-	120,000	-	185,000	+65,000
NHSC Mandatory/7	310,000		310,000	800,000	292,330	-17,670
Subtotal, NHSC	***430,000***	***-***	***430,000***	***800,000***	***477,330***	***+47,330***
Loan Repayment/Faculty Fellowships	1,190	-	1,190	-	2,310	+1,120
Health Professions Training for Diversity:						-
Centers of Excellence	23,711	-	23,711	-	26,711	+3,000
Scholarships for Disadvantaged Students	51,470	-	51,470	-	51,970	+500
Health Careers Opportunity Program	15,000	-	15,000	-	18,500	+3,500
Subtotal, Health Professions Training for Diversity	***90,181***	***-***	***90,181***	***-***	***97,181***	***+7,000***
Health Care Workforce Assessment	5,663	-	5,663	-	5,663	-
Primary Care Training and Enhancement	48,924	-	48,924	-	48,924	-

	FY 2020		FY 2021		FY 2022	
	Final	FY 2020 Supplemental Funding /1,2,3,4	Enacted	FY 2021 Supplemental Funding/5	President's Budget	FY 2022 +/- FY 2021
Oral Health Training Programs	40,673	-	40,673	-	40,673	-
Medical Student Education	50,000	-	50,000	-	50,000	-
Interdisciplinary, Community-Based Linkages:						-
Area Health Education Centers	41,250	-	43,250	-	43,250	-
Geriatric Programs	40,737	-	42,737	-	46,537	+3,800
Behavioral Health Workforce Development Programs	138,916	-	149,916	-	224,874	+74,958
Behavioral Health Workforce Development Programs Mandatory	-	-	-	100,000	-	-
Mental and Behavioral Health Training Mandatory	-	-	-	80,000	-	-
Promote Mental and Behavioral Health Mandatory	-	-	-	40,000	-	-
Subtotal, Interdisciplinary, Community-Based Linkages	***220,903***	**-**	***235,903***	***220,000***	***314,661***	***+78,758***
Public Health Workforce Development:		-				
Public Health/Preventive Medicine	17,000	-	17,000	-	18,000	+1,000
Nursing Workforce Development:		-				-
Advanced Nursing Education	80,581	-	80,581	-	80,581	-
Nursing Workforce Diversity	18,343	-	19,843	-	23,343	+3,500
Nurse Education, Practice and Retention	43,913	-	46,913	-	46,913	-
Nurse Faculty Loan Program	28,500	-	28,500	-	28,500	-
NURSE Corps Scholarship and Loan Repayment Program	88,635	-	88,635	-	88,635	-
NURSE Corps Scholarship and Loan Repayment Program Mandatory	-	-	-	200,000	-	-
Subtotal, Nursing Workforce Development	***259,972***	**-**	***264,472***	***200,000***	***267,972***	***+3,500***
Children's Hospital Graduate Medical Education	340,000	-	350,000	-	350,000	-
Teaching Health Center Graduate Medical Education Mandatory/7	126,500		126,500	330,000	119,290	-7,211
National Practitioner Data Bank (User Fees)	*18,814*	-	*18,814*	-	*18,814*	-
Subtotal, Bureau of Health Workforce (BHW)	**1,649,820**	**-**	**1,679,320**	**1,550,000**	**1,810,818**	**+131,498**
Subtotal, User Fees BHW (non-add)	*18,814*	-	*18,814*	-	*18,814*	-
Subtotal, Discretionary BHW (non-add)	*1,194,506*	-	*1,224,006*		*1,380,384*	*+156,378*
Subtotal, Mandatory BHW (non-add)	*436,500*	-	*436,500*	*1,550,000*	*411,620*	*-24,881*

	FY 2020		FY 2021		FY 2022	
	Final	FY 2020 Supplemental Funding /1,2,3,4	Enacted	FY 2021 Supplemental Funding/5	President's Budget	FY 2022 +/- FY 2021
MATERNAL & CHILD HEALTH:						
Maternal and Child Health Block Grant	687,700	-	712,700	-	822,700	+110,000
Grants to States (non-add)	*558,308*	-	*563,308*	-	*592,308*	+29,000
SPRANS (non-add)	*119,116*	-	*139,116*	-	*220,116*	+81,000
CI*SS (non-add)*	*10,276*	-	*10,276*	-	*10,276*	-
Autism and Other Developmental Disorders	52,344	-	53,344	-	57,344	+4,000
Sickle Cell Service Demonstrations	5,205	-	7,205	-	7,205	-
Early Hearing Detection and Intervention	17,818	-	17,818	-	17,818	-
Emergency Medical Services for Children	22,334	-	22,334	-	28,134	+5,800
Healthy Start	125,500	-	128,000	-	128,000	-
Heritable Disorders	17,883	-	18,883	-	18,883	-
Pediatric Mental Health Care Access Grants	10,000	-	10,000	-	10,000	-
Pediatric Mental Health Care Access Grants Mandatory	-	-	-	80,000	-	-
Screening and Treatment for Maternal Depression	5,000	-	5,000	-	10,000	+5,000
Family-to-Family Health Information Centers Mandatory/8	6,000	-	5,658	-	5,658	-
Maternal, Infant and Early Childhood Home Visiting Program Mandatory/9	376,400	-	377,200	150,000	377,200	-
Subtotal, Maternal and Child Health Bureau (MCHB)	**1,326,184**	-	**1,358,142**	**230,000**	**1,482,942**	**+124,800**
Subtotal, Discretionary MCHB (non-add)	*382,400*	-	*975,284*	-	*1,100,084*	*+124,800*
Subtotal, Mandatory MCHB (non-add)	*382,400*	-	*382,858*	*230,000*	*382,858*	-
HIV/AIDS:						
Emergency Relief - Part A	655,876	26,100	655,876	-	665,876	+10,000
Comprehensive Care - Part B	1,315,005	*24,900*	1,315,005	-	1,345,005	+30,000
AIDS Drug Assistance Program (non-add)	*900,313*	*100*	*900,313*	-	*900,313*	-
Early Intervention - Part C	201,079	30,300	201,079	-	207,079	+6,000
Children, Youth, Women & Families - Part D	75,088	5,100	75,088	-	75,088	-
AIDS Education and Training Centers - Part F	33,611	3,600	33,611	-	33,611	-
Dental Reimbursement Program Part F	13,122	-	13,122	-	13,122	-

	FY 2020		FY 2021		FY 2022	
	Final	FY 2020 Supplemental Funding /1,2,3,4	Enacted	FY 2021 Supplemental Funding/5	President's Budget	FY 2022 +/- FY 2021
Special Projects of National Significance (SPNS)	25,000	-	25,000	-	25,000	-
Ending HIV Epidemic Initiative	70,000	-	105,000	-	190,000	+85,000
Subtotal, HIV/AIDS Bureau	**2,388,781**	**90,000**	**2,423,781**	-	**2,554,781**	**+131,000**
HEALTHCARE SYSTEMS:						
Organ Transplantation	27,499	-	29,049	-	29,049	-
Cell Transplantation Program and Cord Blood Stem Cell Bank	47,275	-	49,275	-	49,275	-
Poison Control Centers	22,896	5,000	24,846	-	24,846	-
340B Drug Pricing Program/Office of Pharmacy Affairs	10,238	-	10,238	-	17,238	+7,000
Hansen's Disease Center	13,706	-	13,706	-	13,706	-
Payment to Hawaii	1,857	-	1,857	-	1,857	-
National Hansen's Disease Program - Buildings and Facilities	122	-	122	-	122	-
Subtotal, Healthcare Systems Bureau (HSB)	**123,593**	**5,000**	**129,093**	-	**136,093**	**+7,000**
RURAL HEALTH:						
Rural Health Policy Development	10,351	-	11,076	-	11,076	-
Rural Health Outreach Grants	79,500	-	82,500	-	90,000	+7,500
Rural Hospital Flexibility Grants	53,609	150,000	55,609	-	57,509	+1,900
State Offices of Rural Health	12,500	-	12,500	-	12,500	-
Radiation Exposure Screening and Education Program	1,834	-	1,834	-	2,734	+900
Black Lung	11,500	-	11,500	-	12,190	+690
Telehealth	29,000	15,000	34,000	-	36,500	+2,500
Rural Communities Opioid Response	110,000	-	110,000	-	165,000	+55,000
Rural Residency Planning and Development	10,000	-	10,500	-	12,700	+2,200
Tribal Health	-	15,000	-	-	-	-
Subtotal, Federal Office of Rural Health Policy	**318,294**	**180,000**	**329,519**	-	**400,209**	**+70,690**
PROGRAM MANAGEMENT	155,300	-	155,300	-	167,971	+12,671
FAMILY PLANNING	286,479	-	286,479	-	340,000	+53,521

	FY 2020		FY 2021		FY 2022	
	Final	FY 2020 Supplemental Funding /1,2,3,4	Enacted	FY 2021 Supplemental Funding/5	President's Budget	FY 2022 +/- FY 2021
FAMILY PLANNING Mandatory	-	-	-	50,000	-	-
Appropriation Table Match	**7,037,259**	**975,000**	**7,207,234**	**-**	**7,813,294**	**+606,060**
Funds Appropriated to Other HRSA Accounts:						
Vaccine Injury Compensation:						
Vaccine Injury Compensation Trust Fund (HRSA Claims)	260,400	-	310,567		316,778	+6,211
VICTF Direct Operations - HRSA	10,200	-	11,200		16,200	+5,000
Subtotal, Vaccine Injury Compensation	**270,600**	**-**	**321,767**	**-**	**332,978**	**+11,211**
Countermeasures Injury Compensation Program /6	-	-	-	-	5,000	+5,000
Discretionary Program Level:						
HRSA	7,056,073	975,000	7,226,048	-	7,832,108	+606,060
Vaccine Direct Operations Budget Authority	10,200	-	11,200	-	16,200	+5,000
Countermeasures Injury Compensation Program /6	-	-	-	-	5,000	+5,000
Total, HRSA Discretionary Program Level	**7,066,273**	**975,000**	**7,237,248**	**-**	**7,853,308**	**+616,060**
Mandatory Programs:	**4,818,900**	**1,320,000**	**4,819,358**	**9,430,000**	**4,699,826**	**-119,533**
Total, HRSA Program Level	**11,885,173**	**2,295,000**	**12,056,606**	**9,430,000**	**12,553,134**	**+496,528**
Less Programs Funded from Other Sources:						
User Fees	*-18,814*	-	*-18,814*	-	*-18,814*	-
Mandatory Programs	*-4,818,900*	*-1,320,000*	*-4,819,358*	*-9,430,000*	*-4,699,826*	*+119,533*
Total, HRSA Discretionary Budget Authority	**7,047,459**	**975,000**	**7,218,434**	**-**	**7,834,494**	**+616,060**

1/Includes $100 million in directed transfers to Health Centers from COVID-19 supplemental appropriations to the PHSSEF (PL 116-123). Excludes permissive transfers and additional funding allocated to HRSA.

2/Includes $1.32 billion in COVID-19 supplemental appropriations for Health Centers, and $275 million in directed transfers to HRSA for Rural Health ($180 million), Ryan White ($90 million), and Poison Control ($5 million) from COVID-19 supplemental appropriations to the PHSSEF (PL 116-136).

3/Includes $600 million in COVID-19 directed transfers to HRSA for Health Centers from COVID-19 supplemental appropriations to the PHSSEF (PL 116-139). Excludes permissive transfers and additional funding allocated to HRSA.

	FY 2020		FY 2021		FY 2022	
	Final	FY 2020 Supplemental Funding /1,2,3,4	Enacted	FY 2021 Supplemental Funding/5	President's Budget	FY 2022 +/- FY 2021
4/Excludes $2 billion allocated to HRSA for Health Care Provider Reimbursement from COVID-19 supplemental appropriations to the PHSSEF (PL 116-127 and PL 116-139). 5/Excludes $8.5 billion allocated to HRSA for Rural Provider Relief. Excludes permissive transfers and additional funding allocated to HRSA (PL 117-002). 6/Since October 2009, CICP has received funding from the Public Health and Social Services Emergency Fund (PHSSEF). 7/Mandatory funds subject to sequestration in FY 2022. 8/Mandatory funds subject to sequestration in FY 2021 and FY 2022. 9/Mandatory funds subject to sequestration in FY 2020, FY 2021, and FY 2022.						

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, **[**$1,683,772,000**]***$1,733,772,000*: Provided, That no more than $1,000,000 shall be available until expended for carrying out the provisions of section 224(o) of the PHS Act: Provided further, That no more than $120,000,000 shall be available until expended for carrying out subsections (g) through (n) and (q) of section 224 of the PHS Act, and for expenses incurred by the Department of Health and Human Services (referred to in this Act as "HHS") pertaining to administrative claims made under such law.

HEALTH WORKFORCE

For carrying out titles III, VII, and VIII of the PHS Act with respect to the health workforce, sections 1128E and 1921 of the Social Security Act, and the Health Care Quality Improvement Act of 1986, **[**$1,224,006,000**]***$1,380,384,000*: Provided, That sections 751(j)(2) and 762(k) of the PHS Act and the proportional funding amounts in paragraphs (1) through (4) of section 756(f) of the PHS Act shall not apply to funds made available under this heading: Provided further, That for any program operating under section 751 of the PHS Act on or before January 1, 2009, the Secretary of Health and Human Services (referred to in this title as the "Secretary") may hereafter waive any of the requirements contained in sections 751(d)(2)(A) and 751(d)(2)(B) of such Act for the full project period of a grant under such section: Provided further, That no funds shall be available for section 340G-1 of the PHS Act: Provided further, That fees collected for the disclosure of information under section 427(b) of the Health Care Quality Improvement Act of 1986 and sections 1128E(d)(2) and 1921 of the Social Security Act

shall be sufficient to recover the full costs of operating the programs authorized by such sections and shall remain available until expended for the National Practitioner Data Bank: Provided further, That funds transferred to this account to carry out section 846 and subpart 3 of part D of title III of the PHS Act may be used to make prior year adjustments to awards made under such section and subpart: Provided further, That **[**$120,000,000**]***$180,000,000* shall remain available until expended for the purposes of providing primary health services, assigning National Health Service Corps ("NHSC") members to expand the delivery of substance use disorder treatment services, notwithstanding the assignment priorities and limitations under sections 333(a)(1)(D), 333(b), and 333A(a)(1)(B)(ii) of the PHS Act, and making payments under the NHSC Loan Repayment Program under section 338B of such Act: **[**Provided further, That, within the amount made available in the previous proviso, $15,000,000 shall remain available until expended for the purposes of making payments under the NHSC Loan Repayment Program under section 338B of the PHS Act to individuals participating in such program who provide primary health services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (as those terms are defined by the Secretary), notwithstanding the assignment priorities and limitations under section 333(b) of such Act:**]** Provided further, That for purposes of the previous **[**two**]**proviso**[s]**, section 331(a)(3)(D) of the PHS Act shall be applied as if the term "primary health services" includes clinical substance use disorder treatment services, including those provided by masters level, licensed substance use disorder treatment counselors: **[**Provided further, That of the funds made available under this heading, $5,000,000 shall be available to make grants to establish or expand optional community-based nurse practitioner fellowship programs that are accredited or in the accreditation process, with a

preference for those in Federally Qualified Health Centers, for practicing postgraduate nurse practitioners in primary care or behavioral health.**]**

Of the funds made available under this heading, $50,000,000 shall remain available until expended for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions: Provided, That, in awarding such grants, the Secretary shall give priority to public institutions of higher education located in States with a projected primary care provider shortage in 2025, as determined by the Secretary: Provided further, That grants so awarded are limited to such public institutions of higher education in States in the top quintile of States with a projected primary care provider shortage in 2025, as determined by the Secretary: Provided further, That the minimum amount of a grant so awarded to such an institution shall be not less than $1,000,000 per year: Provided further, That such a grant may be awarded for a period not to exceed 5 years: Provided further, That amounts made available in this paragraph shall be awarded as supplemental grants to recipients of grants awarded for this purpose in fiscal years **[**2019**]***2020* and **[**2020**]***2021*, pursuant to the terms and conditions of each institution's initial grant agreement, in an amount for each institution that will result in every institution being awarded the same total grant amount over fiscal years **[**2019**]***2020* through **[**2021**]***2022*, provided the institution can justify the expenditure of such funds: 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, **[**$975,284,000**]***$1,100,084,000*: Provided, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than **[**$139,116,000**]***$220,116,000* 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, **[**$2,423,781,000**]***$2,554,781,000*, of which **[**$1,970,881,000**]***$2,010,881,000* shall remain available to the Secretary through September 30, **[**2023**]***2024*, 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 **[**$105,000,000**]***$190,000,000*, to remain available until expended, shall be available to the Secretary for carrying out a program of grants and contracts under title XXVI or section 311(c) of such Act focused on ending the nationwide HIV/AIDS epidemic, with any grants issued under such section 311(c) administered in conjunction with title XXVI of the PHS Act, including the limitation on administrative expenses.

HEALTH CARE SYSTEMS

For carrying out titles III and XII of the PHS Act with respect to health care systems, and the Stem Cell Therapeutic and Research Act of 2005, **[**$129,093,000**]***$136,093,000*, of which

$122,000 shall be available until expended for **[**facilities renovations at the Gillis W. Long Hansen's Disease Center**]** *and other facilities-related expenses of the National Hansen's Disease Program*.

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, **[**$329,519,000**]***$400,209,000*, of which **[**$55,609,000**]***$57,509,000* 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, $20,942,000shall 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, $12,500,000 shall be available for State Offices of Rural Health: Provided further, That **[**$10,500,000**]***$12,700,000* shall remain available through September 30, **[**2023**]***2024*, to support the Rural Residency Development Program: **[**Provided further, That $110,000,000 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**]***$340,000,000*: Provided, That amounts provided to said projects under such title shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that such amounts shall not be expended for any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office.

PROGRAM MANAGEMENT

For program support in the Health Resources and Services Administration, **[**$155,300,000**]***$167,971,000*: 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. 229 Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(a) in subsection (a)(5)(C)—

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

(2) by inserting at the end the following:

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

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

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

SEC. 237. The Secretary of Health and Human Services may waive penalties and administrative requirements in title XXVI of the Public Health Service Act for awards under such title from amounts provided under the heading "Department of Health and Human Services—Health Resources and Services Administration" in this or any other appropriations Act for this fiscal year, including amounts made available to such heading by transfer.

Language Analysis

LANGUAGE PROVISION	EXPLANATION
[Provided further, That, within the amount made available in the previous proviso, $15,000,000 shall remain available until expended for the purposes of making payments under the NHSC Loan Repayment Program under section 338B of the PHS Act to individuals participating in such program who provide primary health services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (as those terms are defined by the Secretary), notwithstanding the assignment priorities and limitations under section 333(b) of such Act:**]**	Specific set-aside language not necessary.
Provided further, That for purposes of the previous **[**two provisos**]** *proviso*, section 331(a)(3)(D) of the PHS Act shall be applied as if the term "primary health services" 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.
[Provided further, That of the funds made available under this heading, $5,000,000 shall be available to make grants to establish or expand optional community-based nurse practitioner fellowship programs that are accredited or in the accreditation process, with a preference for those in Federally Qualified Health Centers, for practicing postgraduate nurse practitioners in primary care or behavioral health.**]**	Specific set-aside language not necessary.
of which $122,000 shall be available until expended for **[**facilities renovations at the Gillis W. Long Hansen's Disease Center**]** *facility-related expenses at the National Hansen's Disease Program*.	Language amended to provide program flexibility to use building and facilities funding at the new and current facility

LANGUAGE PROVISION	EXPLANATION
[Provided further, That $110,000,000 shall be for the Rural Communities Opioids Response Program.**]**	Language removed because a separate funding proviso is unnecessary and duplicative.
Sec. 228 Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended— *(a) in subsection (a)(5)(C)—* *(1) by striking "A covered entity shall permit" and inserting "(i) DUPLICATE DISCOUNTS AND DRUG RESALE.—A covered entity shall permit;" and* *(2) by inserting at the end the following:* *"(ii) USE OF SAVINGS.—A covered entity shall permit the Secretary to audit, at the Secretary's expense, the records of the entity to determine how net income from purchases under this section are used by the covered entity.* *"(iii) RECORDS RETENTION.—Covered entities shall retain such records and provide such records and reports as deemed necessary by the Secretary for carrying out this subparagraph.".* *(b) by adding at the end the following new subsection: "(f) REGULATIONS.—The Secretary may promulgate such regulations as the Secretary determines necessary or appropriate to carry out the provisions of this section.".*	Provision to permit the Secretary to issue regulations on all aspects of the 340B Program and to require covered entities to report on the use of savings to ensure that net income from purchases under the 340B Drug Pricing Program benefit low-income and uninsured patients of the covered entities.
SEC. 237. The Secretary of Health and Human Services may waive penalties and administrative requirements in title XXVI of the Public Health Service Act for awards under such title from amounts provided under the heading "Department of Health and Human Services—Health Resources and Services Administration" in this or any other appropriations Act for this fiscal year, including amounts made available to such heading by transfer.	Language requested to reduce burden on recipients and increase flexibility for grant recipients thereby allowing them to use the funding to better address local needs.

Amounts Available for Obligation[10]

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
General Fund Discretionary Appropriation:			
Appropriation	$7,037,259,000	$7,207,234,000	$7,813,294,000
Coronavirus Preparedness/Response Supplemental Appropriation	+975,000,000		
Subtotal, adjusted general fund discretionary appropriation	**$8,012,259,000**	**$7,207,234,000**	**$7,813,294,000**
Mandatory Appropriation:			
Family to Family Health Information Centers	+6,000,000	+6,000,000	+6,000,000
Primary Health Care Access:			
Community Health Center Fund	+4,000,000,000	+4,000,000,000	+4,000,000,000
National Health Service Corps	+310,000,000	+310,000,000	+310,000,000
Subtotal Primary Health Care Access	**+4,310,000,000**	**+4,310,000,000**	**+4,310,000,000**
Maternal, Infant, and Early Childhood Home Visiting Program	+400,000,000	+400,000,000	+400,000,000
Teaching Health Centers Graduate Medical Education	+126,500,000	+126,500,000	+126,500,000
Coronavirus Preparedness/Response Supplemental Appropriations	+1,320,000,000		
American Rescue Plan Act		+9,430,000,000	
Transfer to the Department of Justice	-5,000,000	-5,000,000	-5,000,000
Mandatory Sequestration	-23,600,000	-23,142,000	-142,676,000
Subtotal, adjusted mandatory appropriation	**4,813,900,000**	**4,814,358,000**	**4,694,824,000**
Subtotal, adjusted appropriation	**$12,826,159,000**	**$12,021,592,000**	**$12,508,118,000**
Offsetting Collections	+18,814,000	+18,814,000	+18,814,000
Subtotal Spending Authority from offsetting collections	**+18,814,000**	**+18,814,000**	**+18,814,000**
Unobligated balance, start of year	+484,454,000	+ 467,222,000	+ 1,580,000,000
Unobligated balance, end of year	+ 467,222,000	+1,580,000,000	+365,000,000
Recoveries from prior year unpaid obligations	-96,674,000	-1,000,000	-
Unobligated balance, lapsing	-2,751,000	-	-
Total obligations	**$13,697,224,000**	**$14,086,628,000**	**$14,471,932,000**

[10] Excludes the following amounts for reimbursable activities carried out by this account: FY 2020 - 12,088,000 and 19 FTE; FY 2021- $12,100.000 and 32 FTE; FY 2022 $13,114,000 and 32 FTE

Authorizing Legislation[11,12]

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
PRIMARY HEALTH CARE:				
Health Centers (Discretionary): Public Health Service (PHS) Act, Section 330, as amended, including by P.L. 111-148, Section 5601; as amended by P.L. 115-123, Division E, Title IX, Section 50901; as amended by P.L. 116-136, Division A, Title III, Section 3211; as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Division BB, Title III, Section 311	Authorized for FY 2021 (and each subsequent year), an amount equal to the previous year's funding adjusted for any increase in the number of patients served and the per-patient costs	$1,562,722,000 Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle G, Section 2601, provides$7.6 billion in one-time mandatory funding for FY 2021 (available until expended) for health centers and community care (i.e., health centers, lookalikes, and Native Hawaiian entities), to address COVID-19.	Authorized for FY 2022 (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, 612,772,000
Health Centers (Community Health Center Fund) (Mandatory): P.L. 111-148, Patient Protection and Affordable Care Act, Section 10503(b)(1); as amended by P.L 111-152, Section 2303; as amended by P.L. 114-10, Section 221; as amended by P.L. 115-96, Division C, Title I, Section 3101; as amended by P.L. 115-123, Division E, Title IX, Section 50901; as amended by P.L. 116-59, Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Division B, Title I, Section 1101; as amended by P.L. 116-69, Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Division B, Title I, Section 1101; as amended by P.L. 116-94, Further Consolidated	$4,000,000,000	$4,000,000,000	$4,000,000,000	$3,905,348,000[13]

[11] 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.

[12] P.L. 116-136, the Coronavirus Aid, Relief, and Economic Security (CARES) Act, established discretionary COVID-19 appropriations, directed to the HHS Secretary, of which a portion was allocated to HRSA for a Provider Relief Fund (PRF). Also, P.L. 117-2, American Rescue Plan Act, Section 9911, amends the Social Security Act by adding a new Section 1150C that provides $8.5 billion in one-time mandatory funding (available until expended) for PRF payments to Medicare and Medicaid rural providers.

[13] Post-sequestration funding level.

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
Appropriations Act, 2020, Division N, Title I, Subtitle D, Sec. 401; as amended by P.L. 116-136, CARES Act, Division A, Title III, Section 3831; as amended by P.L. 116-159, Continuing Appropriations Act, 2021 and Other Extensions Act, Division C, Title I, Section 2101; as amended by P.L. 116-215, Further Continuing Appropriations Act, 2021, and Other Extensions Act, Division B, Title II, Section 1201; as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Division BB, Title III, Sec. 301 (see 42 U.S.C. 254b-2)				
Federal Tort Claims Act Coverage for Health Centers: PHS Act, Section 224(g)-(n), as added by P.L. 102-501; as amended by P.L. 103-183; P.L. 104-73; P.L. 108-163; and P.L. 114-255, Section 9025 (added subsection 224(q) for health center health professional volunteers)	$10,000,000 per fiscal year is authorized under Section 224. Note: This program is funded through annual appropriations that are typically made "available until expended" (i.e., no-year) appropriations.	$120,000,000	$10,000,000	$120,000,000
Federal Tort Claims Act Coverage for Free Clinics: PHS Act, Section 224(o), as added to the PHS Act by P.L. 104-191, Section 194; as amended by P.L. 111-148, Section 10608	$10,000,000 per fiscal year is authorized. Note: This program is funded through annual appropriations for this specific purpose that are typically made "available until expended" (i.e., no-year) appropriations.	$1,000,000	$10,000,000	$1,000,000
HEALTH WORKFORCE:				
National Health Service Corps (NHSC) (Discretionary) PHS Act, Sections 331-338, and 338A-H as amended by P.L. 110-355, Section 3; as amended by P.L. 111-148, Section 10501(n)(1)- (5)	Authorized for FY 2021 (and each subsequent year), based on previous year's funding, subject to adjustment formula	$120,000,000 Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle G , Section 2602, provides $800 million in one-time mandatory funding (available until	Authorized for FY 2022 (and each subsequent year), based on previous year's funding, subject to adjustment formula	$180,000,000

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
		expended) for carrying out sections 338A (NHSC Scholarship Program), 338B (NHSC Loan Repayment Program), and 338I (State Loan Repayment Program (SLRP)). Of that amount, $100 million is available for section 338I(a) (SLRP)		
NHSC (Fund) (Mandatory): P.L. 111-148, Patient Protection and Affordable Care Act, 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, Section 3101(b)(3)(F); as amended by P.L. 115-123, Section 50901, as amended by P.L. 116-59, Division B, Title I, Section 1101, as amended by P.L. 116-69, Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Division B, Title I, Section 1101, as amended by P.L. 116-94, Further Consolidated Appropriations Act, 2020, Division N, Title I, Subtitle D, Section 401; as amended by P.L. 116-136, CARES Act, Division A, Title III, Section 3831; as amended by P.L. 116-159, Continuing Appropriations Act, 2021 and Other Extensions Act, Division C, Title I, Section 2101; as amended by P.L. 116-215, Further Continuing Appropriations Act, 2021, and Other Extensions Act, Division B, Title II, Section 1201; as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Division BB, Title III, Section 301 (see 42 U.S.C. 254b-2)	$310,000,000	$310,000,000	$310,000,000	$292,330,000[14]

[14] Post-sequestration funding level.

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
Mental Health and Substance Use Disorder Training for Health Care Professionals, Paraprofessionals, and Public Safety Officers:	---	Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle H, Section 2703, provides $80 million in one-time mandatory funding (available until expended) for HRSA to award grants for mental and behavioral health training for professionals, paraprofessionals, and public safety officers. Consideration is to be taken for the needs of rural and medically underserved communities	---	
Grants for Health Care Providers to Promote Mental Health Among Their Health Professional Workforce	---	Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle H, Section 2705, provides an additional $40 million (available until expended) to HRSA to award grants for health care providers to promote mental and behavioral health among their health professional workforce. Consideration is to be taken for the needs of rural and medically underserved communities	---	
Students to Service Loan Repayment Program: PHS Act, Sections 338B, as amended by P.L. 107-251, Section 310; as amended by P.L. 108-163, Section 2; as amended by P.L. 111-148, Section 10501	Indefinite Note: An amount based on previous year's funding, subject to adjustment formula	---	Indefinite Note: An amount based on previous year's funding, subject to adjustment formula	--

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
State Loan Repayment Program (SLRP): PHS Act, Section 338I(a)-(i), as amended by P.L. 107-251, Section 315; as further amended by P.L. 110-355, Section 3(e)(2)	Expired Note: The Community Health Center/NHSC Fund (extended by P.L. 116-260), Consolidated Appropriations Act, 2021, Section 301, is used to make SLRP grants	Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle G, Section 2602: Of the $800 million in one-time mandatory funding (available until expended) that would be provided to NHSC, $100 million would be for SLRP, for which the state matching requirement shall not apply	Expired Note: The Community Health Center/NHSC Fund (extended by P.L. 116-260), Consolidated Appropriations Act, 2021, Section 301, is used to make SLRP grants	
Loan Repayments and Fellowships Regarding Faculty Positions (Faculty Loan Repayment): PHS Act, Section 738(a) and 740(b), as amended by P.L. 111-148, Sections 5402 and 10501(d); as amended by P.L. 116-136, CARES Act, Section 3401	$1,190,000	$1,190,000	$1,190,000	$2,310,000
Centers of Excellence: PHS Act, Section 736, as amended by P.L. 111-148, Section 5401); as amended by P.L. 116-136, CARES Act, Section 3401	$23,711,000	$23,711,000	$23,711,000	$26,711,000
Scholarships for Disadvantaged Students: PHS Act, Section 737, as amended by P.L. 111-148, Section 5402(b), authorization of appropriations in Section 740(a); as amended by P.L. 116-136, CARES Act, Section 3401	$51,470,000	$51,470,000	$51,470,000	$51,970,000
Health Careers Opportunity Program: PHS Act, Section 739, as amended by P.L. 111-148, Section 5402, authorization of appropriation in Section 740(c); as amended by P.L. 116-136, CARES Act, Section 3401	$15,000,000	$15,000,000	$15,000,000	$18,500,000
National Center for Workforce Analysis: PHS Act, Section 761(e), as amended by P.L. 111-148, Section 5103; as amended by P.L. 116-136, CARES Act, Section 3401	$5,663,000	$5,663,000	$5,663,000	$5,663,000

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
Primary Care Training and Enhancement: PHS Act, Section 747, as amended by P.L. 111-148, Section 5301; as amended by P.L. 116-136, CARES Act, Section 3401	$48,924,000	$48,924,000	$48,924,000	$48,924,000
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; as amended by P.L. 116-136, CARES Act, Section 3401	$28,531,000	$40,673,000	$28,531,000	$40,673,000
Graduate Medical Education for Physicians: as added by P.L. 115-245, Title II	$25,000,000 (until expended)	$50,000,000	$25,000,000 (until expended)	$50,000,000
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); as amended by P.L. 116-136, CARES Act, Section 3401	$41,250,000	$43,250,000	$41,250,000	$43,250,000
Behavioral Health Workforce Education and Training(BHWET): PHS Act, Sections 755, 756, and 760; as amended by P.L. 114-255, Section 9021 and P.L. 115-271, Section 7073	$50,000,000 for each of fiscal years 2021 through 2023	$112,000,000 Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle H, Section 2711, provides an additional $100 million in one-time mandatory funding (available until expended) to HRSA to award grants (under PHS Act, Section 756) to eligible institutions that provide mental and behavioral health education and training	$50,000,000	$224,874,000[15]

[15] Total amount appropriated to Behavioral Health Workforce Development Programs (includes MBHET)

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
Education and Training Related to Geriatrics [Geriatric Workforce Enhancement Program (GWEP) and Geriatric Academic Career Awards (GACA)]: PHS Act, Section 753, as amended by P.L. 111-148, Section 5305; as amended by P.L. 116-136, CARES Act, Section 3403	$40,737,000 for each of fiscal years 2021 through 2025	$42,737,000	$40,737,000	$46,537,000
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 P.L. 114-255, Section 9021; as amended by P.L. 115-271, Section 7073	(through FY 2023): PHS Act, Section 756, Subsection (a)(1)-- $15,000,000 Subsection (a)(2) $15,000,000; Subsection (a)(3): $10,000,000; Subsection (a)(4): $10,000,000	$37,916,000 Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle H, Section 2711, provides an additional $100 million in one-time mandatory funding (available until expended) to HRSA to award grants (under PHS Act, Section 756) to eligible institutions that provide mental and behavioral health education and training.	(through FY 2023): PHS Act, Section 756, Subsection (a)(1)-- $15,000,000 Subsection (a)(2) $15,000,000; Subsection (a)(3): $10,000,000; Subsection (a)(4): $10,000,000	$224,874,000[16]
Public Health /Preventive Medicine: PHS Act, Sections 765-7686, as amended by P.L. 111-148, Section 10501; as amended by P.L. 116-136, CARES Act, Section 3401 (amends PHS Act, Section 766) Note: PHS Act, Section 770 provides the authorization of appropriations for subpart 2 of Part E of Title VII, which includes Sections 765-768	$17,000,000	$17,000,000	$17,000,000	$18,000,000

[16] Total amount appropriated to Behavioral Health Workforce Development Programs 9includes BHWET)

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
Nursing Workforce Development: Advanced Education Nursing: PHS Act, Section 811, as amended by P.L. 111-148, Title V, Subtitle D, Section 5308; as amended by P.L. 116-136, CARES Act, Section 3404 Note: PHS Act, Section 871(a) provides an authorization of appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D, which includes PHS Act, Section 811	See PHS Act, Section 871(a) , which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D.	$80,581,000	See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D.	$80,581,000
Nursing Workforce Diversity PHS Act, Section 821, as amended by P.L. 111-148, Section 5404; as amended by P.L. 116-136, CARES Act, Section 3404 Note: PHS Act, Section 871(a) provides an authorization of appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D, which includes PHS Act, Section 821	See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D.	$19,843,000	See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D.	$23,343,0000
Nurse Education, Practice, Quality and Retention : PHS Act, Section 831 and *831A, as amended by P.L. 111-148, Sec. 5309; as amended by P.L. 116-136, the CARES Act, Section 3404 (*Note: PHS Act, Section 831A was struck by P.L. 116-136, CARES Act) Note: PHS Act, Section 871(a) provides an authorization of appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D, which includes PHS Act, Section 831	See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D.	$46,913,000	See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D.	$46,913,000
Nurse Faculty Loan Program: PHS Act, Section 846A, as amended by P.L. 111-148, Section 5311; as amended by P.L. 116-136, CARES Act, Section 3404 Note: PHS Act, Section 871(a) provides an authorization of appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D, which includes PHS Act, Section 846A	See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D.	$28,500,000	See PHS Act, Section 871(b), which authorizes appropriations of $117,135,000 for all programs under Title VIII Part E.	$28,500,000

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
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); as amended by P.L. 116-136, CARES Act, Section 3404 Note: PHS Act, Section 871(a) provides an authorization of appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D, which includes PHS Act, Section 846	See PHS Act, Section 871(b), which authorized appropriations of $117,135,000 for all programs under Title VIII Part E.	$88,635,000 Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle G, Section 2603, provides $200 million in one-time mandatory funding (available until expended) to the NURSE Corps	See PHS Act, Section 871(b), which authorized appropriations of $117,135,000 for all programs under Title VIII Part E.	$88,635,000
Children's Hospitals Graduate Medical Education (GME) 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, Section 1; as amended by P.L. 109-307, Section 2; as amended by P.L. 113-98, Sections 2, 3; as amended by P.L. 115-241, Section 2	Direct GME: $105,000,000 Indirect Medical Education: $220,000,000	$350,000,000	Direct GME: $105,000,000 Indirect Medical Education: $220,000,000	$350,000,000
Teaching Health Centers (THC) Graduate Medical Education (GME) 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), as amended by P.L. 115-96 Section 3101(c)(2); as amended by P.L. 115-123, Section. 50901 as amended by P.L. 116-59, Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Section 1101, as amended by P.L. 116-69, Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019,Section 1101, as amended by P.L. 116-94, Division N, Title I, Subtitle D, Section 401; as amended by P.L. 116-136, CARES Act, Section 3831; as amended by P.L. 116-159, Continuing Appropriations Act, 2021 and Other Extensions Act, Section 2101; as amended by P.L. 116-215, Further Continuing Appropriations Act, 2021, and Other Extensions Act, Section 1201;	$126,500,000 (Teaching Health Center GME Program, PHS Act, Section 340H)	$126,500,000 Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle G, Section 2604, provides $330 million in one-time mandatory funding (to remain available until September 30, 2023) to the THCGME Program (under PHS Act, Section 340H) to establish new residency programs, increase the per resident amount, maintain or expand existing residency programs, and make Teaching Health Center Development awards under PHS Act, Section 749A	$126,500,000 (Teaching Health Center GME Program, PHS Act, Section 340H)	$119,290,000[17]

[17] Post-sequestration funding level.

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Title III, Subtitle A, Section 301				
Teaching Health Centers (THC) Development Grants: PHS Act, Section 749A, as added by P.L. 111-148, Section 5508)	Indefinite – at such sums as may be necessary (Teaching Health Centers Development Grants, PHS Act, Section 749A)	Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle G, Section 2604, provides $330 million to THCGME and THC Development Grants in one-time mandatory funding (to remain available until September 30, 2023)	Indefinite – at such sums as may be-necessary (Teaching Health Centers Development Grants, PHS Act, Section 749A)	---
National Practitioner Data Bank: (User Fees) *Title IV, P.L. 99-660, Social Security Act (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 P.L. 115-320, Section 2, *added a new Subsection (k) authority for "Maternity Care Health Professional Target Areas"*	----	---	----	$5,000,000
Grants for Innovative Programs: PHS Act, Section 340G, as amended by P.L. 115-302, , Section 3	FY 2019-2023 $13,903,000	---	FY 2019-2023 $13,903,000	---
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant: Social Security Act, Title V	Indefinite at $850,000,000	$712,700,000	Indefinite at $850,000,000	$822,700,000
Autism Education, Early Detection and Intervention: PHS Act, Section 399BB, as added by P.L. 109-416, Section 3; as amended by P.L. 112-32, Section 2; as amended by P.L. 113-157, Section 4; as amended by P.L. 116-60, Autism Collaboration, Accountability, Research, Education, and Support Act of 2019, Section 3	$50,599,000 (through FY 2024)	$53,344,000	$50,599,000 (through FY 2024)	$57,344,000
Sickle Cell Service Demonstration Grants: P.L. 108-357, American Jobs Creation Act of 2004, Section 712(c), as	$4,455,000 (each of FY 2021 through FY 2023)	$7,205,000	$4,455,000 (each of FY 2021 through FY 2023)	$7,205,000

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
amended by P.L. 115-327, Section 3(b) (which transferred Section 712(c) of P. L. 108–357, and re-designated it as PHS Act, Section 1106				
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; as amended by P.L. 115-71, Section 2	$19,522,758	$17,818,000	$19,522,758	$17,818,000
Emergency Medical Services for Children: PHS Act, Section 1910, as amended by P.L. 105-392, Section 415; as amended by P.L. 111-148, Section 5603(1); as amended by P.L. 113-180, Section 2; as amended by the Emergency Medical Services for Children Program Reauthorization Act of 2019, P.L. 116-49, Section 2	$22,334,000 (through FY 2024)	$22,334,000	$22,334,000 (through FY 2024)	$28,134,000
Healthy Start: PHS Act, Section 330H, as added by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2; as amended by P.L. 116-136, CARES Act, Section 3225	$125,500,000	$128,000,000	$125,500,000	$128,000,000
Heritable Disorders: PHS Act, Section 1109-1112 and 1114, as amended by P.L. 106-310, Section 2601; as amended by P.L. 110-204, Section 2; as amended by P.L. 110-237, Section 1; as amended by P.L. 113-240, Section 10 (see PHS Act, Section 1117- relating to authorization levels for FY 2015 through 2019)	Expired (as of end of FY 2019)	$18,883,000	Expired (as of end of FY 2019)	$18,883,000
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 2021 through FY 2022)	$10,000,000 Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle H, Section 2712, provides $80 million in one-time mandatory funding (available until expended)	$9,000,000 (each of FY 2021 through FY 2022)	$10,000,000
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 2021 through FY 2022)	$5,000,000	$5,000,000 (each of FY 2021 through FY 2022)	$10,000,000

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
Family to Family Health Information Centers: Social Security Act, Section 501(c)(1)(A), as added by P.L. 109-171, Section 6064; reauthorized by P.L. 111-148, Sec. 5507(b), as amended by P.L. 112-240, Section 624; as amended by P.L. 113-67, Section 1203; as amended by P.L. 113-93, Section 207; as amended by P.L. 114-10, Section 216; as amended by P.L. 115-123, Section 50501; as amended by P.L. 116-39, Sustaining Excellence in Medicaid Act of 2019, Section 5	$6,000,000 (each of fiscal years 2021 through 2024)	$5,658,000[18]	$6,000,000 (each of fiscal years 2021 through 2024)	$5,658,000[19]
Maternal, Infant and Early Childhood Visiting (MIECHV) 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, Sec. 218; as amended by P.L. 115-123, Sections 50601-50607; as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Section 10; as amended by P.L. 117-2, American Rescue Plan Act, Title IX, Part 4, Section 9101 (new Social Security Act, Section 511A added after Section 511)	$400,000,000 (each of FY 2021 through FY 2022)	$377,200,000[20] Note: P.L. 117-2, American Rescue Plan Act, Title IX, Part 4, Section 9101, provides $150 million in one-time mandatory funding (through FY 2022) for the MIECHV Program for virtual home visits, emergency supplies and prepaid grocery cards.	$400,000,000 (each of FY 2021 through FY 2022)	$377,200,000[21]
HIV/AIDS:[22]				
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	$665,876,000
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	$1,345,005,000

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

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
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	$207,079,000
Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D: PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	$75,088,000	Expired	$75,088,000
AIDS Education and Training Centers - Part F: PHS Act, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	$33,611,000	Expired	$33,611,000
Dental Reimbursement Program - Part F: PHS Act, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415, as amended by P.L.111-87	Expired	$13,122,000	Expired	$13,122,000
Special Projects of National Significance - Part F: PHS Act, Section 2691, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	$25,000,000	Expired	$25,000,000
Ending HIV Epidemic Initiative: PHS Act, Section 311and PHS Act, Title XXVI	Not Specified	$105,000,000	Not Specified	$190,000,000
HEALTHCARE SYSTEMS:				
Organ Transplantation: 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	$29,049,000	Expired	$29,049,000
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	Expired (as of end of FY 2020)	$18,266,000	Expired (as of end of FY 2020)	$11,266,000
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	Expired (as of end of FY 2020)	$31,009,000	Expired (as of end of FY 2020)	$38,009,000

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
Poison Control: PHS Act, Sections 1271-1274, as amended by P.L. 108-194; as amended by P.L. 110-377; as amended by P.L. 113-77; as amended by P.L. 116-94, Further Consolidated Appropriations Act, 2020, Division N, Title I, Subtitle D, Section 403	Toll-free number: $700,000 Media campaign: $800,000 Grant program: $28,600,000 Note: The amounts authorized in the program's current authorizing statute are through FY 2024	$24,846,000	Toll-free number: $700,000 Media campaign: $800,000 Grant program: $28,600,000 Note: The amounts authorized in the program's current authorizing statute are through FY 2024	$24,846,000
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)	Indefinite – at such sums as may be necessary	$10,238,000	Indefinite – at such sums as may be necessary	$17,238,000
National Hansen's Disease Program: PHS Act, Section 320, as amended by P.L. 105-78, Section 211; as amended by P.L. 107-220	Not Specified	$13,706,000	Not Specified	$13,706,000
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	$122,000
Countermeasures Injury Compensation Program: PHS Act, Sections 319F-3 and 319F-4, as added by P.L. 109-148, Division C, Sections. 1 and 2, as amended by P.L. 113-5, Section. 402 (to Section 319F-3); as amended by P.L. 116-127, Families First Coronavirus Response Act, Sec.6005 (amends PHS Act, Section. 319F-3); as amended by P.L. 116-136, CARES Act Section 3103 (amends PHS Act, Sec. 319F-3)	Not Specified	---	Not Specified	$5,000,000

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
RURAL HEALTH:				
Rural Health Policy Development: Social Security Act, Section 711, and PHS Act, Section 301; as amended (to the Social Security Act, Section 711) by P.L. 108-173; and as amended (to the PHS Act, Section 301) by P.L. 114-255, Sections 2012, 2013, 2035, and 2043	Indefinite	$11,076,000	Indefinite	$11,076,000
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; as amended by P.L. 116-136, CARES Act, Section 3213	$79,500,000 (for each fiscal year through 2025)	$82,500,000	$79,500,000 (for each fiscal year through 2025)	$90,000,000
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	$55,609,000	Expired	$57,509,000
State Offices of Rural Health: PHS Act, Section 338J, as amended by P.L. 105-392, Section 301, and P.L. 115-408, Section 2	$12,500,000 (each of fiscal years 2021 through 2022)	$12,500,000	$12,500,000 (each of fiscal years 2021 through 2022	$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 (Note: FY 2009 expiration was struck by P.L. 109-482, Section 103)	$1,834,000	Not Specified (Note: FY 2009 expiration was struck by P.L. 109-482, Section 103)	$2,734,000
Black Lung: P.L. 91-173, Federal Mine Safety and Health Act, Section 427(a); as amended by P.L. 95-239, Black Lung Benefits Reform Act of 1977, Section 9	$10,000,000d	$11,500,000	$10,000,000	$12,190,000
Telehealth: PHS Act, Section 330I, as amended by P.L. 107-251, as amended by P.L. 108-163; as amended by P.L. 113-55, Section 103; as amended by P.L. 116-136, CARES Act, Section 3212	$29,000,000	$34,000,000	$29,000,000	$36,500,000
Rural Communities Opioid Response: SSA, Section 711, as added by P.L. 100-203, Section 4401; as amended by P.L. 100-360, Section 411(m)(1); as amended by P.L. 101-239, Section 6213(g); as amended by P.L. 108-173, Section 432	Not Specified	$110,000,000	Not Specified	$165,000,000

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
Rural Residency: SSA, Section 711(b)(5), as added by P.L. 100-203, Section 4401; as amended by P.L. 100-360, Section 411(m)(1); as amended by P.L. 101-239, Section 6213(g); as amended by P.L. 108-173, Section 432	Not Specified	$10,500,000	Not Specified	$12,700,000
OTHER PROGRAMS:				
Family Planning: Grants: PHS Act Title X	Expired	$286,479,000	Expired	$340,000,000
Program Management	Indefinite	$155,300,000	Indefinite	$167,971,000
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	$321,767,000	Indefinite	$338,152,000
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 Note: P.L. 115–123, Section 50901(b)(14) struck PHS Act, Subsection (s)	----	---	----	---
School Based Health Centers - Facilities Construction: P.L. 111-148, Section 4101(a); as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Title III, Subtitle A, Section 317	Such Sums As May Be Necessary through FY 2026	---	Such Sums As May Be Necessary through FY 2026	---
School Based Health Centers – Operations: PHS Act, Section 399Z-1, as added by P.L. 111-148, Section 4101(b); as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Title III, Subtitle A, Section 317	Such Sums As May Be Necessary through FY 2026	---	Such Sums As May Be Necessary through FY 2026	---
Health Information Technology Innovation Initiative: PHS Act, Section 330(e)(1)(C), (Grants for Operation of Health Center Networks and Plans), as amended	Such Sums As Are Necessary (within the Section 330 authorization)	---	Such Sums As Are Necessary (within the Section 330 authorization)	---
Health Information Technology Planning Grants: PHS Act, Section 330(c)(1)(B)-(C), as amended	Such Sums As Are Necessary (within the Section 330 authorization)	---	Such Sums As Are Necessary (within the Section 330 authorization)	---

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
Electronic Health Record Implementation Initiative: PHS Act, Section 330(e)(1)(C), as amended	Such Sums As Are Necessary (within the Section 330 authorization)	---	Such Sums As Are Necessary (within the Section 330 authorization)	---
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—111th Congress)	Expired	---	Expired	---
Health Professions Education in Health Disparities and Cultural Competency: PHS Act, Section 741, as amended by P.L. 111-148, Section 5307	Expired	---	Expired	---
Training Opportunities for Direct Care Workers PHS Act, Section 747A, as added by P.L. 111-148, Section 5302	Expired	---	Expired	---
Comprehensive Geriatric Education: PHS Act, Section 865, as re-designated by P.L. 111-148, Section 5310(b)	Expired	---	Expired	---
Continuing Education Support for Health Professionals Serving in Underserved Communities: PHS Act, Section 752, as amended by P.L. 111-148, Section 5403	Such Sums As May Be Necessary	---	Such Sums As May Be Necessary	---
Rural Interdisciplinary Training (Burdick) PHS Act, Section 754; as amended by P.L. 116-136, CARES Act, Section 3401	Not Specified	---	Not Specified	---
Grants for Pain Care Education & Training: PHS Act, Section 759, as added by P.L.111-148, Section 4305 and P.L. 115-271, Section 7073	Such Sums As May Be Necessary for each of the fiscal years 2019 through 2023 (amounts available until expended)	---	Such Sums As May Be Necessary for each of the fiscal years 2019 through 2023 (amounts available until expended)	---
Advisory Council on Graduate Medical Education: PHS Act, Section 762, as amended by P.L. 111-148, Section 5103; as amended by P.L. 116-136, CARES Act, Section 3401	Amounts otherwise appropriated under this PHS Act, Subchapter (V-Health Professions Education) may be utilized by the Secretary to support its activities of the Council	---	Amounts otherwise appropriated under this PHS Act, Subchapter (V-Health Professions Education) may be utilized by the Secretary to support its activities of the Council	---
Health Professions Education in Health Disparities and Cultural Competency: PHS Act, Section 807, as amended by P.L. 111-148, Section 5307	Expired	---	Expired	---

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
Minority Faculty Fellowship Program: PHS Act, Section 738 (authorized appropriation in PHS Act Section 740(b)), as amended by P.L.111-148, Sections. 5402, 10501; as amended by P.L. 116-136, CARES Act, Section 3401	$1,190,000	---	$1,190,000	---
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	Such Sums As Are Necessary (and for each subsequent fiscal year)	---	Such Sums As Are Necessary (and for each subsequent fiscal year)	---
Allied Health and Other Disciplines: PHS Act, Section 755; as amended by P.L. 116-136, CARES Act, Section 3401	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	---
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; as amended by P.L. 116-136, CARES Act, Section 3401	Such Sums As May Be Necessary	---	Such Sums As May Be Necessary	---
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, as added by P.L. 107-188, Section 159 (Public Access Defibrillation Demo), and P.L. 106-505, Section 413 (Rural Access to Emergency Devices)	Expired	---	Expired	---
Rural Emergency Medical Services Training and Equipment Assistance Program: PHS Act Section 330J, as amended by P.L. 115-334, Section12608	Such Sums As May Be Necessary (each of fiscal years 2021 through 2023)	---	Such Sums As May Be Necessary (each of fiscal years 2021 through 2023)	

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 President's Budget
Training Demonstration Program: PHS Act, Section 760, as added by P.L. 114-255, Section 9022	$10,000,000 (each of FY 2021-FY 2022)	---	$10,000,000 (each of FY 2021-FY 2022)	---
Liability Protections for Health Professional Volunteers at Community Health Centers: PHS Act, Section 224(q), as added by P.L. 114-255, Section 9025	Not Specified	---	Not Specified	---

Summary of Changes

2021 Enacted	$7,207,234,000
(Obligations)	($7,207,234,000)
2022 Estimate	$7,813,294,000
(Obligations)	($7,813,294,000)
2021 Mandatory	$4,819,358,000
(Obligations)	($4,819,358,000)
2022 Mandatory	$4,699,826,000
(Obligations)	($4,699,826,000)
Net Change	**$486,528,000**

No.	Program	FY 2021 Enacted		FY 2022 President's Budget	FY 2022+/- FY 2021	
		FTE	Budget Authority	Budget Authority	FTE	Budget Authority
		2,122			+84	
			$ 386,463,790	$ 404,505,103		+$18,041,313
			$ 386,463,790	$ 404,505,103		+ 18,041,313
			$ 386,463,790	$ 404,505,103		+ 18,041,313
			$ 386,463,790	$ 404,505,103		+$18,041,313
	Increases:					
	A. Built in:					
1	January 2022 Civilian Pay Raise		$ 2,351,219	+ 2,645,324		+$294,104
2	January 2022 Military Pay Raise		$ 714,632	+$759,465		+$44,832
3	Civilian Annualization of Jan. 2021		$ 2,429,593	+ 881,775		-1,547,819
4	Military Annualization of Jan. 2021		$ 244,151	+ 253,155		+ 9,004
	Subtotal, built-in increases		**$ 5,739,596**	**$ 4,539,718**		**-$1,199,878**
	B. Program:					
	Discretionary Increases					
1	Health Centers	345	1,562,772,000	1,612,772,000	-	+$50,000,000
2	NHSC	16	120,000,000	185,000,000	-	+$65,000,000
3	Loan Repayment/Faculty Fellowships	-	1,190,000	2,310,000	+ 1	+$1,120,000
4	Centers of Excellence	1	23,711,000	26,711,000	+ 1	+$3,000,000
5	Scholarships for Disadvantaged Students	7	51,470,000	51,970,000	-	+$500,000
6	Health Careers Opportunity Program	2	15,000,000	18,500,000	+ 1	+$3,500,000
7	Geriatric Programs	7	42,737,000	46,537,000	+ 1	+$3,800,000
8	Behavioral Hlth Workforce Development Prog.	15	149,916,000	224,874,000	+ 8	+$74,958,000
9	Public Health/Preventive Medicine	4	17,000,000	18,000,000	-	+$1,000,000
10	Nursing Workforce Diversity	3	19,843,000	23,343,000	-	+$3,500,000
11	Maternal and Child Health Block Grant	53	712,700,000	822,700,000	+ 17	+$110,000,000
12	Autism and Other Developmental Disorders	7	53,344,000	57,344,000	+ 1	+$4,000,000
13	Emergency Medical Services for Children	5	22,334,000	28,134,000	+ 1	+$5,800,000
14	Screening/Treatment for Maternal Depression	1	5,000,000	10,000,000	+ 1	+$5,000,000
15	Emergency Relief - Part A	48	655,876,000	665,876,000	-	+$10,000,000
16	Comprehensive Care - Part B	66	1,315,005,000	1,345,005,000	-	+$30,000,000
17	Early Intervention - Part C	59	201,079,000	207,079,000	+ 4	+$6,000,000
18	Ending HIV/AIDS Epidemic Initiative	29	105,000,000	190,000,000	-	+$85,000,000
19	340B Drug Pricing Prog./Office of Pharmacy Affairs	23	10,238,000	17,238,000	+ 2	+$7,000,000

No.	Program	FY 2021 Enacted		FY 2022 President's Budget	FY 2022+/- FY 2021	
		FTE	Budget Authority	Budget Authority	FTE	Budget Authority
		2,122			+84	
20	Rural Health Outreach Grants	8	82,500,000	90,000,000	+ 1	+$7,500,000
21	Rural Hospital Flexibility Grants	2	55,609,000	57,509,000	+ 1	+$1,900,000
22	Radiation Exposure Screening and Education Prog.	1	1,834,000	2,734,000	-	+$900,000
23	Black Lung	-	11,500,000	12,190,000	-	+$690,000
24	Telehealth	5	34,000,000	36,500,000	+ 1	+$2,500,000
25	Rural Communities Opioid Response	19	110,000,000	165,000,000	+ 2	+$55,000,000
26	Rural Residency Planning and Development	2	10,500,000	12,700,000	-	+$2,200,000
27	Program Management	871	155,300,000	167,971,000	+ 15	+$12,671,000
28	Family Planning	17	286,479,000	340,000,000	+ 18	+$53,521,000
	Subtotal Discretionary Program Increases	**1,616**	**5,831,937,000**	**6,437,997,000**	**+76**	**+$606,060,000**
	Mandatory Increases					
1	MIECHV Mandatory	45	377,200,000	377,200,000	+ 8	-
	Subtotal Mandatory Program Increases	**45**	**377,200,000**	**377,200,000**	**8**	**-**
	Decreases:					
	A. Built in:					
1	Pay Costs	**2,122**	**$ 386,463,790**	**$ 404,505,103**	**+84**	**+$18,041,313**
	Discretionary Decreases	-	-	-	-	-
	Subtotal Discretionary Program Decreases	-	-	-	-	-
	Mandatory Decreases[23]					
1	Teaching Health Centers GME	9	126,500,000	119,290,000	-	-7,210,000
2	Health Centers Mandatory	222	4,000,000,000	3,905,348,000	-	-94,652,000
3	NHSC Mandatory	230	310,000,000	292,330,000	-	-17,670,000
	Subtotal Mandatory Program Decreases	**461**	**4,436,500,000**	**4,316,968,000**	-	**-$119,532,000**
	Net Change Discretionary	**1,616**	**5,831,937,000**	**6,437,997,000**	**+76**	**+606,060,000**
	Net Change Mandatory	**506**	**4,813,700,000**	**4,694,168,000**	**+8**	**-119,532,000**
	Net Change Discretionary and Mandatory	**2,122**	**10,645,637,000**	**11,132,165,000**	**+84**	**+$486,528,000**

[23] The decreases in funding reflect the mandatory sequester.

Budget Authority by Activity
(Dollars in Thousands)

	FY 2020 Operating Level	FY 2021 Enacted	FY 2022 President's Budget
1. PRIMARY CARE:			
Health Centers:			
Health Centers	1,505,522	1,562,772	1,612,772
Health Centers Mandatory	4,000,000	4,000,000	3,905,348
Health Center Tort Claims	120,000	120,000	120,000
Subtotal, Health Centers	***5,625,522***	***5,682,772***	***5,638,120***
Free Clinics Medical Malpractice	1,000	1,000	1,000
Subtotal, Bureau of Primary Health Care	**5,626,522**	**5,683,772**	**5,639,120**
2. HEALTH WORKFORCE:			
National Health Service Corps (NHSC):			
NHSC	120,000	120,000	185,000
NHSC Mandatory	310,000	310,000	292,330
Subtotal, NHSC	***430,000***	***430,000***	***477,330***
Loan Repayment/Faculty Fellowships	1,190	1,190	2,310
Health Professions Training for Diversity:			
Centers of Excellence	23,711	23,711	26,711
Scholarships for Disadvantaged Students	51,470	51,470	51,970
Health Careers Opportunity Program	15,000	15,000	18,500
Subtotal, Health Professions Training for Diversity	***90,181***	***90,181***	***97,181***
Health Care Workforce Assessment	5,663	5,663	5,663
Primary Care Training and Enhancement	48,924	48,924	48,924
Oral Health Training Programs	40,673	40,673	40,673
Medical Student Education	50,000	50,000	50,000
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	41,250	43,250	43,250
Geriatric Programs	40,737	42,737	46,537
Behavioral Health Workforce Development Programs	138,916	149,916	224,874
Subtotal, Interdisciplinary, Community-Based Linkages	***220,903***	***235,903***	***314,661***
Public Health Workforce Development:			
Public Health/Preventive Medicine	17,000	17,000	18,000
Nursing Workforce Development:			
Advanced Nursing Education	80,581	80,581	80,581
Nursing Workforce Diversity	18,343	19,843	23,343
Nurse Education, Practice and Retention	43,913	46,913	46,913
Nurse Faculty Loan Program	28,500	28,500	28,500

	FY 2020 Operating Level	FY 2021 Enacted	FY 2022 President's Budget
NURSE Corps Scholarship and Loan Repayment Program	88,635	88,635	88,635
Subtotal, Nursing Workforce Development	***259,972***	***264,472***	***267,972***
Children's Hospital Graduate Medical Education	340,000	350,000	350,000
Teaching Health Center Graduate Medical Education	126,500	126,500	119,290
National Practitioner Data Bank (User Fees)	*18,814*	*18,814*	*18,814*
Subtotal, Bureau of Health Workforce (BHW)	**1,649,820**	**1,679,320**	**1,810,818**
3. MATERNAL & CHILD HEALTH:			
Maternal and Child Health Block Grant	687,700	712,700	822,700
Autism and Other Developmental Disorders	52,344	53,344	57,344
Sickle Cell Service Demonstrations	5,205	7,205	7,205
Early Hearing Detection and Intervention	17,818	17,818	17,818
Emergency Medical Services for Children	22,334	22,334	28,134
Healthy Start	125,500	128,000	128,000
Heritable Disorders	17,883	18,883	18,883
Pediatric Mental Health Care Access Grants	10,000	10,000	10,000
Screening and Treatment for Maternal Depression	5,000	5,000	10,000
Family-to-Family Health Information Centers Mandatory	6,000	5,658	5,658
Maternal, Infant and Early Childhood Home Visiting Program Mandatory	376,400	377,200	377,200
Subtotal, Maternal and Child Health Bureau	**1,326,184**	**1,358,142**	**1,482,942**
4. HIV/AIDS:			
Emergency Relief - Part A	655,876	655,876	665,876
Comprehensive Care - Part B	1,315,005	1,315,005	1,345,005
AIDS Drug Assistance Program (non-add)	*900,313*	*900,313*	*900,313*
Early Intervention - Part C	201,079	201,079	207,079
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	105,000	190,000
Subtotal, HIV/AIDS Bureau	**2,388,781**	**2,423,781**	**2,554,781**
5. HEALTHCARE SYSTEMS:			
Organ Transplantation	27,499	29,049	29,049
Cell Transplantation Program and Cord Blood Stem Cell Bank	47,275	49,275	49,275
Poison Control Centers	22,896	24,846	24,846
340B Drug Pricing Program/Office of Pharmacy Affairs	10,238	10,238	17,238

	FY 2020 Operating Level	FY 2021 Enacted	FY 2022 President's Budget
Hansen's Disease Center	13,706	13,706	13,706
Payment to Hawaii	1,857	1,857	1,857
National Hansen's Disease Program - Buildings and Facilities	122	122	122
Subtotal, Healthcare Systems Bureau	**123,593**	**129,093**	**136,093**
6. RURAL HEALTH:			
Rural Health Policy Development	10,351	11,076	11,076
Rural Health Outreach Grants	79,500	82,500	90,000
Rural Hospital Flexibility Grants	53,609	55,609	57,509
State Offices of Rural Health	12,500	12,500	12,500
Radiation Exposure Screening and Education Program	1,834	1,834	2,734
Black Lung	11,500	11,500	12,190
Telehealth	29,000	34,000	36,500
Rural Communities Opioid Response	110,000	110,000	165,000
Rural Residency Planning and Development	10,000	10,500	12,700
Subtotal, Federal Office of Rural Health Policy	**318,294**	**329,519**	**400,209**
7. PROGRAM MANAGEMENT	155,300	155,300	167,971
8. FAMILY PLANNING	286,479	286,479	340,000
Total, HRSA Discretionary Budget Authority	**7,037,259**	**7,207,234**	**7,813,294**
FTE (excludes Vaccine and CICP)	**2,122**	**2,491**	**2,657**

Appropriations History Table

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

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2017				
General Fund Appropriation:				
Base	5,733,481,000	5,917,190,000	6,155,869,000	6,213,347,000
Advance				
Supplemental				
Rescissions				
Transfers				-14,100,000
Subtotal	5,733,481,000	5,917,190,000	6,155,869,000	6,199,247,000
FY 2018				
General Fund Appropriation:				
Base	5,538,834,000	5,839,777,000	6,217,794,000	6,736,753,000
Advance				
Supplemental				
Rescissions				
Transfers				-15,857,000
Subtotal	5,538,834,000	5,815,727,000	6,217,794,000	6,720,897,000
FY 2019				
General Fund Appropriation:				
Base	9,559,591,000	6,540,385,000	6,816,753,000	6,843,503,000
Advance				
Supplemental				60,000,000
Rescissions				
Transfers				-20,897,087
Subtotal	9,559,591,000	6,540,385,000	6,816,753,000	6,882,605,973
FY 2020				
General Fund Appropriation:				
Base	5,841,352,000	7,326,109,000	6,928,714,000	7,037,259,000
Advance				
Supplemental				975,000,000
Rescissions				
Transfers				
Subtotal	5,841,352,000	7,326,109,000	6,928,714,000	8,012,259,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2021				
General Fund Appropriation:				
Base	6,289,085,000	7,195,758,000	7,104,535,000	7,207,234,000
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	6,289,085,000	7,195,758,000	7,104,535,000	7,207,234,000
FY 2022				
General Fund Appropriation:				
Base	7,813,294,000			
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal				

Appropriations Not Authorized by Law[24]

HRSA Program	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2021
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	---	---	---
Nursing Workforce Development • Comprehensive Geriatric Education – PHS Act, Section 865	2014	SSAN	4,350,000	---
Emergency Relief - Part A – PHS Act, Sections 2601-10, as amended by P.L. 106-345; as amended by P.L. 109-415; as amended by P.L. 111-87	2013	789,471,000	649,373,000	655,876,000
Comprehensive Care - Part B – PHS Act, Sections 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	1,562,169,000	1,314,446,000	1,315,005,000
Early Intervention Services – Part C – PHS Act, Sections 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	285,766,000	205,544,000	201,079,000
Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D – PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	87,273,000	72,395,000	75,088,000
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
Minority AIDS Initiative – Part F – PHS Act section 2693	2013	--	Varies by Part	--

[24] 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 2021
Heritable Disorders: PHS Act, Section 1109-1112 and 1114, as amended by P.L. 106-310, Section 2601; as amended by P.L. 110-204, Section 2; as amended by P.L. 110-237, Section 1; as amended by P.L. 113-240, Section 10 (see PHS Act, Section 1117- relating to authorization levels for FY 2015 through 2019)	2019	$11,900,000 (Sections 1109-1112); $8,000,000 (Section 1113) (through FY 2019)	$18,883,000	$18,883,000
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	29,049,000
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	2020	23,000,000	17,266,000	11,266,000
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	2020	30,000,000	30,009,000	38,009,000
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	55,609,000
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 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$1,505,522,000	$1,562,772,000	$1,612,772,000	+$50,000,000
Current Law Mandatory Funding	$4,000,000,000	$4,000,000,000	$3,905,348,000[25]	-$94,652,000
FTCA Program	$120,000,000	$120,000,000	$120,000,000	---
Total	**$5,625,522,000**	**$5,682,772,000**	**$5,638,120,000**	**-$44,652,000**
FTE	533	573	607	+34

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; Public Law 116-260.

FY 2022 Authorization: FY 2021 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 2022 Community Health Center Fund Authorization..... $4 billion.

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, behavioral health, and patient support/enabling services. Today, approximately 1,400 health centers operate over 13,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

In 2019, health centers served 29.8 million patients, one in every eleven people living in the United States, providing approximately 123 million patient visits, at an average cost of $1,044 per patient (including Federal and non-Federal sources of funding). In 2019, about 43 percent of

[25] FY 2022 reflects the post-sequestration funding amount.

all health centers served rural areas providing care to over 9 million patients, one in 5 people living in rural areas. Patient services are supported through Federal Health Center grants, Medicaid, Medicare, Children's Health Insurance Program (CHIP), other third party payments, self-pay collections, other Federal grants, and State/local/other resources.

Health Centers have performed a critical role in the U.S. response to the COVID-19 pandemic, while continuing to provide high quality primary health care services for the nation's underserved and vulnerable populations. Through the American Rescue Plan Act, HRSA is providing one-time funding to support health centers in responding to and mitigating the spread of COVID-19, and enhancing health care services and infrastructure. Improvements made with these funds will help health centers to continue meeting the needs of their patient population through the pandemic by providing equitable access to COVID-19 vaccination, testing, and treatment, and supporting critical health center construction, renovation, modernization and other facility improvements.

In addition, to ensure our nation's underserved communities and those disproportionately affected by COVID-19 are equitably vaccinated against COVID-19, HRSA in partnership with the Centers for Disease Control and Prevention (CDC) developed the Health Center COVID-19 Vaccine Program to directly allocate COVID-19 vaccines to HRSA-supported health centers. Through this program, millions of people living in the nation's medically underserved communities and those disproportionately affected by COVID-19 have received vaccines.

Health centers deliver high quality and value-based care by using key quality improvement practices, including health information technology. Seventy-seven 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 2019 including Healthy People 2020 goals for hypertension control and dental sealant services. Overall, 94 percent of health centers met or exceeded Healthy People 2020 goals for at least one clinical measure in 2019. 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[26].

Populations served: Health centers serve a diverse patient population. In 2019:

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

- People in poverty: Over 91 percent of health center patients are individuals or families living at or below 200 percent of the Federal Poverty Guidelines as compared to approximately 33 percent of the U.S. population as a whole.

[26] 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

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

- Special Populations: Some health centers receive specific funding to provide primary care services for certain special populations including individuals and families experiencing homelessness, agricultural workers, those living in public housing, and Native Hawaiians. Health centers served over 1.4 million individuals experiencing homelessness, more than 1 million agricultural workers and their families, over 5.1 million people living in or near public housing and nearly 9,000 Native Hawaiians.

    - Health Care for the Homeless Program: Homelessness continues to affect rural as well as urban and suburban communities in the United States. According to the Department of Housing and Urban Development's 2017 Annual Homeless Assessment Report to Congress, over 1.4 million people experienced sheltered homelessness. In 2018, HRSA-funded health centers provided primary care services for nearly 1.4 million persons in supportive housing and/or experiencing homelessness. The Health Care for the Homeless Program supports coordinated, comprehensive, integrated primary care including substance abuse and mental health services for homeless persons in the United States, serving patients that live on the street, in shelters, or in transitional housing.

    - Migrant Health Center Program: HRSA-funded health centers provided primary care services for over 1 million migratory and seasonal agricultural workers and their families. It is estimated that there are approximately 2.8 million migratory and seasonal agricultural workers in the United States (2016 LSC Agricultural Worker Population Estimate Update). The Migrant Health Center Program supports comprehensive, integrated primary care services for agricultural workers and their families with a particular focus on occupational health and safety.

    - Public Housing Primary Care Program: The Public Housing Primary Care Program increases access for residents of public housing to comprehensive, integrated primary care services. Health centers deliver care at locations on the premises of public housing developments or immediately accessible to residents. HRSA-funded health centers provided primary care services for over 5.1 million people living in or near public housing. The Public Housing Primary Care Program provides services that are responsive to identified needs of the residents and in coordination with public housing authorities.

    - Native Hawaiian Health Care Program: The Native Hawaiian Health Care Program, funded within the Health Center appropriation, improves the health of Native Hawaiians by making health education, health promotion, and disease prevention services available through a combination of outreach, referral, and linkage mechanisms. Services provided include nutrition programs, screening and control of hypertension and diabetes, immunizations, and basic primary care services. Native Hawaiian Health Care Systems provided medical and enabling services to nearly 9,000 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 2019 was 29.8 million; an increase of 11.0 million, or 66 percent, above the 18.8 million patients served in 2009. Of the 29.8 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 92 percent of health centers provide preventive dental services either directly or via contract. In 2019, health centers provided oral health services to over 6.7 million patients, an increase of 76 percent since 2010. In 2019, about 2.9 million people received behavioral health services at health centers, an increase of over 100 percent from 2014 to 2019 due to significant Health Center Program investments in behavioral health services.

From FY 2016 through FY 2019, HRSA invested $540 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 ongoing annual investments are projected to remain in health center continuation awards in FY 2020 and beyond, and 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 93 percent since 2016 with the number of patients receiving screening, brief intervention, referral and treatment (SBIRT) increasing from 716,677 in 2016 to 1,381,408 in 2019. From 2016–2019, the number of health center providers eligible to prescribe MAT increased over 300 percent (from 1,700 in 2016 to 7,095 in 2019) and the number of patients receiving MAT increased 266 percent (from 39,075 in 2016 to 142,919 in 2019).

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 2019, exceeding the target of 73.0 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 25 percent of the total health center patient population served in 2019. In 2019, the health center rate was 8.0 percent, lower than the 2019 national rate of 8.3 percent, and has consistently been lower than the national rate during the past several years.

Health center patients, including low-income individuals, racial/ethnic minority groups, and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate health disparities. The Health Center Program began reporting data from all grantees on the control of hypertension and diabetes via its Uniform Data System in 2008. In 2019, 65 percent of adult health center patients with diagnosed hypertension had blood pressure under adequate control (less than 140/90) compared to 61 percent[27] nationally. Additionally in 2019, 68 percent of adult health center patients with type 1 or 2 diabetes had their most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent) compared to 60 percent[28] nationally.

[27] 2019 National Committee for Quality Assurance, Medicaid HMO average.
[28] 2019 National Committee for Quality Assurance, Medicaid HMO average.

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 2020, more than three-fourths of HRSA-funded health centers were recognized as PCMHs. In addition, health centers have advanced quality and accountability by adopting Health Information Technology (HIT), including the use of certified Electronic Health Records (EHRs), telehealth and other technologies that advance and enable quality improvement. Over 99 percent of all health centers reported having an EHR in 2019.

Promoting Efficiency: Health centers provide cost-effective, affordable, quality primary health care services. The Program's efficiency measure tracks the ratio of medical patients per medical physicians in health centers, which focuses on maximizing the overall efficiency and scope of clinical provider teams, recognizing the valuable and cost effective contributions of physician assistants, nurse practitioners, and certified nurse midwives to health center patient access to comprehensive, quality primary care services. In 2018 and 2019, the number of medical patients per physician in health centers was approximately 1,780.

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 successfully manage hypertension by race/ethnicity. (Sripipatana A, Pourat N, Chen X, Zhou W, Lu C. Exploring racial/ethnic disparities in hypertension care among patients served by health centers in the United States. *J Clin Hypertens (Greenwich)*. 2019;21(4):489-498. doi:10.1111/jch.13504).

- Health center organizational characteristics positively associated with cancer screening rates include provider-patient staffing ratios, electronic health record status, percentage revenue from public capitated managed care, and local primary care provider availability. (Chuang E, Pourat N, Chen X, et al. Organizational Factors Associated with Disparities in Cervical and Colorectal Cancer Screening Rates in Community Health Centers. *J Health Care Poor Underserved*. 2019;30(1):161-181. doi:10.1353/hpu.2019.0014).

- NHSC clinicians complement non-NHSC clinicians in primary care and mental health care. They help enhance the provision of patient care in CHCs, particularly in dental and mental health services, the 2 major areas of service gaps. (Xinxin Han, Patricia Pittman, Clese Erikson, Fitzhugh Mullan, and Leighton Ku; "The Role of the National Health Service Corps Clinicians in Enhancing Staffing and Patient Care Capacity in Community Health Centers" Medical Care. 57(12):1002–1007, December 2019).

- Health centers' support for ambulatory care accreditation improve quality of care and reduce health disparities in underserved communities across the United States. (Nair S,

Chen J; “Improving Quality of Care in Federally Qualified Health Centers Through Ambulatory Care Accreditation” Journal of Healthcare Quality 2018 Oct; 40(5):301-309).

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

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

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

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

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

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

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

Federal Tort Claims Act (FTCA) Program: The Health Center Program administers the FTCA Program, under which participating health centers, their employees and eligible contractors may be deemed to be Federal employees qualified for medical malpractice liability protection under the FTCA. As Federal employees, they are immune from suit for medical malpractice claims while acting within the scope of their employment. The Federal Government assumes responsibility for such claims. In addition, the FTCA Program supports risk mitigation activities, including reviews of risk management plans and sites visits as well as risk management technical assistance and resources to support health centers. The enactment of the 21st Century Cures Act in December of 2016 extended liability protections for volunteers at deemed health centers under the FTCA Program. In accordance with the statute, HRSA implemented FTCA coverage for volunteers in FY 2018. Nearly 300 volunteers were covered under the FTCA Program in FY 2019. Overall, in FY 2018, 110 claims were paid totaling $109.3 million, in FY 2019, 150 claims were paid totaling $135 million, and in FY 2020, 117 claims were paid totaling $93.5 million. Currently, there are 770 FTCA Program claims outstanding. As the number of health center patients continues to grow, it is projected that the amount of annual claims paid will continue to increase through FY 2022.

Funding History

FY	Amount
FY 2018	$1,621,709,000
FY 2018 Mandatory	$3,825,000,000
FY 2019	$1,616,720,000
FY 2019 Mandatory	$4,000,000,000
FY 2020	$1,625,522,000
FY 2020 Mandatory	$4,000,000,000
FY 2021	$1,682,722,000
FY 2021 Mandatory	$4,000,000,000
FY 2022 President's Budget	$1,732,772,000
FY 2022 President's Budget - Mandatory	$3,905,348,000[29]

[29] FY 2022 reflects the post-sequestration amount.

Budget Request

The FY 2022 Budget Request for the Health Center Program is $1.73 billion in discretionary resources, which is an increase of $50.0 million from the FY 2021 Enacted level. In addition, FY 2021 Omnibus (P.L. 116-260), provided mandatory resources of $4.0 billion for each fiscal year through FY 2023. In 2022, Health Centers mandatory funding will be reduced by $94.7 million through sequestration pursuant to Balanced Budget and Emergency Deficit Control Act (BBEDCA). In FY 2022, the Health Center Program will provide care for approximately 29.8 million patients.

At the Budget Request level, the Health Center Program will continue to focus on the optimization of virtual care. The disproportionate impact of COVID-19 on vulnerable populations across the U.S. has highlighted the need to promote new, innovative ways to deliver primary health care services, including the increased use of technology and telehealth. It has also increased the awareness of the need to reduce health disparities among minority and at-risk populations and to better address the underlying health conditions that create elevated risks for heart attacks, strokes, and earlier death rates.

This request will ensure that current health centers can continue to provide essential primary health care services to their patient populations, including continuation of supplemental awards initiated in FY 2016 through FY 2019 targeting mental health services and substance use disorder services focusing on the treatment, prevention, and/or awareness of opioid abuse. The request also supports costs associated with the grant review and award process, operational site visits, information technology, and other program support costs. The FY 2022 Budget Request also supports $120 million for the FTCA Program, which is equal to the FY 2021 Enacted level.

The Ending the HIV Epidemic in the U.S. (EHE) initiative is an HHS-wide effort to reduce new infections by 75 percent in the first five years of the initiative and by 90 percent over a 10-year period, with the goal of decreasing the number of new HIV infections to fewer than 3,000 per year. The first phase of the EHE initiative is focused on 48 counties, Washington, D.C., San Juan (PR), and seven states that have a substantial rural HIV burden.

The HRSA Health Center Program provides HIV testing and prevention services, HIV care and treatment where appropriate, and also assists with responding quickly to HIV cluster detection efforts. The HRSA Health Center Programs' primary focus in the Ending the HIV Epidemic in the U.S. initiative is on expanding outreach, care coordination, and access to Pre-Exposure Prophylaxis (PrEP)-related services to people at high risk for HIV transmission through selected health centers in the identified jurisdictions. In FY 2020, the first year of the Initiative, HRSA provided $54 million in resources to 195 health centers that received Health Center/Ryan White Program funding and/or were located in close proximity to a Ryan White Program where no jointly funded health center currently existed in the target jurisdiction. In FY 2021, HRSA anticipates awarding approximately $48 million to support additional health center participation in the targeted jurisdictions.

The Budget Request level includes $152 million, including an additional $50 million in discretionary funding, which will support an additional 140 health centers, resulting in the total

participation of approximately 440 health centers across the country. The Health Centers Program will provide prevention and treatment services to people at high risk for HIV transmission, including Pre-Exposure Prophylaxis (PrEP)-related services, outreach, and care coordination through new grant awards in areas currently served by health centers.

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

The FY 2022 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 2022 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 2022 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 2022 target for the program's diabetes management measure is 67 percent of adult patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent).

The Health Center Program will continue to promote efficient, value-based care, and aims to keep the ratio of medical patients per medical physicians at approximately 1,775 patients. The FY 2022 Request also supports efforts to improve the value, quality, and program integrity in all

[30] 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

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.

The Health Center Program will also 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 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
1.I.A.1: Number of patients served by health centers (Output)	FY 2019: 29.8M Target: 27.2M (Target Exceeded)	29.8M	29.8M	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 2019: 92.5% 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 2019: 96% Target: 88% (Target Exceeded)	93%	93%	Maintain
1.I.A.2.d: Number of HIV tests conducted (Output)	FY 2019: 2.7M Target: 2.4M (Target Exceeded)	2.8M	3.0M	+0.2M
1.E.1 Medical cost per medical visit at health centers compared to the national cost[31]	FY 2018: $200 Target: Below National Cost (Discontinued)	Discontinued	Discontinued	N/A
1.E.2:Number of medical patients per medical physician in health centers	FY 2019: 1,777 Target: 1,777 (Baseline)	1,775	1,775	Maintain

[31] Measure discontinued and replaced due to data reliability, timeliness, and relevancy in a value-based health care system.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 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 2019: 8.0%, below national rate of 8.3% Target: Below national rate (Target Met)	Below national rate	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 2019: 65% Target: 63% (Target Exceeded)	63%	63%	Maintain
1.II.B.4: Percentage of adult health center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent) (Outcome)	FY 2019: 68% Target: 69% (Target Not Met, but improved)	67%	67%	Maintain
1.II.B.1: Percentage of pregnant health center patients beginning prenatal care in the first trimester (Output)	FY 2019: 74% Target: 73% (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 2019: 91% Target: 91% (Target Met)	91%	91%	Maintain
1.I.A.3: Percentage of health centers with at least one site recognized as a patient centered medical home (Output)	FY 2019: 76% Target: 65% (Target Exceeded)	75%	75%	Maintain

Grants Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 Budget Level
Number of Awards	1,392	1,376	1,376
Average Award	$3.6 million	$3.6 million	$3.6 million
Range of Awards	$400,000 – $23 million	$400,000 – $23 million	$400,000 – $23 million

Free Clinics Medical Malpractice

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
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 2022 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 2019, 12,015 health care providers received Federal malpractice insurance through the Free Clinics Medical Malpractice Program, slightly less than the Program target. In FY 2017, 237 clinics operated with FTCA deemed clinicians; in FY 2018, 239 clinics participated, and in FY 2019, 236 clinics participated, exceeding the program target in each year.

Promoting Efficiency: The Free Clinics Medical Malpractice Program is committed to improving overall efficiency by controlling the Federal administrative costs necessary to deem each provider. By restraining these annual administrative costs, the Program is able to provide an increasing number of clinicians with malpractice coverage, thus building the free clinic workforce capacity nationwide and increasing access to care for the target populations served by these clinics. In FY 2017 the cost was $7 per provider, which was unusually low due to no need to support system enhancement costs in FY 2017. Costs in FY 2018 were $38 per provider and in FY 2019 costs were $22 per provider. In each year, the Program performance target has been exceeded.

In FY 2020, there were no paid claims under the Free Clinics Medical Malpractice Program. There is 1 claim currently outstanding, and the Program Fund has a current balance of approximately $3.6 million.

Funding History

FY	Amount
FY 2018	$1,000,000
FY 2019	$1,000,000
FY 2020	$1,000,000
FY 2021 Enacted	$1,000,000
FY 2022 President's Budget	$1,000,000

Budget Request

The FY 2022 Budget request for the Free Clinics Medical Malpractice Program is $1.0 million, which is equal to the FY 2021 Enacted. 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 2022 focus on maintaining FY 2021 target levels for the number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage at 11,000, while also maintaining the number of free clinics operating with FTCA deemed 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 2022.

The FY 2022 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 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
2.I.A.1: Number of free clinic health care providers deemed eligible for FTCA malpractice coverage (Output)	FY 2019: 12,015 Target: 10,000 (Target Exceeded)	11,000	11,000	Maintain
2.1: Patient visits provided by free clinics sponsoring FTCA deemed clinicians (Output)	FY 2019: 563,197 Target: 475,000 (Target Exceeded)	500,000	500,000	Maintain
2.I.A.2: Number of free clinics operating with FTCA deemed clinicians (Output)	FY 2019: 236 Target: 220 (Target Exceeded)	220	220	Maintain
2.E: Administrative costs of the program per FTCA covered provider (Efficiency)	FY 2019: $22 Target: $75 (Target Exceeded)	$75	$75	Maintain

Health Workforce TAB

HEALTH WORKFORCE

National Health Service Corps (NHSC)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$120,000,000	$120,000,000	$185,000,000	+$65,000,000
Current Law Mandatory Funding	$310,000,000	$310,000,000	$292,330,000 [32]	-$17,670,000
Total	$430,000,000	$430,000,000	$477,330,000	+$47,330,000
FTE	220	249	264	+15

Authorizing Legislation: Public Health Service Act, Sections 331-338H, as amended by Public Law No: 116-260

FY 2022 Authorization 9/30/2023

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, 2020, there were 7,203 primary care HPSAs, 6,487 dental HPSAs, and 5,733 mental health HPSAs.

The NHSC recruits clinicians who demonstrate a commitment to serve the Nation's medically underserved populations at NHSC-approved sites, which are located in HPSAs. NHSC-approved sites provide care to individuals regardless of their ability to pay. As of September 30, 2020, there are 18,548 NHSC-approved sites across the United States. 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.

[32] FY 2022 reflects the post-sequestration funding amount.

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.

FY 2021 represented the largest field strength ever for NHSC. As of September 30, 2020, there are 16,299 primary care medical, dental, and mental and behavioral health practitioners providing service nationwide in the following programs:

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 response to the COVID-19 pandemic, the NHSC has enabled the program's clinicians to be increasingly flexible in their use of telemedicine. This has, in part, resulted in more than 40 percent of NHSC applicants indicating that their site currently uses telemedicine.

The NHSC is collaborating with HRSA's Primary Care Training and Enhancement (PTCE): Training Champions Program, the Addiction Medicine Fellowship (AMF), and the Teaching Health Center Graduate Medical Education (THCGME) Program to bolster the primary care and behavioral health workforce in rural and underserved communities. In FY 2021, the NHSC will provide a funding priority to applicants who have completed a fellowship through the PCTE: Training Primary Care Champions Program, the AMF Program, or a postgraduate medical or dental training program funded by HRSA through the THCGME Payment Program.

- The PCTE: Training Primary Care Champions program trains community-based primary care professionals to lead health care transformation, enhance recruitment and retention in community-based settings, and enhance academic-community partnerships to support positive community-based training experiences in underserved communities.
- The AMF Program trains addiction medicine specialists who work in underserved, community-based settings that integrate primary care with mental health disorders and substance use disorder (SUD) prevention and treatment services.

NHSC Substance Use Disorder (SUD) Workforce LRP: Since FY 2018, funding has been appropriated 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 supports the recruitment and retention of health professionals needed in underserved areas to provide evidence-based SUD treatment and prevent overdose deaths. Providers receive loan repayment assistance to reduce their educational financial debt in exchange for service at SUD Treatment Facilities.

SUD Providers include:

- Allopathic/Osteopathic Physicians, Nurse Practitioners, Physician Assistants with Drug Addiction Treatment Act 2000 Waivers
- Licensed or certified health professionals providing SUD services; and
- Licensed primary care and mental & behavioral health professionals.

NHSC Rural Community LRP: A portion of the FYs 2018- through 2021 appropriations provided funding for the NHSC Rural Community LRP, a program for providers working to combat the opioid epidemic in the nation's rural communities. The NHSC Rural Community LRP has made FY 2020 loan repayment awards in coordination with the Rural Communities Opioid Response Program initiative within the Federal Office of Rural Health Policy (FORHP) to provide evidence-based substance use treatment, assist in recovery, and to prevent overdose deaths across the nation.

Both the NHSC SUD LRP and the NHSC Rural Community LRP will continue to make FY 2021 awards to clinicians addressing the opioid crisis.

NHSC and the Indian Health Service (IHS): FYs 2019 through - 2021 appropriations directed funding to support -awards in the aforementioned NHSC LRPs 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 (ITUs). 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. The NHSC made awards to all eligible clinicians serving in ITUs in both FY 2019 and FY 2020. It should be noted, that these entities do not need directed funding to be eligible to receive providers that are supported through NHSC scholarship and loan repayment activities. In FY 2021, NHSC set aside $15 million towards awards for providers in these entities. In FY 2022, NHSC anticipates an additional $15 million in funding for these providers.

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

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

The combination of these programs serves the immediate needs (through loan repayers) of underserved communities and supports the development of a pipeline (through Scholars and Students to Service awardees) poised to meet the needs of these communities upon completion of their training. The tables below show the students in the NHSC pipeline that are training to serve the underserved and the number and type of primary care providers currently serving in the NHSC and providing care in underserved areas. States receiving funding from this opportunity are encouraged to allow health professionals to practice to the full extent of their license.

NHSC Student Pipeline by Program as of 09/30/2020

Programs	**Students**
Scholarship Program	1,106
Students to Service Program	421
Total	**1,527**

NHSC Student Pipeline by Discipline as of 09/30/2020

Disciplines	**Students**
Allopathic/Osteopathic Physicians	950
Dentists	315
Nurse Practitioners	78
Physician Assistants	156
Certified Nurse Midwives	28
Total	**1,527**

NHSC Field Strength by Program as of 09/30/2020

Programs	Clinicians
Scholarship Program Clinicians	573
Loan Repayment Program Clinicians	10,237
State Loan Repayment Program Clinicians	2,146
SUD Workforce Loan Repayment Program	2,240
Rural Community Loan Repayment Program	645
Student to Service Loan Repayment Program	388
Total	**16,229**

NHSC Field Strength by Discipline as of 09/30/2020

Disciplines	Clinicians
Allopathic/Osteopathic Physicians	2,304
Dentists	1,568
Dental Hygienists	428
Nurse Practitioners	3,082
Physician Assistants	1,324
Nurse Midwives	207
Mental and Behavioral Health Professionals	7,173
Other State Loan Repayment Program Clinicians	143
Total	**16,229**

Average NHSC New Award by Program as of 09/30/2020

Program	Average Award Amount
Scholarship Program	$236,624
Students to Service Loan Repayment Program	$116,878
Loan Repayment Program	$41,044

NHSC is committed to continuous performance improvement. The short-term retention rate among NHSC participants who completed their service obligation in FY 2019 is 81 percent, meaning that more than 2,000 clinicians continue to provide primary care services to underserved communities 1-2 years after completing their service commitment. In FY 2019, HRSA began using a newly-developed Clinician Dashboard to calculate retention rate for NHSC providers[33]. The Clinician Dashboard uses National Provider Identifier numbers from the Centers for Medicare and Medicaid Services as a baseline in conjunction with other data sources to assist in determining the current practice locations of providers who previously served in the NHSC. It allows HRSA to calculate a more accurate retention rate that is not dependent on survey response rates.

[33] Bureau of Health Workforce Clinician Dashboards.

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

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

Program Specific Eligibility: For NHSC SP, participants must be enrolled or accepted for enrollment as a full-time student pursuing a degree in a NHSC-eligible discipline at an accredited health professions school or program located in a State, the District of Columbia, or a U.S. territory.

For all NHSC LRPs participants must be practicing in a NHSC-eligible discipline with qualified student loan debt for education that led to their degree; maintaining a current, full, unencumbered, unrestricted health professional license, certificate, or registration to practice in the discipline and State in which the loan repayer is applying to serve, and either have accepted a position to work or are currently working in a NHSC-approved site in a HPSA.

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

For the NHSC Students to Service LRP participants must be enrolled as a full-time student in the final year at a fully accredited medical school located in an eligible allopathic or osteopathic degree program or school of dentistry. Medical students must be planning to complete an accredited primary medical care residence in a NHSC-approved specialty.

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

Funding History

FY	Amount
FY 2018 Discretionary	$105,000,000
FY 2018 Current Law Mandatory	$310,000,000
FY 2019 Discretionary	$120,000,000
FY 2019 Current Law Mandatory	$310,000,000
FY 2020 Enacted Discretionary	$120,000,000
FY 2020 Current Law Mandatory	$310,000,000
FY 2021 Discretionary Enacted	$120,000,000
FY 2021 Current Law Mandatory	$310,000,000
FY 2022 Discretionary Request	$185,000,000
FY 2022 Current Law Mandatory	$292,330,000[34]

Budget Request

The FY 2022 discretionary National Health Service Corps (NHSC) Budget Request of $185.0 million is $65.0 million above the FY 2021 Enacted level. The FY 2021 Omnibus, P.L. 116-260, provided mandatory resources of $310.0 million for each fiscal year through FY 2023.[35] In 2022, NHSC mandatory funding will be reduced by $17.7 million through sequestration pursuant to Balanced Budget and Emergency Deficit Control Act (BBEDCA).

The discretionary request includes $180.0 million specifically for loan repayment for clinicians to provide opioid and substance use disorder treatment, of which $15.0 million will be for clinicians serving in ITUs, and $5.0 million for Maternity Care Target areas to implement requirements contained in the Improving Access to Maternity Care Act. Specifically, the Maternity Care Target areas funding will: (1) establish criteria for maternity care health professional target areas (MCTAs), that identify geographic areas within primary care health professional shortage areas (HPSAs) that have a shortage of maternity care health professionals; (2) identify MCTAs using the criteria established by HRSA; (3) distribute maternity care health professionals using the newly-identified MCTAs; and (4) collect and publish data comparing the availability and need for maternity care health services in HPSAs and in areas within such HPSAs. The funding will allow HRSA's data contractors to enhance data collection capabilities and will allow State Primary Care Office grantees the ability to hire or implement additional data collection methodologies for the newly included provider types that MCTAs will track.

In FY 2022, the NHSC program anticipates making 137 new and 12 continuation scholarship awards, 4,404 new and 2,728 continuation loan repayment awards and 167 Students to Service loan repayment awards.

[34] FY 2022 reflects the post-sequestration amount.
[35] FY 2022 and FY 2023 are subject to sequestration.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
4.I.C.1: Number of individuals served by NHSC clinicians (Outcome)	FY 2020: 17.0 Million Target: 14.8 Million (Target Exceeded)	15.7 million	15.95 million	+0.25 million
4.I.C.2: Support field strength (participants in service) of the NHSC (Outcome)	FY 2020: 16,229 Target: 13,700 (Target Exceeded)	14,338	15,187	+849
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 2020: 81% Target: 80% (Target Exceeded)	80%	80%	Maintain
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants. (Efficiency) (Baseline: FY 2007 = 0.8%)	FY 2019: 1.3% Target: <2.0% (Target Exceeded)	≤ 2.0%	≤ 2.0%	Maintain
4.I.C.6: Number of NHSC sites (Outcome)	FY 2020: 18,548 Target: 18,000 (Target Exceeded)	18,000	18,000	Maintain

Loan Repayments/Scholarships Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Loan Repayments	$355,000,000	$311,000,000	$338,762,000
State Loan Repayments	$15,000,000	$19,000,000	--[36]
Scholarships	$38,000,000	$37,000,000	36,608,000
Students to Service Loan Repayment	$20,000,000	$19,000,000	$20,000,000

NHSC Awards Table

Program	2014	2015	2016	2017	2018	2019	2020	2021	2022
Scholarships	190	196	205	181	222	200	251	149	137
Scholarship Continuation	7	11	8	7	7	11	12	20	12
Loan Repayment	2,775	2,934	3,079	2,554	3,262	4,012	5,963	3,963	4,404
Loan Repayment Continuations	2,105	1,841	2,111	2,259	2,384	2,385	2,355	2,350	2,728
State Loan Repayment	464	620	634	535	625	812	712	783	---[37]
Students to Service Loan Repayment	79	96	92	175	162	127	148	158	167
Total Awards	**5,620**	**5,698**	**6,129**	**5,711**	**6,662**	**7,547**	**9,441**	**7,423**	**7,448**

[36] SLRP will be funded by the $100 million set aside for the program in the American Rescue Plan. It will be competed in FY 2022
[37] *Ibid*

NHSC Field Strength Table as of 9/30/2020

Program:	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Scholars	459	458	437	405	463	506	573	540	545
Loan Repayment	7,648	8,062	8,593	8,362	8,849	10,221	13,122	13,524	12,778
Students to Service Loan Repayment	1,135	1,136	1,378	179	277	369	388	517	456
State Loan Repayment	-	27	85	1,233	1,350	1,957	2,146	1,250	1408
Total Field Strength	**9,242**	**9,683**	**10,493**	**10,179**	**10,939**	**13,053**	**16,229**	**15,831**	**15,187**

Faculty Loan Repayment Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$1,190,000	$1,190,000	$2,310,000	$1,120,000
FTE	---	---	1	+1

Authorizing Legislation: Public Health Service Act, Sections 738 and 740, as amended by Public Law No: 116-13.

FY 2022 Authorization $1,190,000

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. FLRP awards a maximum of $40,000 for a two-year service obligation. The employing institution must also make payments to the faculty member that match the amount paid by HRSA. In FY 2020, FLRP made 20 new loan repayment awards. In FY 2021, FLRP anticipates making 21 new loan repayment awards.

Funding History

FY	Amount
FY 2018	$1,187,000
FY 2019	$1,184,000
FY 2020	$1,190,000
FY 2021 Enacted	$1,190,000
FY 2022 President's Budget	$2,310,000

Budget Request

The FY 2022 Budget Request for the Faculty Loan Repayment Program (FLRP) of $2.3 million is an increase of $1.1 million above the FY 2021 Enacted level. In FY 2021, FLRP will make 21 awards and in FY 2022, FLRP will make approximately 40 awards. The additional funding will fund more awardees, supporting the program's aims to recruit and retain health professions

faculty members and to encourage students to pursue faculty roles in their chosen health care field.

Loans Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	20	21	40

Health Professions Training for Diversity

Centers of Excellence

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$23,711,000	$23,711,000	$26,711,000	+$3,000,000
FTE	1	1	2	+1

Authorizing Legislation: Public Health Service Act, Section 736, as amended by Public Law No: 116-136.

FY 2022 Authorization $23,711,000

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

The Centers of Excellence (COE) Program provides grants to health professions schools and other public and nonprofit health or educational entities to serve as innovative resource and education centers for the recruitment, training and retention of underrepresented minority (URM) students and faculty. These award recipients also focus on facilitating faculty and student research on health issues particularly affecting URM groups. In FY 2020 and FY 2021, the COE Program supported 19 grantees. In FY 2022, the COE Program will be open for new competition and anticipates supporting approximately 22 grantees.

In Academic Year 2019-2020, the COE Program supported 141 training programs and activities designed to prepare individuals either to apply to a health professions training program or to maintain enrollment in such programs during the academic year. Award recipients develop programming focused on mentorship and academic support, and faculty recruitment and development. These programs supported 1,359 trainees across the country with stipend support of whom 99 percent were considered underrepresented minorities in the health professions. In addition, 72 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 4,934 students of whom 3,246 completed their programs. Seventy-nine percent of the 3,246 students that completed the program were underrepresented minorities.

Grantees partnered with 216 health care delivery sites, to provide 3,728 clinical training experiences to health professions trainees. The clinical experiences are designed to help prepare health professions students to provide quality health care to diverse populations. The training emphasizes the importance of cultural competency and the impact of health disparities on overall

health outcomes. Approximately 30 percent of training sites used by COE grantees were primary care settings and 43 percent were in medically underserved communities.

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

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

Funding History

FY	Amount
FY 2018	$23,652,000
FY 2019	$23,593,000
FY 2020	$23,711,000
FY 2021 Enacted	$23,711,000
FY 2022 President's Budget	$26,711,000

Budget Request

The FY 2022 Budget Request for the Centers of Excellence program of $26.7 million is $3.0 million above the FY 2021 Enacted level. In FY 2020, the COE program made 19 awards and in FY 2021, the COE program will continue supporting these 19 grantees. The COE program also plans to continue supporting health workforce activities that strengthen the national capacity to produce a high quality, diverse healthcare workforce. These funds support HBCUs and other minority serving intuitions. In FY 2022, COE program anticipates making approximately 22 awards.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [38]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
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 2019: 17% Target: 13% (Target Exceeded)	18%	13%	-5%
6.I.C.21: Percent of program participants who received academic retention support and maintained enrollment in a health professions degree program	FY 2019: 51% Target: 50% (Target Exceeded)	40%	50%	+10%

Program Activity Data

COE Program Outputs	Year and Most Recent Result	FY 2020 Target	FY 2021 Target	FY 2022 Target
Number of health professions students participating in research on minority health-related issues	FY 2019: 619	600	600	600
Number of faculty members participating in research on minority health-related issues	FY 2019: 509	500	500	500

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	19	19	22
Average Award	$1,173,423	$1,173,423	$1,173,423
Range of Awards	$615,000-$3,177,641	$615,000-$3,177,641	$615,000-$3,177,641

[38] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.

Scholarships for Disadvantaged Students

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$51,470,000	$51,470,000	$51,970,000	+$500,000
FTE	6	7	7	---

Authorizing Legislation: Public Health Service Act, Sections 737 and 740, as amended by Public Law No: 116-136

FY 2022 Authorization $51,470,000

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 FY 2020, the SDS Program had 86 grantees and it is anticipated that the SDS program will continue to have 86 grantees in FY 2021 and FY 2022.

In Academic Year (AY) 2019-2020, the SDS Program provided scholarships to 2,992 students from disadvantaged backgrounds, slightly above the FY 2019 target. The majority of students were considered under-represented minorities (URMs) in their prospective professions (65 percent).

Additionally, 1,325 students who received SDS-funded scholarships successfully graduated from their degree programs by the end of Academic Year 2019-2020. Upon graduation, 68 percent intended to work or pursue additional training in medically underserved communities, and 49 percent intended to work or pursue additional training in primary care settings. In response to the COVID-19 pandemic, 28 percent of training sites offered COVID-19 related services and 22 percent of students received COVID-19 related training.

HRSA recently completed a five-year review of SDS data. Between AY 2014-2019, SDS trained 12,356 students. One hundred percent of students across all five years were from environmentally, economically, or educationally disadvantaged backgrounds; sixty-four percent were underrepresented minorities. Throughout the five-year period, the program invested nearly $190 million in scholarship dollars. In addition, 92 percent of students received one or more type of academic support and 76 percent received one or more type of social support. Through these investments, 7,306 students completed the program graduating and receiving health professions degrees. Over 2,800 of graduates received degrees in professions with known

shortages. Sixty-eight percent of graduates reported that they intended to work in a medically underserved community. One year later, 51 percent of the 3,793 who provided follow-up data were already working in medically underserved areas.

In FY 2020, SDS directed funds to educate midwives to address the national shortage of maternity care providers, and specifically to address the lack of diversity in the maternity care workforce. Additionally, in an effort to combat health workforce shortages, approximately 24 percent of funds were designated to for graduate programs in behavioral and mental health and 23 percent were designated for programs in Allied Health.

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

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

Funding History

FY	Amount
FY 2018	$48,705,000
FY 2019	$48,726,000
FY 2020	$51,470,000
FY 2021 Enacted	$51,470,000
FY 2022 President's Budget	$51,970,000

Budget Request

The FY 2022 Budget Request for the Scholarships for Disadvantaged Students program of $51.97 million is $.500 million above the FY 2021 Enacted level. In FY 2021, the SDS program anticipates making 86 awards, In FY 21, the SDS program will expose students to primary care and placements in Medically Underserved Communities (MUCs) by improving distribution, diversity, and supply of primary care providers; improving and strengthening the health profession and nursing workforce by facilitating the entry of individuals from disadvantaged backgrounds into those professions, and improving quality and access to healthcare to individuals in MUCs. The additional funds in FY 2022 will be used to support the 86 current grantees in increasing the number of scholarship awards distributed to students.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[39]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.22: Number of disadvantaged students with scholarships	FY 2019: 2,992 Target: 2,800 (Target Exceeded)	2,390	2,500	+110

Program Activity Data

SDS Program Outputs	Year and Most Recent Result	FY 2020 Target	FY 2021 Target	FY 2022 Target
Number of URM students with scholarships	FY 2019: 1,946	1,869	1,500	1,500
Percent of students who are URMs	FY 2019: 65%	62%	62%	62%

[39] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	86	86	86
Average Award	$558,824	$558,824	$558,824
Range of Awards	$137,676-$650,000	$137,676-$650,000	$137,676-$650,000

Health Careers Opportunity Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$15,000,000	$15,000,000	$18,500,000	+$3,500,000
FTE	1	2	3	+1

Authorizing Legislation: Public Health Service Act, Sections 739 and 740(c) as amended by Public Law No: 116-136.

FY 2022 Authorization $15,000,000

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

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

These HCOP activities are an integral part of structured programming for students throughout the academic year. Exemplary activities of HCOP grantees include post-baccalaureate, summer, and other programs that provide disadvantaged students with often previously unheard of knowledge, experiences, and opportunities to participate in individualized and tailored academic coursework and community work in the health professions school areas. In addition, the HCOP National Ambassador Program, a longitudinal, integrated curriculum-based program, provides assist to students from disadvantaged backgrounds with matriculating through the educational pipeline. The current five-year project period ends on August 31, 2023.

In Academic Year 2019-2020, the National HCOP Academies supported 174 training programs and activities to promote interest in the health professions among prospective, disadvantaged students. In total, HCOP grantees reached 2,841 disadvantaged trainees across the country through structured programs. The establishment of National HCOP Academies is aimed at increasing the numbers of students in formal-structured programs in order to meet established targets.

HCOP grantees partnered with 167 sites to provide 3,549 clinical health profession trainings in primary care, emphasizing experiences in rural and underserved communities for HCOP student

trainees (e.g., academic institutions, community-based organizations, and hospitals). Approximately 55 percent of these training sites were located in medically underserved communities and/or rural settings. In response to the COVID-19 pandemic, 22 training sites offered COVID-19 related services. Additional students participated in HCOP activities and programs as well bringing 4,259 total students into the health professions pipeline of whom 2,813 completed their training.

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

Funding History

FY	Amount
FY 2018	$14,154,000
FY 2019	$14,118,000
FY 2020	$15,000,000
FY 2021 Enacted	$15,000,000
FY 2022 President's Budget	$18,500,000

Budget Request

The FY 2022 Budget Request for the Health Careers Opportunity Program (HCOP) of $18.5 million is $3.5 million above the FY 2021 Enacted level. In FY 2021, HCOP made 21 awards. In FY 2022, the additional funds will be used for supplemental funding for the current 21 HCOP grantees. The primary purpose for these supplemental funds will be to expand programmatic efforts to increase recruitment of students desiring to enter the health professions. This includes community colleges and other educational entities, which have strategic partnerships that enable support for diverse trainees to work towards earning a health professions degree that will allow them to eventually provide health care in rural and underserved communities.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[40]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.51: Number of HCOP trainees from disadvantaged backgrounds participating in academic programming, clinical training and/or student support services	FY 2019: 4,259 (Baseline)	N/A	5,200	N/A
6.I.C.52: Percent of HCOP health professions program completers who intend to work in primary care settings	FY 2019: 2% (Baseline)	N/A	2%	N/A

Program Activity Data

HCOP Outputs	Year and Most Recent Result	FY 2020 Target	FY 2021 Target	FY 2022 Target
Total number of URM students participating in all HCOP programs	FY 2019: 2,671	3,000	3,000	3,200

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	21	21	21
Average Award	$653,957	$653,957	$820,957
Range of Awards	$572,361-$665,227	$572,361-$665,227	$739,361-$832,227

40 Most recent results are for Academic Year 2019-2020 and funded in FY 2019.

Health Care Workforce Assessment

The National Center for Health Workforce Analysis

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$5,663,000	$5,663,000	$5,663,000	---
FTE	5	8	8	---

Authorizing Legislation: Public Health Service Act, Sections 761, 792, and 806(f), as amended by Public Law 116-136.

FY 2022 Authorization $5,663,000

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments:

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

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

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

NCHWA continues to model supply and demand of health professionals across a range of health occupations, and makes health workforce information available through reports and online databases. Several publications have been released during Calendar Years 2019 through 2021

- Women's Health Service Provider Projections, 2018-2030
- Oral Health Workforce Projections, 2017-2030
- Behavioral Health Workforce Projections, 2017-2030
- Allied Health Workforce Projections, 2016-2030

NCHWA also oversees nine Health Workforce Research Centers that perform and disseminate research and data analysis on health workforce issues of national importance, and provide technical assistance to regional and local entities on workforce data collection, analysis, and reporting.[41] Together, these nine Centers examine a broad range of issues related to various sectors of the health care workforce, including (but not limited to) occupations in Oral Health, Long Term Services and Supports, Allied Health, Behavioral Health, emerging health workforce issues, and health equity in health workforce education and training. Research conducted by these HWRCs aims to strengthen the evidence base for effective education and training programs that can enable and empower a health workforce capable of fostering and ensuring health equity for all populations. Examples of research include:

- Looking across a range of health care professions and providers to develop a comprehensive picture of how current health workforce education and training programs incorporate consideration of health equity, including social needs, social determinants of health, and related elements, into their programs.
- Developing a deeper understanding of the current behavioral health workforce and its readiness related to addressing the current opioid public health emergency.
- Investigating in real-time the impact of the COVID-19 pandemic on sectors of the U.S. health workforce, such as long term services and support occupations.
- Evaluating health workforce education and training programs to understand their impact on how increasing access to primary care; mitigating provider shortages in underserved areas; delivering integrated primary, behavioral, and oral health care; addressing health workforce diversity; and strengthening community/provider partnerships.

In FY 2020, NCHWA continued to develop a projection model that allows a more sophisticated analysis and projection of health workforce supply and demand, taking into account changing national demographics, the demand for health care services, and the impact those changes have on the delivery of health care. NCHWA anticipates publicly releasing a new interactive projection visualization tool in FY 2021.

In an effort to better understand and demonstrate the outcomes of BHW programs, NCHWA has been developing and publicly releasing Program Accomplishment and Outcomes reports for grant programs overseen by the Bureau of Health Workforce. The eleven reports released in FY 2021 highlight the ways in which BHW programs have impacted access, supply, distribution and quality of the health workforce.

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

Funding History

FY	Amount
FY 2018	$5,663,000
FY 2019	$5,635,000
FY 2020	$5,663,000
FY 2021 Enacted	$5,663,000
FY 2022 President's Budget	$5,663,000

Budget Request

The FY 2022 Budget Request for NCHWA of $5.7 million is the same as the FY 2021 Enacted level.

In FY 2021 and FY 2022, NCHWA will continue to deliver reports and evaluations that support the Administration's goal of better understanding the impact of the COVID-19 pandemic on the U.S. health care workforce, as well as advancing current efforts to understand and document BHW's role in enhancing access, supply, distribution and quality of the US health workforce. Additionally, the NCHWA will continue its work on improving access to behavioral health services, including substance use treatment and prevention services. This includes collecting data and conducting studies on models of behavioral health care delivery systems, the extent of their use, and the staffing ratios required to implement those systems. This new information will soon be incorporated into NCHWA's projection model to enhance its capabilities with emerging models of care.

Further, the NCHWA will continue to disseminate information from and utilize data within the 2018 National Sample Survey of Registered Nurses, to help better understand the nation's nursing profession, as well as federal investments in nursing education and training. Finally, NCHWA will recompete its cooperative agreement for the Health Workforce Research Centers in FY 2022.

Grants Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	9	9	9
Average Award	$500,000	$500,000	$500,000
Range of Awards	$447,164-$900,000	$447,164-$900,000	$447,164-$900,000

Primary Care Training and Enhancement Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$48,924,000	$48,924,000	$48,924,000	---
FTE	6	6	6	---

Authorizing Legislation: Public Health Service Act, Section 747, as amended by Public Law No: 116-136.

FY 2022 Authorization .....$48,924,000.

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

Program Description and Accomplishments:

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

Program	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Primary Care Training and Enhancement	$21,201,184	$21,201,184	$21,201,184
Training Primary Care Champions	$7,513,767	$7,513,767	$7,513,767
Academic Units for Primary Care Training and Enhancement	$4,467,071	$4,467,071	$4,467,071
Primary Care Training and Enhancement: Integrating Behavioral Health and Primary Care (PCTE-IBHPC) Program	$3,598,770	$3,598,770	$3,598,770
Primary Care Training and Enhancement (PCTE) - Physician Assistant (PA) Program	$3,081,542	$3,081,542	$3,081,542
Primary Care Training and Enhancement: Residency Training in Primary Care (PCTE-RTPC)	$9,061,666	$9,061,666	$9,061,666

The PCTE Program includes eight cohorts:

Primary Care Training and Enhancement (PCTE): The PCTE Program is designed to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, teachers, and researchers. The PCTE Program is focused on training for transforming health care systems, particularly enhancing the clinical training experience of trainees.

In Academic Year 2019-2020, PCTE grantees trained 2,728 primary care residents and fellows, 6,673 medical students, 1,960 students in physician assistant programs, and 2,833 students from collaborating interprofessional disciplines (including public health students, psychology students, dental students, and nursing students) for a total of 14,194 trainees, 3,796 of whom completed their programs at the end of the academic year. PCTE grantees partnered with 1,140 health care delivery sites (e.g., physician's offices, hospitals, and ambulatory practice sites) to provide clinical training experiences to trainees.

Approximately 28 percent of the sites offered substance use treatment services and 17 percent of the sites offered COVID-19 related services. Approximately 54 percent of these sites were located in medically underserved communities, 26 percent were located in rural areas, and 61 percent were primary care settings. Approximately 62 percent of trainees received training in substance use treatment, 67 percent received training in opioid use treatment, 25 percent received COVID-19 related training, and 30 percent received training in telehealth.

With regard to the continuing education of the current workforce, PCTE grantees delivered 142 unique continuing education courses that focused on emerging issues in the field of primary care to 6,927 faculty members and current practicing providers. In addition, PCTE grantees developed or enhanced and implemented 1,541 different curricular activities, most of which were new academic courses, clinical rotations, and workshops for health professions students, residents and fellows that reached 39,823 trainees. PCTE grantees also supported 196 different faculty-focused training programs and activities during the academic year, reaching 4,236 faculty-level trainees. The last cohort for the PCTE grantees will end on June 30, 2021.

Primary Care Medicine and Dentistry Clinician Educator Career Development Award: The Primary Care Medicine and Dentistry Clinician Educator Career Development Awards, which support the development of future clinician educator faculty and leaders in primary care medicine and dentistry while also supporting innovative projects that involve the transformation of health care delivery systems.

In Academic Year 2019-2020, the Primary Care Medicine and Dentistry Clinician Educator Career Development Award program supported 22 faculty, including 15 individuals from the field of medicine, 5 in dentistry, and 2 physician assistants. In addition, grantees developed or enhanced 105 curricula activities offered to 7,390 individuals. Grantees also sponsored 113 faculty development activities to 977 faculty members, and grant-funded faculty taught 74 courses to 3,154 students and advanced trainees.

Academic Units for Primary Care Training and Enhancement:
The Academic Units for Primary Care Training and Enhancements strengthens the primary workforce by establishing, maintaining or improving academic units or programs that improve clinical teaching and research in the fields of family medicine, general internal medicine, or general pediatrics. The primary care workforce is an essential component of any high functioning health care system. Six Academic Units (AUs) for Primary Care Training and Enhancement grants were awarded in 2016. The overarching goal of the program is to improve primary care clinical teaching and research to strengthen the primary care workforce. Academic Units achieve this goal through: 1) systems-level research to inform primary care training; 2) dissemination of best practices and resources; and 3) community of practice activities to promote the widespread enhancement of primary care training to produce a diverse, high quality primary care workforce. The AUs completed two research projects and two research policy briefs in FY 2020. Selected research was published in a supplemental issue of the Journal Health Care for the Poor and Underserved in November 2020 entitled *National Academic Units for Primary Care Training and Enhancement, HRSA*. The six projects have completed webinar series, as well as vetted resource materials for use by faculty and practicing physicians.

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

In Academic Year 2019-2020, PCTE-TPCC provided fellowships to 122 physicians and 28 physician assistants, of which 34 were from an underrepresented minority background and 70 reported coming from a rural or disadvantaged background. Among the physicians, 70 were from Family Medicine, 25 were from Internal Medicine, 22 were from Pediatrics, one was from Internal Medicine/Family Medicine, and the remainder from Internal Medicine/Pediatrics. PCTE-TPCC recipients developed or enhanced and implemented 266 different curricular activities, most of which were new academic courses, continuing education courses, and workshops that reached 1,458 trainees. PCTE-TPCC fellows also participated in 61 different faculty-focused training programs and activities during the academic year. Approximately 45 percent of fellows received training in substance use treatment, 49 percent received specific training on integrated behavioral health in primary care, 30 percent received COVID-19 related training, and 28 percent received training in telehealth.

Primary Care Training and Enhancement (PCTE): Integrating Behavioral Health and Primary Care (IBHPC) Program: In FY 2020, HRSA supported 9 PCTE-IBHPC Programs to fund innovative training programs that integrate behavioral health care into primary care, particularly in rural and underserved settings with a special emphasis on the treatment of opioid use disorder.

In Academic Year 2019-2020, PCTE-IBHPC provided training to 390 individuals, of which 265 were from an underrepresented minority background and 85 reported coming from a rural or disadvantaged background. Approximately 82 percent of trainees received training in primary care settings and 47 percent were trained in MUC areas.

Primary Care Training and Enhancement (PCTE) - Physician Assistant (PA) Program: In FY 2020, HRSA supported 11 PCTE-PA programs to increase the number of primary care physician assistants, particularly in rural and underserved settings, and improve primary care training in order to strengthen access to and delivery of primary care services nationally.

In Academic Year 2019-2020, the PCTE-PA program trained 43 physician assistants (PAs), 79 percent of which were underrepresented minorities or from disadvantaged backgrounds. One hundred percent of PAs received training in substance use treatment, opioid use treatment, integrated behavioral health in primary care, and COVID-19; ninety-one percent received training in telehealth. Grantees offered 81 courses and training activities, which reached an additional 2,392 trainees. In addition, grantees partnered with 148 sites to offer clinical training experiences. Thirty-seven percent of sites were in primary care settings, 38 percent in rural settings, and 19 percent in medically underserved communities. In response to COVID-19, 66 percent of sites offered COVID-19 related services.

Primary Care Training and Enhancement (PCTE) – Residency Training in Primary Care: In FY 2020, HRSA established the PCTE-Residency Training in Primary Care to enhance accredited residency training programs in family medicine, general internal medicine, general pediatrics or combined internal medicine and pediatrics (med-peds) in rural and/or underserved areas, and encourage program graduates to choose primary care careers in these areas. The PCTE-Residency Training Program in Primary Care will report data for the first time in July 2021. Results will be reported in the 2023 Congressional Justification.

Primary Care Training and Enhancement (PCTE) – Community Prevention and Maternal Health: In FY 2021, HRSA established the PCTE – Community Prevention and Maternal Health to train primary care physicians in maternal health care clinical services or population health in order to improve maternal health outcomes. The program will increase the number of primary care physicians trained in public health and general preventive medicine with maternal health care expertise and the number of primary care physicians trained in enhanced obstetrical care practicing in rural and/or underserved areas. The Notice of Funding Opportunity was issued on December 11, 2020. The program is funded for an estimated $15,783,000 and will award approximately 26 grants.

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 2018	$48,802,000
FY 2019	$48,680,000
FY 2020	$48,924,000
FY 2021 Enacted	$48,924,000
FY 2022 President's Budget	$48,924,000

Budget Request

The FY 2022 Budget Request of $48.9 million is the same as the FY 2021 Enacted level. In FY 2022, PCTE plans to make 98 continuation awards. The request prioritizes funding for health workforce activities that include training primary care physicians in maternal health and obstetrical care and primary care residency training in rural and/or underserved areas. Both the PCTE-CPMH and PCTE-RTPC aim to increase the distribution of primary care physicians who are ready to practice in and lead the transformation of healthcare systems aimed at improving access and quality of care.

Outcomes and Outputs Table[42]

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[43]	FY 2021 Target[44]	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.24: Number of physicians completing a Bureau of Health Workforce-funded residency or fellowship	FY 2019: 830 Target: 700 (Target Exceeded)	200	200	Maintain
6.I.C.25: Number of physicians graduating from a Bureau of Health Workforce-funded medical school	FY 2019: 1,584 Target: 1,000 (Target Exceeded)	200	N/A[45]	N/A
6.I.C.26: Number of physician assistants graduating from a Bureau of Health Workforce-funded program	FY 2019: 590 Target: 300 (Target Exceeded)	100	200	+100

[42] The PCTE Program supports primary care workforce growth and diversification, curricular innovations, and development of academic *infrastructure*. The current outcome measures reflect these objectives. Awards emphasize new and evidence-based education strategies such as interprofessional education and care, community based practice experience, and education responsive to learners' and patients' needs, the evaluation and outcome measures are adjusted accordingly.
[43] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.
[44] New FY 2020 NOFO focuses solely on primary care medical residents in ACGME-approved medical residencies. Grants funding medical schools and physician assistant schools are not renewed. New residency programs will steadily increase number of graduates as these programs are three years in length.
[45] This measure will be discontinued in FY 2022 as new grants will focus support on medical residencies and physician assistant training programs.

Program Activity Data

PCTE Program Outputs	Year and Most Recent Result	FY 2020 Target	FY 2021 Target[46]	FY 2022 Target
Percent of physician and physician assistant trainees receiving at least a portion of their clinical training in an underserved area	FY 2019: 46%	50%	50%	50%
Percent of physician and physician assistant graduates and program completers who are minority and/or from disadvantaged backgrounds	FY 2019: 30%	30%	30%	30%
Number of physicians training in a Bureau of Health Workforce-funded residency or fellowship	FY 2019: 2,728	2,000	300	400
Number of medical students training in a Bureau of Health Workforce-funded medical school	FY 2019: 6,673	4,000	300	N/A
Number of physician assistant students training in a Bureau of Health Workforce-funded program	FY 2019: 1,960	1,000	200	400

[46] New FY 2020 NOFO focuses solely on primary care medical residents in ACGME-approved medical residencies. Grants funding medical schools are not renewed. New residency programs will steadily increase number of graduates as these programs are three years in length.

Grant Awards Table[47]

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	121	115	98
Average Award	$381,444	$425,426	$499,339
Range of Awards	$93,800-$749,962	$185,849-$600,000	$299,000-$600,000

[47] This table includes the PCTE portion of the 22 awards for the Primary Care Medicine and Dentistry Clinician Educator Career Development Program, which is co-funded by the Oral Health Programs. The FY 2020 award amount is approximately $4 million. Nearly $3 million from PCTE and $1.08 million from Oral Health Programs. This table includes the $3 million in PCTE funds; the Oral Health Program funds are accounted for in the Grants Award Table below.

Oral Health Training Programs

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$40,673,000	$40,673,000	$40,673,000	---
FTE	6	6	6	---

Authorizing Legislation: Public Health Service Act, Sections 748 and 340G,[48] as amended by Public Law No: 116-136.

FY 2022 Authorizations:.....$28,531,000

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 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene[49] and Dental Faculty Loan Repayment	$26,675,000	$26,675,000	$26,675,000
State Oral Health Workforce Improvement Grant	$13,998,000	$13,998,000	$13,998,000

Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program: The Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program aims to improve access to, and the delivery of, oral health care services by increasing the supply of qualified health care workforce and enhancing health care workforce education and training. These programs do this through educational programs, which integrate oral health and primary care, through interprofessional health care teams, and educating the workforce to provide patient-centered care addressing the social determinants of health, incorporating age-friendly health care,

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

[49] 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.

and caring for individuals with complex medical conditions. This Program also supports the Primary Care Medicine and Dentistry Clinician Educator Career Development Awards and the Primary Care Dental Faculty 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. Due to the well-documented need for developing faculty in dental academia the Dentistry Clinician Educator Career Development Program's next funding opportunity announcement will focus on dentistry and oral health specifically. Previously, this program focused only on full time-faculty and has now been expanded to develop community-based, part-time faculty. Most dental school faculty do not have access to a formal faculty development program. Changes to the program will improve the competence of full-time, part-time and community-based faculty to develop/enhance training focused on improving care for vulnerable and underserved populations. Additionally, this programmatic change incorporates feedback from listening sessions with dental directors/dentists working at community health centers

In Academic Year 2019-2020, grantees of the Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program trained 11,121 dental and dental hygiene students in pre-doctoral training degree programs; 494 dental residents and fellows in advanced primary care dental residency and fellowship training programs; and 256 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 non-profit 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 Development and Loan Repayment Program: The purpose of this program is to increase the number of dental and dental hygiene faculty in the workforce by assisting dental and dental hygiene training programs attract and retain faculty through loan repayment.

In Academic Year 2019-2020, the Dental Faculty Development and Loan Repayment Program provided financial support to 38 dental faculty with a median award of $25,795 in direct financial support. Nine reported a rural background, fifteen a disadvantaged background and twelve were underrepresented minorities. Grantees developed or enhanced 82 curricula that were offered to 2,993 individuals. In addition, grantees sponsored 58 faculty development programs for 256 dental faculty. Faculty funded through the Dental Faculty Development and Loan Repayment Program offered 87 courses to 2,739 advanced trainees from general dentistry (78 percent) and pediatric dentistry (7 percent).

Dental Faculty Loan Repayment Program: The purpose of this program is to enhance recruitment and retention of dental faculty through faculty loan repayment and faculty development.

In Academic Year 2019-2020, the Dental Faculty Loan Repayment Program provided financial support to 64 dental faculty with a median award of $15,550 in direct financial support. Seven reported a rural background, fourteen a disadvantaged background, and twenty-four were underrepresented minorities. Grantees sponsored 34 faculty development programs for 167

dental faculty. Faculty funded through the Dental Faculty Loan Repayment Program offered 94 courses to 3,166 trainees.

Eligible Entities: Programs of general, pediatric, or public health dentistry in public or private nonprofit dental or dental hygiene schools, or approved residency or advanced education programs in the practice of general, pediatric, or public health dentistry.

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

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

In Academic Year 2019-2020, the State Oral Health Workforce Improvement Grant Program continued to carry out community-based prevention activities authorized under statute. Grantees established 11 new oral health facilities for children with unmet needs in dental HPSAs, and expanded seven oral health facilities in dental HPSAs to provide education, prevention, and restoration services to 10,084 patients.

Grantees also supported 43 teledentistry facilities, replaced two water fluoridation systems to provide optimally fluoridated water to 9,522 individuals, provided dental sealants to 7,492 children, provided topical fluoride to 38,008 individuals, provided diagnostic or preventive dental services to 43,440 persons, and provided oral health education to 92,493 persons. The program provided direct financial support to 18 dental students and 108 dental residents. Of these 126 students and residents, approximately 31 percent reported coming from a rural background, 27 percent reported coming from a disadvantaged background, and 23 percent from an underrepresented minority group.

In FY 2021, the program will be continued to support 35 continuing states grants. In FY 2022, the program will support three continuing state grants and hold a new competition to fund an estimated 32 new awards at an estimated amount of $400,000 each. HRSA will continue to include additional activities, as allowed by Sec.340G(b)(13) of the program authority, to focus on HHS and HRSA priorities and other oral health workforce trends at the state level such as

activities related to opioids, the impact of COVID-19, and the use of dental therapist to meet the oral health needs of rural, underserved, and tribal populations in accordance with state laws.

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

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Oral Health Service Providers	• Primary and Secondary Education • Pre- and Postdoctoral Programs • Residency Programs • Continuing Education	• Integration of oral and primary care medical delivery systems. • Supporting oral health providers practicing in advanced roles. • Teledentistry. • Expand or establish oral health services and facilities in Dental HPSAs. • Placement of dental trainees. • Partnerships with dental training institutions. • Expand a state dental office. • Advancing pain management and improving access to opioid treatment services. • Dental workforce programs designed to address risk factors common to childhood obesity and dental caries. • Activities related to emerging oral health workforce needs such as opioids, workforce impacts from COVID-19, and the increasing adoption of dental therapy models by States to meet the needs of their underserved populations.

Funding History

FY	Amount
FY 2018	$40,571,000
FY 2019	$40,471,000
FY 2020	$40,673,000
FY 2021 Enacted	$40,673,000
FY 2022 President's Budget	$40,673,000

Budget Request

The FY 2022 Budget Request of $40.7 million is the same as the FY 2021 Enacted level. In FY 2021, the Oral Health Training Program made 112 awards. In FY 2022, HRSA will continue increasing 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. Specifically, HRSA intends to make 112 awards to continue the support of dental faculty development, support of innovative oral health programs, and to enhance clinical predoctoral dental and dental hygiene trainees' ability to care for populations and individuals with medically complex conditions.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[50]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.27: Number of dental students trained	FY 2019: 11,121 Target: 9,500 (Target Exceeded)	4,000	4,000	Maintain
6.I.C.28: Number of dental residents trained	FY 2019: 494 Target: 450 (Target Exceeded)	520	520	Maintain
6.I.C.29: Number of faculty trained	FY 2019: 256 Target: 200 (Target Exceeded)	160	160	Maintain

[50] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.

Program Activity Data

Oral Health Training and Workforce Program Outputs	Year and Most Recent Result	FY 2020 Target	FY 2021 Target	FY 2022 Target
Percent of students and residents trained who are URMs	FY 2019: 26%	20%	20%	20%
Number of dentists completing a Bureau of Health Workforce-funded dental residency or fellowship	FY 2019: 234	350	300	300
Number of dentists graduating from a Bureau of Health Workforce-funded dental school	FY 2019: 2,658	1,200	1,000	1,000

Grant Awards Table – Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene[51]

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	47	47	47
Average Award	$378,189	$378,189	$378,189
Range of Awards	$142,144-$650,000	$142,144-$650,000	$142,144- $650,000

Grant Awards Table – Dental Faculty Loan Repayment Programs

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	30	30	30
Average Award	$230,739	$230,739	$230,739
Range of Awards	$81,000-$350,000	$81,000-$350,000	$81,000- $350,00

[51] 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.

Grant Awards Table – State Oral Health Workforce Improvement Grant Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	35	35	35
Average Award	$340,103	$340,103	$340,103
Range of Awards	$91,533-$400,000	$91,533- $400,000	$91,533- $400,000

Medical Student Education Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$50,000,000	$50,000,000	$50,000,000	---
FTE	---	---	---	---

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

FY 2022 Authorization ..... Not Specified[52]

Allocation Method ..... Grants

Program Description and Accomplishments:

The purpose of the Medical Student Education (MSE) Program is to provide grants to public institutions of higher education to expand or support graduate education for medical students preparing to become physicians in the top quintile of states with a projected primary care provider shortage in 2025[53]. The program is designed to prepare and encourage medical students who are training in the most underserved states to choose residencies and careers in primary care that serve tribal communities, rural communities, and/or medically underserved communities (MUCs) after they graduate. The MSE Program supports the development of medical school curricula, clinical training site partnerships, and faculty training programs, with the goal of educating medical students who are likely to choose career paths in primary care, especially for tribal communities, rural communities, and/or MUCs.

In FY 2020, HRSA awarded five additional applications from the FY 2019 MSE Notice of Funding Opportunity. These grants are fully funded for the four-year project period. Remaining funds from the FY 2020 appropriation were used to supplement the five FY 2019 awardees in their second of a four-year, fully funded project period. In FY 2021, HRSA plans to provide supplemental funding in the amount of $50,000,000 to the 10 recipients.

[52]Consolidated Appropriations Act, 2021, Title II (Public Law No. 116-260, Title II) Department of Defense and Labor, Health and Human Services, and Education Appropriations Act authorized $50 million in appropriations, to remain available until expended.

[53] 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.

In Academic Year 2019-2020, the first year for reporting, MSE awardees trained 551 medical students. Over a quarter of these students were from rural or disadvantaged backgrounds. MSE awardees developed and expanded medical school curricula and training focused on the skills necessary to practice primary care in rural, tribal, and other underserved communities. They offered 32 training activities and courses to 1,146 health professionals. In addition, MSE awardees enhanced community-based partnerships with 50 sites to offer experiential training opportunities in primary care settings (88 percent), medically underserved communities (68 percent), and rural areas (66 percent).

Awardees are using telehealth modalities and telemedicine networks to connect clinicians to rural patients and to provide care and education through telemedicine. Seventy percent of MSE trainees received training in telehealth and 46 percent of sites offered telehealth services. In response to the Novel Coronavirus (COVID-19) pandemic, 15 percent of medical students received COVID-19 related training and 46 percent of experiential training sites offered COVID-19 related services. Given that this was the first year of the program, there were no graduates as medical school typically requires four years.

Eligible Entities:

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

Funding History

FY	Amount
FY 2018	---
FY 2019	$25,000,000
FY 2020	$50,000,000
FY 2021 Enacted	$50,000,000
FY 2022 President's Budget	$50,000,000

Budget Request

The FY 2022 Budget Request of $50.0 million for the Medical Student Education (MSE) Program is the same as the FY 2021 Enacted level. In FY 2021, MSE made 10 awards. As all grantees are fully funded for the four-year project periods, these activities will continue in 2022. In FY 2022, HRSA anticipates making 10 supplemental awards. Grant activities will focus on increased time and rotations in the rural and underserved areas to cover housing, travel and other training costs. Funds will be used to provide training and support to preceptors in the rural areas. In addition, funds will enhance curriculum to address health equity and population health, focusing on the needs of vulnerable populations.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result) [54]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.59: Number of medical students trained in underserved states	FY 2019: 551 (Baseline)	N/A	550	N/A
6.I.C.60: Number of medical students matched to primary care residencies	---[55]	TBD	TBD	TBD

Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	10	10	10
Average Award	$2,860,065	$6,431,356	$6,452,877.80
Range of Awards	$1,750,000-$4,004,767	$5,098,749.10-$6,943,792.10	$6,102,305-$6,750,000

[54] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.
[55] Baseline for this measure will be set for the FY 2020 and reported in the FY 2023 Congressional Justification.

Interdisciplinary, Community-Based Linkages

Area Health Education Centers Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$41,250,000	$43,250,000	$43,250,000	---
FTE	3	3	3	---

Authorizing Legislation: Public Health Service Act, Section 751, as amended by Public Law No: 116-136

FY 2022 Authorization $41,250,000

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

Program Description and Accomplishments:

The Area Health Education Centers (AHEC) Program supports 48 cooperative agreements with a project period that runs from September 1, 2017 through August 31, 2022. The purpose of the AHEC Program is to develop and enhance education and training networks within communities, academic institutions, and community-based organizations. In turn, these networks develop the health care workforce, broaden the distribution of the health workforce, enhance health care quality, and improve health care delivery to rural and underserved areas and populations. AHECs develop and maintain a diverse health care workforce and broaden the distribution of the health workforce. The redesigned AHEC Program invests in interprofessional networks that address social determinants of health and incorporate field placement programs for rural and medically-underserved populations.

In Academic Year 2019-2020, the AHEC Program supported various types of pre-pipeline, pipeline, and continuing education training activities for thousands of trainees across the country. AHEC grantees implemented 2,003 unique continuing education courses that were delivered to 155,249 practicing professionals nationwide, 75,708 of whom (49 percent) were concurrently employed in medically underserved communities. They also enhanced or developed 1,829 courses and training activities for 32,240 AHEC scholars and other health professionals. In response to the COVID-19 pandemic, HRSA provided supplemental funding to 43 AHEC grantees to support telehealth activities. Grantees had about one month in Academic Year 2019-2020 to implement these activities. In this short amount of time, grantees were able to successfully offer 31 continuing education courses and 19 courses and training activities using these funds. These courses are included in the totals reported above.

AHEC grantees partnered with 5,092 training sites to provide 31,025 clinical training experiences to student trainees (e.g., ambulatory practice sites, physician offices, and hospitals).

Approximately 59 percent of these training sites were primary care settings, 67 percent were located in medically underserved communities, 45 percent were in rural areas, and 17 percent offered COVID-19 related services.

In Academic Year 2019-2020, the AHEC Scholars Program supported 5,632 AHEC Scholars. The AHEC Scholars Program is an interprofessional educational and training program targeted towards health professions students and consists of a specialized curriculum focused on six core topic areas and health care delivery within rural/underserved areas and populations. The six core topic areas include: (a) interprofessional education, (b) social determinants of health, (c) behavioral health integration, (d) cultural competency, (e) practice transformation, and (f) current and emergent health issues.

Approximately 38 percent of AHEC Scholars came from a rural background and nearly 46 percent came from a disadvantaged background. Approximately 50 percent of AHEC Scholars received training in a rural setting, 61 percent in a primary care setting, and 90 percent in a medically underserved community. Over 33 percent of AHEC Scholars received training on integrating behavioral health in primary care and 17 percent received training in substance use treatment. Nearly 100 percent of AHEC scholars received training on interprofessional education, logging close to 380,000 hours of training on this topic. The AHEC Scholars program is a two-year commitment. In AY 2019-2020, 1,347 AHEC Scholars completed the program. Nearly 36 percent intend to work or pursue further training in a medically underserved community, 25 percent in a primary care setting, and 24 percent in a rural area. The percent of AHEC program completers practicing in medically underserved communities and/or rural areas is collected one-year after program completion. This data will be available next year and reported as part of the 2023 Congressional Justification.

HRSA recently completed a five-year review of AHEC data. Between Academic Year 2014-2019, AHEC trained over 1.8 million individuals and recorded over 1.7 million program completers. Forty-two percent of AHEC's program completers were from a rural background, 40 percent were from disadvantaged backgrounds, and 29 percent were underrepresented minorities. Over this five-year period, AHEC delivered more than 21,000 continuing education courses, which provided training to nearly one million health professionals. Approximately 92 percent of AHEC trainees participated in multi-disciplinary, non-degree training programs such as enrichment activities; college academic support; community-based outreach and education; pre-college or pre-diploma/certification preparation; summer programs; and training activities for current health profession students, residents, and fellows. Each of the five years, 62 percent or more of AHEC's experiential training sites were in medically underserved communities, 60 percent or more were in primary care settings, and 40 percent or more were in rural areas.

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 2018	$38,154,000
FY 2019	$39,055,000
FY 2020	$41,250,000
FY 2021 Enacted	$43,250,000
FY 2022 President's Budget	$43,250,000

Budget Request

The FY 2022 Budget Request for the Area Health Education Centers program of $43.3 million is the same as the FY 2021 Enacted level. In FY 2021 and FY 2022, the AHEC Program plans to maintain funding for 48 awards to continue to increase the number of students in the health professions who will pursue careers in primary care and are prepared to practice in rural and underserved areas and populations.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[56]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.49: Number of AHEC scholars trained in medically underserved communities and/or rural areas.	FY 2019: 5,399 (Baseline)	N/A	5,350	N/A
6.I.C.50: Percent of AHEC program completers practicing in medically underserved communities and/or rural areas.	FY 2019: 20% (Baseline)	N/A	20%	N/A

Program Activity Data

AHEC Program Outputs	Year and Most Recent Result	FY 2020 Target	FY 2021 Target	FY 2022 Target
Number of medical students who participated in community-based clinical training	FY 2019: 8,727	11,500	11,500	11,500
Number of other health professions trainees who participated in community-based clinical training	FY 2019: 11,483	11,000	11,000	11,000
Number of trainees who received CE on topics including cultural competence, women's health, diabetes, hypertension, obesity, and health disparities	FY 2019: 155,249	140,000	140,000	140,000

[56] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	48	48	48
Average Award	$809,483	$809,483	$809,483
Range of Awards	$249,967-$1,927,055	$249,967-$1,927,055	$249,967-$1,927,055

Geriatrics Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$40,737,000	$42,737,000	$46,537,000	+$3,800,000
FTE	6	7	8	+1

Authorizing Legislation: Public Health Service Act, Sections 750, 753 and 865, as amended by Public Law No: 116-136

FY 2022 Authorizations:.....$40,737,000

Allocation Method ..... Cooperative Agreement

Program Description and Accomplishments:

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

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

Program	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Geriatrics Workforce Enhancement Program	$38,737,000	$40,670,475	$44,433,205
Geriatrics Academic Career Awards (GACA) Program	$2,000,000	$2,066,525	$2,103,795

In Academic Year 2019-2020, GWEP grantees provided training for 56,603 students and fellows participating in a variety of geriatrics-focused degree programs, field placements, and fellowships. Of these trainees, 46,107 graduated or completed their training during the current academic year. GWEP grantees partnered with 302 health care delivery sites (e.g., hospitals, long-term care facilities, and academic institutions) to provide clinical training experiences to trainees. Approximately 42 percent of these sites were located in medically underserved communities, and 45 percent were primary care settings.

With regard to the continuing education of the current workforce, 290,161 faculty and practicing professionals participated in 2,068 unique continuing education courses offered by GWEP grantees, 906 of which were specifically focused on Alzheimer's disease and related dementia. More than 400 continuing education courses used COVID telehealth funding which reached over 54,000 individuals.

The redesign of the GWEP program in FY 2019 shifts its focus to transforming clinical training environments into integrated geriatrics and primary care systems to become age-friendly health systems that incorporate the principles of value-based care and alternative-payment models (e.g., Advanced Alternative Payment Models [AAPMs], bundled payment, Comprehensive Primary Care Plus [CPC+], etc.).

As a result of the redesign, GWEP grantees developed or enhanced and implemented 5,853 different curricular activities. Most of these were new continuing education courses, academic courses, and workshops, which together reached 205,322 people. Finally, with regard to faculty development, results showed that GWEP grantees supported 448 different faculty-focused training programs and activities during the academic year, reaching 10,872 faculty-level trainees.

In FY 2021, the GWEP program received an additional $2,000,000 in funding. The funding will provide COVID-19 specific education and training to the nursing home workforce and to improve care to nursing home residents. The goal of this program is to 1) educate and train the nursing home workforce, to care for nursing home residents and their families and caregivers during the COVID-19 pandemic and the recovery phase, and 2) to partner with nursing homes and community-based organizations to address gaps in health care for nursing home residents, promote age-friendly nursing homes, and address the social determinants of health. Approximately 10 grants will be funded. In FY 2022, HRSA anticipates funding an additional year for the 10 FY 2021 supplemental awards.

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.[57] 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.[58] The education and training of health professionals in the area of geriatrics are hindered by a shortage of faculty, inadequate and variable academic curricula and clinical experiences, and a lack of opportunities for advanced training. In order to address these issues, faculty with expertise in geriatrics are needed to train the workforce to provide specialized care to improve health outcomes for older adults.

Consequently, in FY 2019, HRSA funded the Geriatrics Academic Career Awards (GACA) Program to support the career development of junior faculty in geriatrics at accredited schools of allopathic medicine, osteopathic medicine, nursing, social work, psychology, dentistry,

[57] 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.
[58] Id.

pharmacy, or allied health. Faculty with expertise in geriatrics are needed to train the workforce and provide specialized care to improve health outcomes for older adults. Under the GACA program, career development awards were made to support individual junior faculty who will provide interprofessional clinical training and become leaders in academic geriatrics. The goals of the program are for the GACA candidate to develop the necessary skills to lead health care 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.

In Academic Year 2019-2020, GACA supported the career development of 26 junior faculty in geriatrics from the following disciplines: geriatric psychiatry, social work, addiction counseling, family medicine, internal medicine, geriatrics medicine, general dentistry, advanced practice nursing, pharmacy, occupational therapy, and physical therapy. They had 2,634 contact hours in a primary care setting, 941 contact hours in a medically underserved community, and 503 contact hours in a rural area. The majority of GACA recipients provided clinical services in a primary care setting (23) and/or a medically underserved community (14). There were 10 in rural settings. There were 34 articles published and 62 conference presentations. Approximately 58 percent of GACA awardees received training in telehealth, and 31 percent received training in opioid use treatment. Furthermore, 42 percent of GACA faculty received COVID-19 related training.

GACA awardees developed or enhanced and implemented 363 different curricular activities. The delivery modes used to offer course or training activities were classroom-based, distance learning, hybrid, clinical rotation, experiential/field-based, grand rounds, and simulation-based training. These together reached 18,692 people. With regard to faculty instruction, GACA awardees offered 307 courses during the academic year, reaching 14,692 students and clinicians with the delivery mode used to offer course including classroom-based, clinical rotation, hybrid, archived/self-paced distance learning, real-time/live distance learning, and other types.

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

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

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

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

Funding History

FY	Amount
FY 2018	$40,635,000
FY 2019	$40,534,000
FY 2020	$40,737,000
FY 2021 Enacted	$42,737,000
FY 2022 President's Budget	$46,537,000

Budget Request

The FY 2022 Budget Request of $46.5 million is $3.8 million above the FY 2021 Enacted level. In FY 2021 and FY 2022, the GWEP program will make 48 awards to support the education and training of health professions students, residents, fellows, and faculty; healthcare providers; and direct care workers who will provide healthcare to older adults. The $3.8 million will fund approximately 11 supplemental grant recipients to train and educate the nursing home workforce and their families with knowledge and skills for self-management and/or care delivery for older adults. In FY 2021 and FY 2022, the GACA program will make 25 career development awards to support individual junior faculty who will provide interprofessional clinical training and become leaders in academic geriatrics.

Outcomes and Outputs Measures

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[59]	FY 2021 Target[60]	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.12: Number of Bureau of Health Workforce-sponsored educational offerings provided on Alzheimer's disease and related dementias	FY 2019: 906 Target: 500 (Target Exceeded)	150	500	+350
6.I.C.13: Number of trainees participating in educational offerings on Alzheimer's disease and related dementias	FY 2019: 146,024 Target: 51,000 (Target Exceeded)	10,000	100,000	+90,000
6.I.C.32: Number of continuing education trainees in geriatrics programs	FY 2019: 290,161 Target: 125,000 (Target Exceeded)	50,000	200,000	+150,000
6.I.C.33: Number of students who received geriatric-focused training in settings across the care continuum	FY 2019: 56,603 Target: 23,000 (Target Exceeded)	10,000	50,000	+40,000

Program Activity Data

Geriatrics Program Outputs	Year and Most Recent Result	FY 2020 Target[61]	FY 2021 Target	FY 2022 Target
Number of continuing education offerings delivered by grantees	FY 2019: 2,068	1,000	1,000	2,000
Number of faculty members participating in geriatrics trainings offered by grantees	FY 2019: 10,872	8,000	8,000	10,500
Number of individuals trained in new or enhanced curricula relating to the treatment of health problems of elderly individuals	FY 2019: 205,322	140,000	130,000	200,000

[59] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.
[60] Targets were lowered in FY 21 to account for new program awardees beginning work.
[61] Reduction in targets for FY 20 and 21 account for new program awardees beginning work.

GWEP Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	48	48	48
Average Award	$748,233	$741,108	$818,191
Range of Awards	$535,014-$755,000	$611,584-$750,000	$611,584 - $1,086,363

GACA Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	26	25	25
Average Award	$76,200	$77,191	$78,195
Range of Awards	$76,200	$77,191	$78,195

Behavioral Health Workforce Development Programs

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$138,916,000	$149,916,000	$224,874,000	+$74,958,000
FTE	14	15	29	+14

Authorizing Legislation: Public Health Service Act, Sections 755, 756 and 760, as amended by Public Law No: 114-255.

FY 2022 Authorization ..... $50,000,000[62]

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

Program Description and Accomplishments:

The purpose of Behavioral Health Workforce Development Programs is to develop and expand the behavioral health workforce serving populations across the lifespan, including in rural and medically underserved areas. Opioid use and its resulting deaths have impacted the lives of individuals and families, crippled communities, and depleted limited resources.

HRSA uses projections data and other information about the behavioral health workforce to develop and adjust programs to ensure that they are responsive to the Nation's emerging needs. For example, a recent Kaiser Family Foundation Issue Brief[63] explored the dual impacts of efforts to reduce the spread of COVID-19 on behavioral health: the economic downturn has increased stress and vulnerability to behavioral health conditions at the same time isolating and quarantining have reduced access to behavioral health services:

- "A broad body of research links social isolation and loneliness to poor mental health; and recent data shows that significantly higher shares of people who were sheltering in place (47%) reported negative mental health effects resulting from worry or stress related to coronavirus than among those not sheltering in place (37%). Negative mental health effects due to social isolation may be particularly pronounced among older adults and households with adolescents, as these groups are already at risk for depression or suicidal ideation.
- Research shows that job loss is associated with increased depression, anxiety, distress, and low self-esteem and may lead to higher rates of substance use disorder and suicide. Recent polling data shows that more than half of the people who lost income or employment reported negative mental health impacts from worry or stress over

[62] The 21st Century Cures Act (P.L. 114-255) authorized $50 million through FY 2022.
[63] Panchal, Nirmita, et al. The Implications of COVID-19 for Mental Health and Substance Use, Kaiser Family Foundation. Published April 21, 2020.

coronavirus; and lower income people report higher rates of major negative mental health impacts compared to higher income people."

The need for a behavioral health workforce is even more glaring in the COVID-19 context. Suspected overdoses nationally jumped 18 percent in March 2020, compared with last year, 29 percent in April and 42 percent in May 2020, according to the Overdose Detection Mapping Application Program (www.odmap.org), a federal initiative that collects data from ambulance teams, hospitals and police.

HRSA's 2020 Behavioral Health Workforce Projections Report estimated national-level health workforce needs for several behavioral health occupations between 2017 and 2030. The report estimated the demand for addiction counselors is expected to increase 15 percent by 2030, with demand exceeding supply and leading to a deficit of addiction counselors of approximately 11,530 FTE. Also, the report estimated that by 2030, the supply of psychiatrists is expected to decrease by approximately 20 percent.[64] The COVID epidemic exacerbates an existing imbalance in the supply of and demand for mental and behavioral health providers across the US. Future updates to these health workforce projections will be posted on HRSA's website.

By 2025, HRSA's Behavioral Health Workforce Education and Training (BHWET) Program is projected to eliminate over 40% of the projected shortfall of behavioral health providers, and provide thousands of new paraprofessionals to enhance the nation's health workforce capacity in critical areas of need. Since the program began, 6,787 new paraprofessionals have begun work as community health workers, peer paraprofessionals, and substance use/addictions workers.

The Behavioral Health Workforce Development budget line supports the Behavioral Health Workforce Education and Training (BHWET) Program, the Graduate Psychology Education (GPE) Program, the Opioid Workforce Expansion Programs (OWEP), the Behavioral Health Workforce Development Technical Assistance and Evaluation (BHWD TAE) Program, the Addiction Medicine Fellowship (AMF) Program, the Integrated Substance Use Disorder Treatment (ISTP) Program, a loan repayment program for the Substance Use Disorder Treatment Workforce, and the Opioid-Impacted Family Support Program (OIFSP).

[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.2020.Behavioral Health Workforce Projections, 2017-2030. Rockville, Maryland.

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Behavioral Health Workforce Development	$120,916,000	$130,916,000	$199,874,000
Graduate Psychology Education	$18,000,000	$19,000,000	$25,000,000
Total Behavioral Health Workforce Development Programs[65]	**$138,916,000**	**$149,916,000**	**$224,874,000**

Behavioral Health Workforce Development: The Behavioral Health Workforce Development (BHWD) programs support a number of activities to expand the behavioral workforce as well as enhance the training of the pipeline and current workforce. In Fiscal Year 2022, these programs will support a number of activities, which are described below.

- ***BHWET Program:*** This program increases the number of behavioral health providers entering and continuing practice, with special emphasis on prevention and clinical intervention and treatment for those at risk of developing mental and substance use disorders, and the involvement of families in the prevention and treatment of behavioral health conditions. In FY 2021, HRSA will support approximately 135 BHWET Professional and Paraprofessional grantees.

  In Academic Year 2019-2020, the BHWET Program supported training for 6,119 individuals. Of the total students supported, 3,254 graduate-level social workers, psychologists, school and clinical counselors, psychiatric nurse practitioners, and marriage and family therapists were trained as well as 2,865 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).

  Nearly 46 percent of the BHWET trainees received training in substance use treatment and 29 percent received training in opioid use treatment. Furthermore, 44 percent received training in behavioral health primary care integration. By the end of the Academic Year, 4,449 students graduated from these degree and certificate-bearing programs and entered the behavioral health workforce. Upon program completion, 22 percent of students intended to pursue training and/or employment to serve at-risk children, adolescents, and transitional-aged youth. Further, upon graduation, 49 percent of students intended to pursue training and/or employment in a medically underserved area and/or rural setting.

  BHWET grantees partnered with 2,439 training sites (e.g., hospitals, ambulatory practice sites, and academic institutions) to provide 6,392 clinical training experiences for

[65] Includes appropriations from both MBHET and BWHET lines.

BHWET student trainees. Approximately 72 percent of these training sites were located in medically underserved communities where trainees provided over 1.4 million hours of behavioral health services to patients and clients. Over 30 percent of the sites offered opioid use treatment services and 50 percent of the sites offered substance use treatment services. Training at partnered sites incorporated interdisciplinary team-based approaches, where 15,481 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 1,959 behavioral health-related courses and training activities, reaching over 54,000 students and advanced trainees (i.e., psychology interns and fellows and psychiatry residents).

- **BHWET- Community Improvement Program (CIP):** This new program seeks to enhance community-based training partnerships for students preparing to become behavioral health professionals and paraprofessionals focused on improving health equity.

- ***OWEP Program:*** In FY 2019, HRSA awarded approximately $69 million for the Opioid Workforce Expansion Programs (OWEP) for Professionals and Paraprofessionals. The OWEP program allows eligible institutions to improve community-based training for students preparing to become behavioral health professionals and paraprofessionals focused on opioid use disorder and other substance use disorders. These awards support HHS's priority to end the opioid crisis.

  In Academic Year 2019-2020, the OWEP Program supported training for 1,001 individuals. Of the total students supported, 510 graduate-level social workers, psychologists, psychiatrists, addiction counselors, psychiatric nurse practitioners, and marriage and family therapists were trained as well as 491 students training to become behavioral health paraprofessionals (such as peer paraprofessionals, community health workers, outreach workers, behavioral health aides, mental health workers, and substance abuse/addictions workers).

  Over 82 percent of the OWEP trainees received training in substance use treatment and nearly 86 percent received training in opioid use treatment. Furthermore, approximately 34 percent received training in behavioral health primary care integration and 40 percent received training in telehealth. By the end of the Academic Year, 537 students graduated from these degree and certificate-bearing programs and entered the behavioral health workforce. Moreover, upon graduation, 45 percent of OWEP students intended to pursue training and/or employment in a medically underserved area and 20 percent intended to pursue training and/or employment in a primary care setting. Among OWEP paraprofessional students who completed their program, 17 percent intended to become State certified paraprofessionals.

  OWEP grantees partnered with 457 training sites (e.g., hospitals, ambulatory practice sites, and academic institutions) to provide 881 clinical training experiences for OWEP student trainees. Approximately 76 percent of these training sites were located in medically underserved communities where trainees provided over 250,000 hours of

behavioral health services to patients and clients. Approximately 58 percent of the training sites offered opioid use treatment services and 75 percent offered substance-use treatment services. Training at partnered sites incorporated interdisciplinary team-based approaches, where 1,970 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with OWEP students. OWEP grantees used grant funds to develop, enhance, and implement 281 behavioral health-related courses and training activities, reaching over 7,180 students and advanced trainees (i.e., psychology interns and fellows and psychiatry residents).

- ***The Behavioral Health Workforce Development Technical Assistance and Evaluation (BHWD TAE) Program:*** This program develops and provides tailored technical assistance (TA) to current and future grant recipients in the BHWET-Professionals, BHWET-Paraprofessionals, OWEP- Professionals, OWEP-Paraprofessionals, and GPE Program. This program will fund one award with a $2.5 million investment.

- ***Addiction Medicine Fellowship (AMF) Program:*** The AMF program seeks to increase the number of board certified addiction medicine and addiction psychiatry specialists trained in providing interprofessional behavioral health services, including OUD and SUD prevention, treatment, and recovery services, in underserved, community-based settings.

- ***Integrated Substance Use Disorder Treatment Program (ISTP)***: In FY 2021, HRSA will award approximately $10 million to support approximately 4 awardees to expand the number of nurse practitioners, physician assistants, health service psychologists, and social workers trained to provide mental health and SUD services in underserved community-based settings that integrate primary care and mental health and SUD services.

- ***Opioid-Impacted Family Support Program (OIFSP):*** In FY 2021, HRSA anticipates making $16.8 million via continuation awards and additional support to grantees. OIFSP seeks to train paraprofessionals to support children and families impacted by OUDSUD in underserved areas. The program will also provide professional development opportunities and educational support to increase the number of paraprofessional trainees receiving a certificate upon completion of the program.

- ***Loan Repayment Program for Substance Use Disorder Treatment Workforce***: This Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program provides for the repayment of educational loans for individuals working in a full-time SUD treatment job that involves direct patient care in either a Mental Health Professional Shortage Area or a county where the overdose death rate exceeds the national average. In FY 2022, SUD treatment workforce loan repayment participants will be fulfilling part of their required SUD treatment service commitments, and HRSA anticipates making 112 awards with approximately $28 million in funding in FY 2021.

The Graduate Psychology Education (GPE) Program: This program supports innovative doctoral-level health psychology programs that foster an interprofessional approach to providing

behavioral health and substance use prevention and treatment services in high need and high demand areas through academic and community partnerships. Through these efforts, the GPE Program transforms clinical training environments and aligns with HRSA's mission to improve health outcomes and address health disparities through access to quality services, a skilled health workforce, and innovative, high-value programs. In FY 2022, HRSA anticipates making approximately $25 million in new awards to 55 recipients.

- In Academic Year 2019-2020, the GPE Program provided stipend support to 251 students participating in practice, internships, or post-doctoral residency programs in psychology. The majority of students who received a stipend were trained in medically underserved communities (93 percent) and/or a primary care setting (77 percent). Of the 94 students who completed GPE-supported programs, 79 percent intended to become employed or pursue further training in medically underserved communities and 41 percent intended to become employed or pursue further training in primary care settings.

- GPE grantees partnered with 210 sites (e.g., hospitals, ambulatory practice sites, and academic institutions) to provide 829 clinical training experiences for psychology graduate students as well as 3,358 interprofessional team-based care trainees who participated in clinical training along with the psychology graduate students. Approximately 89 percent of these training sites were located in medically underserved communities and 73 percent were primary care and/or rural settings. Approximately 77 percent of the sites offered substance use treatment services and 83 percent offered telehealth services.

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

Eligible Entities:

BHWET/OWEP 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.

GPE: American Psychological Association (APA)-accredited doctoral level schools and programs of health service psychology or school psychology.

BHWD TAE: Health professions schools, academic health centers, State or local governments, or other public or private nonprofit entities that provide services and training to health professions. A nationally recognized accrediting body, as specified by the U.S. Department of Education, must accredit applicants that are institutions of higher education.

AMF: Sponsoring institutions of accredited addiction medicine fellowship programs or accredited addiction psychiatry fellowship programs, or a consortium consisting of at least one teaching health center and one sponsoring institution of an addiction medicine or addition psychiatry fellowship program.

ISTP: Teaching Health Centers, Federally Qualified Health Centers, Community Mental Health Centers, Rural Health Clinics, health centers operated by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization or an entity with a demonstrated record of success in providing training for nurse practitioners, physician assistants, health service psychologists, and social workers.

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

Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program: Individuals who are United States citizen, national, or permanent resident; fully licensed or credentialed physicians, nurses, and behavioral health clinicians, including paraprofessionals, who provide SUD treatment, recovery or associated health care services at a STAR Loan Repayment Program-approved facility located in either a HPSA designated for Mental Health or a county where the overdose death rate for the past three years exceeds the national average.

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

Funding History

FY	Amount
FY 2018	$111,766,000
FY 2019	$111,916,000
FY 2020	$138,916,000
FY 2021 Enacted	$149,916,000
FY 2022 President's Budget	$224,874,000

Budget Request

The FY 2022 Budget Request for Behavioral Health Workforce Development Programs of $224.9 million is $75.0 million above the FY 2021 Enacted level. This increased funding support's the Administration's priority to combat the opioids epidemic. This includes supporting existing programs such as BHWET Professional, BHWET Paraprofessional, OIFSP and the AMF program. The funding will also support programs that will be making new awards in FY 2022. The request includes approximately $25 million in new awards for the Graduate Psychology Education Program to strengthen the health workforce to address the opioid epidemic by training professionals in team-based prevention, treatment, and recovery services across all its behavioral health workforce program. The request includes funding for the new BHWET-Community Improvement Program to enhance community-based training partnerships for students preparing to become behavioral health professionals and paraprofessionals focused on improving health equity. Additionally, the request includes $28 million for the STAR Loan Repayment Program to recruit and retain medical, nursing, behavioral/mental health clinicians and paraprofessionals who provide direct treatment or recovery support of patients with or in recovery from a substance use disorder. In FY 2022, the BHWD programs anticipate making approximately 502 new and continuation awards, and plans to continue to increase the number of behavioral professionals and paraprofessionals entering the health workforce equipped to work on integrated, interprofessional team-based care. All the BHWD programs will work to expand the behavioral health workforce to address the nation's unmet mental and behavioral health care needs brought about by the opioid epidemic.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result[66]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.34: Number of students currently receiving training in behavioral health degree and certificate programs	FY 2019: 6,119 Target: 4,500 (Target Exceeded)	4,500	6,000	+1,500
6.I.C.35: Number of graduates completing behavioral health programs and entering the behavioral health workforce	FY 2019: 4,449 Target: 3,000 (Target Exceeded)	3,000	5,000	+2,000
6.I.C.53: Number of OWEP trainees currently receiving training in opioid-related behavioral health degree and certificate programs	FY 2019:1,001 (Baseline)	N/A	N/A	N/A[67]

[66] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.
[67] This program is not funded in FY 2022.

Measure	Year and Most Recent Result /Target for Recent Result[66]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.54: Number of OWEP graduates completing opioid-related behavioral health programs and entering the behavioral health workforce	FY 2019: 537 (Baseline)	N/A	N/A	N/A[68]
6.I.C.36: Number of graduate-level psychology students supported in GPE program	FY 2019: 251 Target: 170 (Target Exceeded)	200	400	+200
6.I.C.37: Number of interprofessional students trained in GPE program	FY 2019: 3,358 Target: 1,900 (Target Exceeded)	1,900	4,000	+2,100
6.I.C.61: Number of new addiction medicine and addiction psychiatry fellowship graduates entering workforce	---[69]	TBD	TBD	TBD
6.I.C.62: Number of substance use disorder treatment providers receiving loan repayment	---[70]	TBD	TBD	TBD

[68] This program is not funded in FY 2022.
[69] Baseline for this measure will be set for FY 2020 and reported in the FY 2023 Congressional Justification.
[70] Baseline for this measure will be set for FY 2020 and reported in the FY 2023 Congressional Justification.

Program Activity Data

Program Outputs	Year and Most Recent Result	FY 2020 Target	FY 2021 Target	FY 2022 Target
Number of GPE clinical training experiences that incorporated interprofessional team-based care training	FY 2019: 829	400	400	600

Behavioral Health Workforce Development Programs Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	207	207	211
Average Award	$396,984	$396,984	$449,501
Range of Awards	$26,560-$800,000	$26,560-$800,000	$26,560-$800,000

Loan Repayment Program for Substance Use Disorder Treatment Workforce

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	---	112	112
Average Award	---	$250,000	$250,000
Range of Awards	---	$50,000-$250,000	$50,000-$250,000

GPE Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	49	49	55
Average Award	$361,558	$361,558	$361,558
Range of Awards	$83,235 - $450,000	$83,235 - $450,000	$83,235 - $450,000

Public Health Workforce Development

Public Health and Preventive Medicine Training Grant Programs

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$17,000,000	$17,000,000	$18,000,000	+$1,000,000
FTE	4	4	4	---

Authorizing Legislation: Public Health Service Act, Sections 765-768 and 770, as amended by Public Law No: 116-136.

FY 2022 Authorization $17,000,000

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 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Public Health Training Centers Program	$9,700,258	$9,700,258	$10,200,258
Preventive Medicine Residency Program	$7,299,742	$7,299,742	$7,799,742

Public Health Training Centers (PHTC) Program: The PHTC Program 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.

The National Coordinating Center (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 2019-2020, Regional PHTCs partnered with 278 sites to provide more than 345 clinical training experiences to student trainees (e.g., local health departments, academic institutions, and community-based organizations). Approximately 74 percent of these training sites were located in medically underserved communities and 29 percent were located in primary care settings. With regard to the continuing education (CE) of the current workforce, PHTC grantees delivered 2,779 unique CE courses to 307,750 trainees during the academic year, approximately 25 percent of whom were practicing professionals concurrently employed in medically underserved communities. Over 6,000 instructional hours for continuing education were offered in the 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. The program aims to increase the number and quality of preventive medicine residents and physicians to support access to preventive medicine to improve the health of communities.

In Academic Year 2019-2020, the PMR Program financially supported 85 residents, the majority of whom received clinical or experiential training in a primary care setting (81 percent) and/or a medically underserved community (71 percent). Approximately 39 percent of residents received training in substance use treatment and 67 percent received training in telehealth. Of the 57 residents who completed their residency training programs during the academic year, 33 percent intended to pursue employment or further training in medically underserved communities. PMR grantees partnered with 195 sites to provide 549 clinical training experiences for PMR residents (e.g., academic institutions, ambulatory care sites, State and local health departments, and hospitals).

Approximately 41 percent of these training sites were located in medically underserved communities and 32 percent were primary care settings. More than 23 percent of these training sites offered substance use treatment services and 26 percent of these sites offered telehealth services. The intent of the Preventive Medicine Residency Program is to prepare physicians for positions in public health. Physicians completing the residency program are prepared to work in a variety of settings including state and local health departments, health systems, companies, and government.

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

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

Funding History

FY	Amount
FY 2018	$17,000,000
FY 2019	$16,915,000
FY 2020	$17,000,000
FY 2021 Enacted	$17,000,000
FY 2022 President's Budget	$18,000,000

Budget Request

The FY 2022 Budget Request for the Public Health and Preventive Medicine Training Grant Programs of $18.0 million is $1.0 million above the FY 2021 Enacted level. In FY 2021, the PHPM programs made 27 awards. In FY 2022, the PHPM programs anticipate making 27 awards. Specifically, the Public Health Training Centers will provide supplements to the current 10 regional awardees and support the development and implementation of training focused on regional needs and that align with agency priorities. Some activities include development of micro learning instructional sessions on real time public health issues, aiding in the formulation of state and local workforce development plans, and expanding regional Public Health Leadership Institutes.

The Preventive Medicine Residency Program will make 17 continuation awards as well as supplements to current grantees. The supplemental awards will support enhanced experiential activities that align with their grant objectives. The supplemental awards will also address the public health needs as a result of the COVID-19 pandemic with a focus on increasing outreach to the underserved through rotations in rural health departments and FQHCs in rural areas.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[71]	FY 2021 Target	FY 2022 Target	FY 2022Target +/- FY 2021 Target
6.I.C.9: Number of trainees participating in continuing education sessions delivered by PHTCs	FY 2019: 307,750 Target: 150,000 (Target Exceeded)	160,000	300,000	+140,000
6.I.C.18: Number of instructional hours offered by PHTCs	FY 2019: 6,074 Target: 6,000 (Target Exceeded)	6,000	6,500	+500
6.I.C.19: Number of PHTC-sponsored public health students that completed field placement practicums in State, Local, and Tribal Health Departments	FY 2019: 282 Target: 140 (Target Exceeded)	180	280	+100

[71] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.

Program Activity Data

PMR Program Outputs	Year and Most Recent Result	FY 2020 Target	FY 2021 Target	FY 2022 Target
Number of preventive medicine residents participating in residencies	FY 2019: 85	75	75	80
Number of preventive medicine residents completing training	FY 2019: 57	40	40	50
Percent of program completers who are URMs	FY 2019: 26%	20%	20%	20%

Grant Awards Table – Public Health Training Centers Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	10	10	10
Average Award	$891,381	$891,381	$933,231
Range of Awards	$767,470-$1,087,248	$767,470-$1,087,248	$802,320-$1,125,098

Grant Awards Table – Preventive Medicine Residency Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	17	17	17
Average Award	$389,141	$391,056	$413,265
Range of Awards	$349,956 -$400,000	$365,405 -$400,000	$396,049-$422,264

Nursing Workforce Development

Advanced Nursing Education Programs[72]

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$80,581,000	$80,581,000	$80,581,000	---
FTE	9	10	10	---

Authorizing Legislation: Public Health Service Act, Section 811 as amended by Public Law No: 116-136

FY 2022 Authorization $137,837,000

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

In Academic Year 2019-2020, grantees of the ANEW Program trained 4,817 nursing students of which one third of them were underrepresented minorities and/or from disadvantaged backgrounds. The ANEW program produced 1,604 graduates who were ready to enter the health care workforce. Of the 2,267 students who were directly funded by ANEW, the majority trained in primary care settings (75 percent) and/or medically underserved communities (65 percent) and received training in telehealth (60 percent) and/or opioid use treatment (45 percent). More than one in four students who were directly funded received COVID-19 related training. One-year post graduation data showed that over half of the trainees were pursuing additional training in a

[72] Includes funding for the Advanced Nursing Education and Nurse Optional Fellowship Program.

medically underserved community. In addition, 47 percent of the recently graduated individuals were working in a primary care setting.

In addition, ANEW grantees supported 116 faculty and 76 preceptors. To provide clinical training experiences to nursing students, grantees partnered with 2,433 clinical training sites in primary care settings (77 percent), medically underserved communities (68 percent), and/or rural areas (32 percent). ANEW grantees offered 500 curricula, provided 122 continuing education courses to practicing professionals, and offered 132 faculty and preceptor development programs.

HRSA anticipates $39 million in 57 continuation awards for the ANEW program in FY 2022.

Advanced Nursing Education-Sexual Assault Nurse Examiners (ANE-SANE) Program: The ANE-SANE Program funds advance nursing education and supports partnerships that train and certify Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs), and Forensic Nurses (FNs) to practice as sexual assault nurse examiners (SANEs). The program aims to increase the supply and distribution of qualified working SANEs and expand access to sexual assault forensic examinations. By expanding access to SANEs, the ANE-SANE program aims to provide better physical and mental health care for survivors of sexual assault and domestic violence leading to better evidence collection and potentially higher prosecution rates. The program also provides support and resources to help improve the practice and retention of SANEs.

In Academic Year 2019-2020, grantees from the ANE-SANE program trained 1,467 students and produced 228 graduates. The majority of trainees were from a rural and/or disadvantaged background (56 percent). About one in five SANE trainees received their training in rural areas and just over 40 percent of them received their training in medically underserved communities. Approximately 28 percent of the students participated in COVID-19 related training. The ANE-SANE grantees partnered with 149 clinical training sites in primary care settings (18 percent), medically underserved communities (77 percent), and/or rural areas (24 percent). SANE grantees developed and/or enhanced 80 courses.

In FY 2021, HRSA plans to continue supporting the training of SANEs through partnerships that promote recruitment of trainees, interagency collaboration, and integration of trauma-informed, evidence-based sexual assault and domestic violence services into training and practice settings. The FY 2021 funding also focuses on promoting partnerships with HRSA-supported health centers, other HRSA-funded sites, and critical shortage facilities; and supporting technical assistance to improve processes and address system-level and structural barriers to SANE training and practice. HRSA estimates making 16 new awards in FY 2021. HRSA anticipates $9 million in 16 continuation awards for the ANE-SANE program in FY 2022.

Nurse Anesthetist Traineeships (NAT) Program: The NAT Program aims to increase the number of Certified Registered Nurse Anesthetists (CRNAs) providing care, especially to rural and underserved populations.

In Academic Year 2019-2020, grantees of the NAT Program provided direct financial support to 1,827 nurse anesthetist students. Students received clinical training in medically underserved

communities (73 percent) and/or primary care settings (35 percent) during the academic year. In addition, NAT trainees participated in COVID-19 related training (41 percent) and/or opioid use treatment (82 percent). Of these students, 1,249 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 20 percent planned to pursue employment or further training in a primary care setting.

In a five-year retrospective study, data showed the NAT program supported 7,971 individual anesthetist students of whom 6,492 graduated from their degree programs and entered the nursing workforce. Graduates from the NAT program over these five years increased the supply of nurse anesthetists in the United States by 15 percent. One-year post-graduation data showed that 47 percent of the NAT graduates were employed or pursing additional training in a medically underserved community. The NAT program increased CRNAs in rural areas in the United States. Twenty-three percent of the nursing students who intended to work in rural areas were able to obtain employment in that setting. HRSA anticipates $2.25 million in funding for 81 continuation awards for the NAT program in FY 2022.

Advanced Nursing Education Nurse Practitioner Residency (ANE-NPR) Program: The ANE-NPR Program prepares 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 supports preceptor development, and encourages eligible entities to develop training programs supporting the placement and retention of NPs in rural and underserved settings.

In Academic Year 2019-2020, the ANE-NPR program trained 94 nurse practitioner (NP) residents and 84 preceptors. There were a total of 16 NP resident graduates in the first year of the program. Sixty-three percent of first year graduates are currently employed in FQHCs or look-alikes and Rural Health Clinics. In addition, grantees from this program provided direct support to 19 faculty. Almost all of the NP residents received training in medically underserved communities (99 percent) and/or a primary care setting (99 percent).

Moreover, the majority of the NP residents participated in trainings related to COVID-19 (93 percent), opioid use treatment (91 percent) and/or telehealth (84 percent). The ANE-NPR grantees partnered with 122 clinical training sites to provide experiential training experiences to students. The majority of these sites where located in primary care settings (58 percent) and/or medically underserved communities (80 percent). A total of 792 courses where enhanced or developed, and 173 continuing education courses were offered. This program also supported 65 faculty and preceptor development training and activities. In FY 2022, HRSA plans to provide $22 million in 36 continuation funding for the ANE-NPR Program.

***Advanced Nursing Education- Nurse Practitioner Residency Integration Program (ANE-NPRIP*)**: In FY 2020, HRSA established the ANE-NPRIP Program with nurse practitioner optional fellowship funds to establish or expand community-based nurse practitioner and nurse midwife residency/fellowship programs that are accredited or in the accreditation process for

practicing postgraduate nurse practitioners in primary care or behavioral health. This program gives preference to Federally Qualified Health Centers (FQHCs).

In FY 2020, HRSA planned for five awards, received 15 applications, and was able to make 10 new awards totaling approximately $5 million. Out of the ten awards, five grantees are FQHCs (50 percent) and three of the grantees partners with FQHCs (30 percent). One of the ten grantees is mainly focused on serving rural areas, while three of the ten grantees are partnered with rural health clinics. During the inaugural year of AY 2020-2021, the ANE-NPRIP grantees projected to train 48 NP residents.

In FY 2022, HRSA plans to provide $5 million in 10 continuation funding for ANE-NPRIP.

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

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Nurse Practitioners • Nurse Midwives • Nurse Anesthetists • Nurse Educators • Sexual Assault Nurse Examiners • Registered Nurses • Forensic Nurses • Clinical Nurse Specialists	• Graduate (master's and doctoral) • Advanced education training	• Enhance advanced nursing education and practice • Provide traineeships to students in advanced nursing education programs • Provide post graduate Nurse Practitioner and Nurse Midwife transition-to-practice experience through residency programs • Develop academic-practice partnerships. • Support faculty and preceptor development. • Provide infrastructure development support. • Provide post-graduation employment assistance to support employment in rural and/or underserved settings.

Funding History

FY	Amount
FY 2018	$74,311,000
FY 2019	$74,210,000
FY 2020	$80,581,000
FY 2021 Enacted	$80,581,000
FY 2022 President's Budget	$80,581,000

Budget Request

The FY 2022 Budget Request for the Advanced Nursing Education Programs of $80.6 million is the same as the FY 2021 Enacted level. In FY 2022, the ANE programs anticipates making 200 continuation awards and plans to address the nationwide primary care provider shortage by increasing supply, distribution and access to nurse practitioners, nurse midwives and clinical nurse specialists, as well as respond to the need to increase the number of SANEs and nurse anesthetists available to provide specialized care. The request prioritizes funding for health workforce activities for training, preparing and connecting qualified clinicians to serve in areas of the nation 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)[73]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.38: Number of students trained in advanced nursing degree programs	FY 2019: 4,817 Target: 3700 (Target Exceeded)	3,700	4,500	+800
6.I.C.39: Percent of students trained who are URMs and/or from disadvantaged backgrounds	FY 2019: 34% Target: 27% (Target Exceeded)	36%	36%	Maintain
6.I.C.40: Number of graduates from advanced nursing degree programs	FY 2019: 1,604 Target: 900 (Target Exceeded)	1,000	1,400	+400

[73] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.

Program Activity Data

ANE Program Outputs	Year and Most Recent Result	FY 2020 Target	FY 2021 Target	FY 2022 Target
Number of students supported in NAT program	FY 2019: 1,827	2,400	2,400	2,400
Number of graduates from NAT program	FY 2019: 1,249	1,050	1,050	1,200
Percent of NAT graduates who are minority and/or from disadvantaged backgrounds	FY 2019: 28%	30%	30%	30%
Percent of graduates from NAT programs employed in underserved areas	FY 2019: 57%	45%	45%	50%
Number of graduates from ANE-SANE program	FY 2019: 228	300	300	300

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	204	204	200
Average Award	$766,539	$766,539	$766,539
Range of Awards	$1,000--$1,000,000	$1,000 - $1,000,000	$1,000 - $1,000,000

Nursing Workforce Diversity

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$18,343,000	$19,843,000	$23,343,000	+$3,500,000
FTE	3	3	3	---

Authorizing Legislation: Public Health Service Act, Sections 821, as amended by Public Law No: 116-136

FY 2022 Authorization $137,837,000

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 overarching goal of the NWD program is to increase access to high quality, culturally aligned registered nurse providers that reflect the diversity of the communities in which they serve. This goal is accomplished by assisting students from disadvantaged backgrounds to become registered nurses through student stipends, scholarships, pre-entry preparation and retention activities; facilitating diploma or associate degree registered nurses to become baccalaureate-prepared registered nurses; and preparing practicing registered nurses for advanced nursing education.

In FY 2020, HRSA supported a new NWD program, NWD-Eldercare Enhancement (NWD-E2). The NWD-E2 program strengthens the eldercare workforce communities where there are health care disparities related to access and delivery of care through the expansion of these opportunities for students from disadvantaged backgrounds. NWD-E2 aims to achieve a sustainable eldercare nursing workforce and equip the nursing students with the competencies necessary to address health care disparities related to access and delivery of care of elderly populations in rural and underserved areas. In FY 2020 HRSA supported the continuation of 34 continuing grant awards and 2 new awards.

In Academic Year 2019-2020, the NWD Program supported 66 college-level degree programs as well as 157 training programs and activities designed to recruit and retain health professions students. These programs trained 11,620 students, including 5,027 students who graduated or completed their programs. Degree programs had 5,888 enrolled students and academic support programs had 5,732 participants this academic year.

In addition to providing support to students, NWD grantees partnered with 963 training sites during the academic year to provide 10,811 clinical training experiences to trainees across all

programs. Approximately 43 percent of training sites were located in medically underserved communities and 35 percent were in primary care settings.

For the NWD program, a retrospective case study was conducted using data from Academic Year 2014-2015 through Academic Year 2018-2019. The NWD Program provided 33,813 training opportunities for nursing students and produced 15,876 graduates. Nursing students were nearly five times more likely to be Hispanic/Latino and two times more likely to identify as Black or African American compared to national nursing estimates. Among students that participated in a degree program, almost half of the students that earned pre-licensures came from disadvantaged backgrounds (48 percent). Since AY 2014-2015, the NWD grantees partnered with 2,442 individual training sites to provide a total of 53,316 experiential training opportunities. Overall, 45 percent of the clinical training sites were located in a medically underserved community, and 34 percent were located in a primary care setting. 20 percent were located in a rural area.

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

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

Funding History

FY	Amount
FY 2018	$17,300,000
FY 2019	$17,257,000
FY 2020	$18,343,000
FY 2021 Enacted	$19,843,000
FY 2022 President's Budget	$23,343,000

Budget Request

The FY 2022 Budget Request for the Nursing Workforce Diversity programs of $23.3 million is $3.5 million above the FY 2021 Enacted level. In FY 2021, the NWD program will provide funding to support 2 continuation grant awards and 31 new awards. In FY 2022, the NWD program will provide funding to support 29 continuing awards and 6 new awards.

The NWD and NWD-E2 programs will continue to assist students from disadvantaged backgrounds to become registered nurses through student stipends, scholarships, pre-entry preparation and retention activities; facilitating diploma or associate degree registered nurses to become baccalaureate-prepared registered nurses; and preparing practicing registered nurses for advanced nursing education.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[74]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.41: Percent of program participants who are URMs and/or from disadvantaged backgrounds	FY 2019: 100% Target: 95% (Target Exceeded)	98%	98%	Maintain
6.I.C.42: Number of program participants who participated in academic support programs during the academic year	FY 2019: 5,732 Target: 3,300 (Target Exceeded)	4,500	6,000	+1,500
6.I.C.43: Number of program participants who are enrolled in a nursing degree program	FY 2019: 5,888 Target: 2,800 (Target Exceeded)	2,500	5,000	+2,500

[74] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.

Program Activity Data

NWD Program Outputs	Year and Most Recent Result	FY 2020 Target	FY 2021 Target	FY 2022 Target
Percent of URM students	FY 2019: 45%	60%	60%	60%
Number of nursing students graduating from nursing programs	FY 2019: 1,751	2,500	2,500	2,500

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	36	33	35
Average Award	$471,884	$471,884	$471,884
Range of Awards	$95,679 - $495,750	$95,679 - $555,000	$95,679 - $555,00

Nurse Education, Practice, Quality and Retention Programs

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$43,913,000	$46,913,000	$46,913,000	---
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Sections 831 and 831A, as amended by Public Law No: 116-136

FY 2022 Authorizations.....$137,837,000

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments:

The Nurse Education, Practice, Quality and Retention (NEPQR) Programs address national nursing needs and strengthen the capacity for basic nurse education and practice under three priority areas: Education, Practice and Retention. The Programs support academic, service and continuing education projects to enhance nursing education, improve the quality of patient care, increase nurse retention, and strengthen the nursing workforce.

The NEPQR Programs have a variety of statutory goals and purposes that support the development, distribution and retention of a diverse, culturally competent health workforce that can adapt to the population's changing health care needs and provide the highest quality of care for all. Woven throughout the Programs is the aim to increase the number of Bachelor of Science in Nursing (BSN) students exposed to enhanced curriculum and with meaningful clinical experience and training in medically underserved and rural communities, who will then be more likely to choose to work in these settings upon graduation.

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 purpose of this three-year program is to increase the access to and quality of behavioral health services through team-based care models in interprofessional nurse-led primary care teams in rural or underserved areas. The IPCP-BHI program will increase the training of the current and future nursing workforce, and strengthen their ability to provide integrated behavioral health care services in primary care settings through academic-practice partnerships. In FY 2020, HRSA made 17 new awards. In FY 2021, HRSA will continue to support the 17 awards made in FY 2020.

In Academic Year 2019-2020, IPCP grantees trained 868 individuals and produced 509 graduates. Grantees partnered with 42 clinical sites to provide interprofessional team-based training to 849 individuals. Approximately 71 percent of the clinical training sites were located

in medically underserved communities, and 81 percent were in primary care settings. More than 50 percent of interprofessional trainees were practicing nurses and nursing students, while 393 were trainees from other health care disciplines, including medical, dental, and behavioral health. HRSA awarded approximately $8 million in new awards to 17 grantees in FY 2020.

Registered Nurses in Primary Care (RNPC) Training Program: The RNPC program was initiated in July 2018, 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. 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.

In Academic Year 2019-2020, the RNPC program trained 1,576 individuals in primary care nursing programs and produced 505 graduates. Over 40 percent of nursing students received training in substance use treatment (43 percent), in addition to participating in training related to COVID-19 (36 percent) and/or opioid use treatment (45 percent). RNPC grantees partnered with 455 training sites to provide experiential training. These training sites were located in primary care settings (75 percent), medically underserved communities (76 percent), or rural areas (38 percent). The majority of the clinical training sites offered COVID-19 related services (56 percent). In addition, clinical sites provided telehealth service (57 percent) and integrated behavioral health services in primary care (37 percent). HRSA awarded approximately $27 million in continuation awards to 42 grantees in FY 2020 and FY 2021.

Veteran Registered Nurses in Primary Care (VNPC) Training Program: The VNPC program was initiated in 2019 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. The purpose of this three-year training program is to recruit and train veteran nursing students and current registered nurses (RNs) to practice to the full scope of their license in community-based primary care teams to increase access to care, with an emphasis on veteran care, chronic disease prevention and control, including mental health and substance use conditions. HRSA awarded approximately $3.5 million in continuation awards to seven grantees in FY 2020 and FY 2021

In Academic Year 2019-2020, the VNPC program trained 56 veterans to obtain their Bachelor of Science in Nursing (BSN). The majority of the trainees received training in medically underserved communities (61 percent) and for more than 40 percent of trainees, their experiential training was in primary care settings. In addition, individuals were trained in opioid use treatment (32 percent), in telehealth (50 percent) and/or participated in COVID-19 related training (29 percent). The VNPC grantees partnered with 18 clinical training sites to offer experiential training. These training sites were located in medically underserved communities (56 percent) and/or primary care settings (44 percent). In addition, clinical sites offered services related to COVID-19 (72 percent), integrated behavioral health services in primary care (67 percent), opioid use treatment (50 percent) and/or substance use treatment (61 percent).

Simulation Education Training (SET) Program*:* The NEPQR-SET program was initiated in FY 2020 to enhance public health nursing education and practice with the use of simulation-based technology to advance the health of patients, families, and communities in rural and medically underserved areas experiencing diseases and conditions that affect public health including high burden of stroke, heart disease, behavioral and mental health, maternal mortality, HIV/AIDS and or obesity. HRSA awarded $2.2 million in new awards to five grantees in FY 2020. HRSA anticipates making 11 new awards in FY 2021.

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

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

Funding History

FY	Amount
FY 2018	$41,733,000
FY 2019	$41,704,000
FY 2020	$43,913,000
FY 2021 Enacted	$46,913,000
FY 2022 President's Budget	$46,913,000

Budget Request

The FY 2022 Budget Request for the Nurse Education, Practice, Quality and Retention Programs of $46.9 million is the same as the FY 2021 Enacted level. In FY 2020, the NEPQR program provided funding to support 49 continuation awards and 22 new awards. In FY 2021, the NEPQR programs provided funding to support 66 continuation awards and 11 new awards. In FY 2022, the NEPQR programs will provide funding to support 17 continuation awards and approximately 47 new awards to increase the education and training of nursing student to provide care in community-based settings.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[75]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.57: Number of NEPQR nursing students trained in primary care	FY 2019: 1,632 (Baseline)	N/A	1,600	N/A
6.I.C.58: Number of NEPQR trainees and professionals participating in interprofessional team-based care	FY 2019: 2,947 (Baseline)	N/A	2,900	N/A

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	71	77	64
Average Award	$633,358	$633,358	$657,755
Range of Awards	$392,168 -$778,571	$392,168 -$750,000	$315,511 - $1,000,000

[75] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.

Nurse Faculty Loan Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$28,500,000	$28,500,000	$28,500,000	---
FTE	3	4	4	---

Authorizing Legislation: Public Health Service Act, Section 846A and 847(f), as amended by Public Law No: 116-136.

FY 2022 Authorization $117,135,000

Allocation Method .....Formula Grant

Program Description and Accomplishments:

The Nurse Faculty Loan Program (NFLP), which began in 2003, seeks to increase the number of qualified nurse faculty by providing funding to accredited schools of nursing to establish and operate a student loan fund and provide loans to students enrolled in advanced education nursing degree programs who are committed to becoming nurse faculty. In exchange for completion of up to four years of post-graduation full-time nurse faculty employment in an accredited school of nursing, the program authorizes cancelation of up to 85 percent of any such student loan (plus interest thereon).

In Academic Year 2019-2020, 45 schools received new NFLP awards. Awardees supported 2,270 nursing students pursuing graduate level degrees with the intent of serving as nurse faculty. By the end of the Academic Year, 659 trainees graduated, 89 percent of whom intended to teach nursing.

The number of schools receiving a new NFLP award does not equate to the number of schools providing NFLP loans to graduate-level nursing students. New NFLP awards are made to eligible new applicants (with no current NFLP award) and continuing applicants (with current NFLP award), who apply for the funding annually. In order to receive a new NFLP award, continuing applicants must meet certain criteria with regard to program compliance and loan fund balances. However, even schools that do not receive new awards may continue making loans from the student loan fund accounts they have already established. NFLP grantees are expected to continue conducting training activity and maintaining the loan fund account throughout the duration of the project.

In FY 2022, HRSA plans to make 80 new awards to new and continuing NFLP applicants.

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, post-masters and doctoral)	• Using the federal contribution to establish and/or maintain a student loan fund. • Contribute an amount equal to or at least one-ninth of the federal contribution, to the loan fund account. • Conduct an active training program for students pursuing a course of study in an advanced education nursing degree program that prepares them to become nurse faculty. • Provide loan funds to advanced education nursing students to cover the costs of tuition, fees, books, laboratory expenses, and other educational expenses. • Provide cancelation of up to 85 percent of the original student loans (plus interest thereon) for completion of up to four years of post-graduation service as full-time nurse faculty. • Collect on principal and interest on all loans made from the NFLP student loan fund (and any other earnings of the fund) for deposit into the fund.

Funding History

FY	Amount
FY 2018	$28,500,000
FY 2019	$13,433,000
FY 2020	$28,500,000
FY 2021 Enacted	$28,500,000
FY 2022 President's Budget	$28,500,000

Budget Request

The FY 2022 Budget Request for Nurse Faculty Loan Program of $28.5 million is the same as the FY 2021 Enacted level. In FY 2021, the NFLP anticipates making 80 awards and plans to connect nurse faculty to areas of need by targeting application outreach to schools in rural/underserved areas and supporting NFLP graduates to fulfill their service obligation as nurse faculty in rural and underserved areas. The request prioritizes funding for health workforce activities that provide grants to schools who make loans to students in exchange for their service as nurse faculty.

In FY 2022, NFLP will continue to support enhancing the diversity of the health workforce by increasing the number of trainees from URM, rural, and disadvantaged backgrounds.

Additionally, the funds will help increase the number of nursing faculty working in rural and underserved areas, and in other 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)[76]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.46: Number of graduate-level nursing students who received a loan	FY 2019: 2,270 Target: 1,000 (Target Exceeded)	1,900	1,900	Maintain
6.I.C.47: Number of loan recipients who graduated from an advanced nursing degree program	FY 2019: 659 Target: 400 (Target Exceeded)	400	600	+200

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	81	80	80
Average Award	$329,477	$329,477	$329,477
Range of Awards	$15,900 - $2,040,607	$15,900 - $2,040,607	$15,900 - $2,040,607

[76] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.

Nurse Corps

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$88,635,000	$88,635,000	$88,635,000	---
FTE	28	30	39	+9

Authorizing Legislation: Public Health Service Act, Section 846 as amended by Public Law No: 116-136

FY 2022 Authorization $117,135,000

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

Program Description and Accomplishments:

HRSA's nursing and primary care projections generally indicate that the supply of nurses will outpace demand at a national level in 2030. However, maldistribution of nurses is projected to be a continued problem. In addition, projections at the national-level mask a distributional imbalance of registered nurses (RN) at the state-level. Specifically, seven states are projected to experience a shortage of RNs by 2030.[77] Furthermore, as the Administration seeks to continue to address the opioid epidemic and other substance use disorders across the nation, the Nurse Corps program is critical to ensure access to high quality adequate behavioral health nursing workforce. In addition, the COVID-19 pandemic has added a new layer of challenges to the preservation and expansion of the nursing workforce.

Stress and burnout among the nursing workforce are among the most pressing concerns. Gaps in personal protective equipment, the risks of acquiring COVID-19, and concerns about transmitting the virus to family and loved ones can all contribute to burnout and an interest in changing to other careers.[78] Nurses have been reported to experience stress associated with separation from family, sleep deprivation and heavy workloads created by health system demand and staff shortages.[79] Nurses serving throughout the country, especially those on the front lines battling this pandemic are seeing an increased demand for their services.

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; (2) access to

[77] DHHS (US), Health Resources and Services Administration, National Center for Health Workforce Analysis. (2017) Supply and Demand Projections of Nursing Workforce: 2014-2030.
[78] Fernandez PR, Lord H, Halcomb PE, et al. Implications for COVID-19: a systematic review of nurses' experiences of working in acute care hospital settings during a respiratory pandemic [published online ahead of print, 2020 May 8]. *Int J Nurs Stud*. 2020;103637. doi:10.1016/j.ijnurstu.2020.103637
[79] Huang, L., Rong Liu, H., 2020. Emotional responses and coping strategies of nurses and nursing college students during COVID-19 outbreak. medRxiv.

behavioral health services by increasing funding for scholarships and loan repayment assistance for behavioral health training and service for Nurse Practitioners (NPs) specializing in psychiatric mental health; and (3) access to women's and maternal health services by increasing funding for scholarships and loan repayment assistance to scholars pursuing degrees and clinicians serving in this specialty area.

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, 2020, over three-quarters of the Nurse Corps providers were serving in community-based settings and 22 percent served in rural communities.

The Nurse Corps Program includes:

Nurse Corps Loan Repayment Program (LRP): Nurse Corps LRP, which began in 1988, aims to assist in the recruitment and retention of professional RNs, including advanced practice RNs (APRNs), (i.e., nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, clinical nurse specialists) who are dedicated to working in CSFs or as faculty in eligible 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 2020, 58 percent of Nurse Corps LRP participants extended their service commitment for an additional year, exceeding the 52 percent target; and in FY 2020, 84 percent of Nurse Corps participants were retained in service at a CSF for up to two years beyond the completion of their Nurse Corps service commitment.[80] In addition, in FY 2020, 96 percent of Nurse Corps SP awardees are pursuing their baccalaureate degree or advanced practice degree.

In FY 2021, HRSA plans to continue directing up to 20 percent of scholarship and loan repayment awards to NPs specializing in psychiatric-mental health with the goal of leveraging

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

HRSA funding to address the opioid crisis. In FY 2021, Nurse Corps will fund an estimated 252 scholarship (new and continuation) and 753 loan repayment (new and continuation) awards.

Additionally, Nurse Corps supports increasing the skilled workforce of women's health nurses who are trained to provide care for women, and practice in rural and underserved communities. Maternal mortality and morbidity are key indicators of women's health worldwide. Each year more than 300,000 women across the globe die from complications associated with pregnancy or childbirth.[81] In 2015, the U.S. ranked 46th among the 181 countries with a maternal mortality rate that is among the highest of developed countries.[82] Too often, women cannot initiate prenatal care within the first trimester of their pregnancy due to lack of access to providers or coverage for services.[83] Provider availability, knowledge, training, and preparedness, as well as access to life-saving medication and tools are factors that impact high maternal mortality rates. In FY 2021 and FY 2022, HRSA plans to expand the set aside funding for women's and maternal health services up to $5M each for scholarship and loan repayment awards for the funding of women's health NPs, certified nurse midwifery (CNM), and certified obstetrics and gynecology RNs that was piloted in FY 2020. This proposal is in support of the Improve Access to Maternity Care Act 42 USC 201.

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 CSF or at an accredited, public or private 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 2018	$87,107,000
FY 2019	$86,701,000
FY 2020	$88,635,000
FY 2021 Enacted	$88,635,000
FY 2022 President's Budget	$88,635,000

[81] "Trends in Maternal Mortality: 1990 to 2015." *World Health Organization*, 24 Jan. 2020, www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en.
[82] World Health Organization. "Maternal Mortality." *World Health Organization*, 24 Oct. 2019, www.who.int/gho/maternal_health/mortality/maternal/en.
[83] Schlesinger, Mark, and Karl Kronebusch. "The Failure of Prenatal Care Policy for the Poor." *Health Affairs*, 2020, pp. 91–111, doi.org/10.1377/hlthaff.9.4.91.

Budget Request

The FY 2022 Budget Request for the Nurse Corps program of $88.6 million is the same as the FY 2021 Enacted level. This request will fund an estimated 244 scholarship (new and continuation) and 681 loan repayment (new and continuation) awards. This request will allow the program to maintain its efforts to address the anticipated demand for nurses in CSFs. Additionally, the funds will help increase the number of well-trained nurses available to provide mental/behavioral health and women's/maternal health services in communities experiencing a shortage in nurses.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 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 2020: 58% Target: 52% (Target Exceeded)	52%	52%	Maintain
5.I.C.5: Proportion of Nurse Corps LRP/SP participants retained in service at a critical shortage facility for at least one year beyond the completion of their Nurse Corps LRP/SP commitment.	FY 2019: 85% 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 2020: 96% Target: 85% (Target Exceeded)	85%	85%	Maintain
5.E.1: Default rate of Nurse Corps LRP and SP participants. *(Efficiency)*	FY 2020: LRP: 2.27% Target: 3% (Target Exceeded) SP: 7.1% Target: 15% (Target Exceeded)	LRP: 3% SP: 15%	LRP: 3% SP: 15%	Maintain

Nurse Corps Loans/Scholarships Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Loans	$53,719,072	$59,090,000	$59,090,000
Scholarships	$24,837,380	$29,545,000	$29,545,000

Nurse Corps Awards

	2015	2016	2017	2018	2019	2020	2021	2022
Scholarships								
New Awards	257	230	198	215	220	244	238	229
Continuation Awards	12	12	14	4	6	13	14	15
Loan Repayment								
New Awards	590	518	501	544	561	465	431	413
Continuation Awards	319	365	340	279	292	291	322	268
Total	**1,178**	**1,125**	**1,053**	**1,042**	**1,079**	**1,013**	**1,005**	**925**

Nurse Corps Field Strength

	2015	2016	2017	2018	2019	2020	2021	2022
Scholarship	396	476	362	465	450	415	476	498
Loan Repayment	1,313	1,219	1,181	1,129	1,279	1,293	1,102	1,005
Loan Repayment Nurse Faculty	321	321	331	271	199	135	116	106
Total	**2,030**	**2,016**	**1,874**	**1,865**	**1,928**	**1,843**	**1,694**	**1,609**

Children's Hospitals Graduate Medical Education Payment Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$340,000,000	$350,000,000	$350,000,000	---
FTE	16	16	16	---

Authorizing Legislation: Public Health Service Act, Section 340E. The Dr. Benjy Frances Brooks Children's Hospital GME Support Reauthorization Act of 2018 (P.L. 115-241) reauthorized the program through fiscal year 2023.

FY 2022 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 Payment Program helps eligible hospitals maintain GME programs to support graduate training for physicians to provide quality care to children. It supports the training of residents to care for the pediatric population and enhances the supply of primary care and pediatric medical and surgical subspecialties.

A sufficient and appropriate health workforce, efficient organization of health care teams, and training in value-based models of care are all critical components to supporting new models of care that drive value and quality throughout the entire system. In FY 2021, the CHGME Payment Program implemented the third year of the Quality Bonus System (QBS), authorized by statute to allow the Secretary of HHS to distribute bonus payments to participating CHGME hospitals that meet quality standards specified by the Secretary. The goal of the QBS is to recognize and incentivize awardees with high quality training to meet the pediatric workforce needs of the nation. The CHGME QBS is the first of its kind for any federal GME payment program and responds to changes occurring in the larger health care arena. The CHGME QBS is the only flexibility allowed in the legislation in the CHGME Payment Program in how payments can be distributed.

The FY 2021 and FY 2022 CHGME QBS payments aim to incentivize individual level reporting for all residents supported by the CHGME Payment Program. In order to qualify for the QBS payment, awardees must complete individual level documentation for all residents supported by the CHGME Payment Program in the FY 2021 and FY 2022 Annual Performance Reports (AY 2020-2021 and AY 2021-2022). In FY 2022, HRSA will implement a pay for performance QBS based on the recommendations and data collected through an evaluation contract with the George Washington University. The CHGME QBS will link bonus payments with measures that address

issues of access related to general shortages and mal-distribution of generalists and subspecialists, including in rural and urban underserved areas, efforts to assure a diverse and inclusive pediatric workforce, and educational priorities that prepare all pediatricians to practice as part of a care team.

The CHGME Payment Program supports the training of residents in graduate medical education in freestanding children's teaching hospitals and supports a Full-Time Equivalent (FTE) Assessment conducted annually to verify the number of FTE resident counts reported by eligible awardees. In FY 2020, the CHGME Payment Program distributed $323,713,555 to 59 eligible awardees, including $1,589,804 in QBS payments to 29 awardees who met the eligibility requirements. For FY 2021, the CHGME Payment Program will award $332,470,465 to the same 59 eligible awardees including a QBS payment for those who meet the QBS eligibility criteria. For FY 2022, the CHGME Payment Program plans on the same level funding as the prior fiscal year and number of eligible awardees. The CHGME Payment Program has an annual project period from October 1, 2021 to September 30, 2022.

In FY 2020, 59 children's hospitals received CHGME funding. During FY 2019 (AY 2019-2020), the most recent year for which FTE information was reported, the CHGME hospitals trained 7,757 resident full-time equivalents (FTEs).[84] Among these FTEs, 41 percent were pediatric residents, 32 percent were pediatric subspecialty residents, and 27 percent were residents training in other primary disciplines such as family medicine.

During Academic Year 2019-2020, the most recent year for which performance information is available, CHGME-funded hospitals served as sponsoring institutions for 42 residency programs and 252 fellowship programs. In addition, they served as major participating rotation sites for 628 additional residency and fellowship programs. CHGME supported the training of 5,433 pediatric residents that included general pediatrics residents, as well as residents from seven types of combined pediatrics programs (e.g., internal medicine/ pediatrics).

Additionally, 3,055 pediatric medical subspecialty residents, 322 pediatric surgical subspecialty residents, and 403 adult and pediatric dentistry residents were trained. CHGME funding was also responsible for the training of 4,037 adult medical and surgical specialty residents such as family medicine residents who rotate through children's hospitals for pediatrics training. The total number of funded residents and fellows during Academic Year 2019-2020 was 13,250. During their training, these medical residents and fellows provided care during more than 1.6 million patient encounters in primary care settings in addition to providing over 4.7 million patient contact hours in medically underserved communities.

Of the full-time residents and fellows who completed their training during Academic Year 2019-2020, approximately 61 percent of these CHGME-funded physicians chose to remain and practice in the state where they completed their residency training. Among 358 health care delivery sites utilized for residency training, 44 percent provided telehealth services, 22 percent offered substance use treatment services, and 26 percent offered COVID-19 related services.

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

Approximately 26 percent of residents received training in opioid use treatment, 34 percent received training in telehealth, and 52 percent received COVID-19 related 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 • Dentists • Psychiatry	• Graduate medical education	• Operate accredited graduate medical education programs for residents and fellows. • Submit an annual report on the status and expansion of GME in their institutions.

Funding History

FY	Amount
FY 2018	$314,213,000
FY 2019	$323,382,000
FY 2020	$340,000,000
FY 2021 Enacted	$350,000,000
FY 2022 President's Budget	$350,000,000

Budget Request

The FY 2022 Budget Request for the CHGME program of $350.0 million is the same as the FY 2021 Enacted level.

The Budget request enables HRSA to continue to support approximately 7,757 physicians FTEs for direct and indirect medical expenses for graduate medical education. Direct medical education spending includes expenditures related to stipends and fringe benefits for residents, salaries and fringe benefits of supervising faculty, costs associated with providing the GME training programs and institutional overhead costs. Indirect medical education spending includes expenditures associated with the productivity of the hospital staff as they assist in training residents, and the processing of additional diagnostic tests that residents may order during their clinical experience.

The FY 2022 funding request will support the FTE resident verification through an annual FTE Assessment contract to ensure funded FTEs counts are reported correctly and are not funded by other federal programs to avoid an overlap in payments. The funding will also support costs associated with the award process, program performance reviews, QBS eligibility reviews, and information technology and other program support costs. The funding will further support

additional information technology enhancements that ensure accurate certification of FTE counts and analysis of QBS data needed to determine payments.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[85]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
7.I.A.1: Maintain the number of FTE residents training in eligible children's teaching hospitals	FY 2019: 7,757 Target: 6,700 (Target Exceeded)	7,140	7,700	+560
7.VII.C.1: Percent of hospitals with verified FTE residents counts and caps	FY 2019: 100% Target: 100% (Target Met)	90%	90%	Maintain
7.E: Percent of payments made on time	FY 2019: 100% Target: 100% (Target Met)	100%	100%	Maintain

Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	59	59	59
Average Award	$5,486,670	$5,635,092	$5,635,092
Range of Awards	$29,233-$23,300,699	$32,222-$24,614,100	$32,222-$24,614,100

[85] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.

Teaching Health Center Graduate Medical Education Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$126,500,000	$126,500,000	$119,290,000[86]	-$7,211,000
FTE	8	10	16	+6

Authorizing Legislation: Public Health Service Act, Section 340H, as amended by Public Law No. 116-260.

FY 2022 Authorization ..... Expires 9/30/2023

Allocation Method ..... Formula Based Payment

Program Description and Accomplishments:

Primary care physician shortages persist, particularly in rural and other underserved communities.[87] As of June 30, 2020, an estimated 79 million people live in primary care Health Professional Shortage Areas (HPSAs), 58 million live in dental HPSAs, and 116 million live in mental health HPSAs.[88] Access to high quality primary care is associated with improved health outcomes and lower costs.[89, 90] A number of strategies are effective in incentivizing providers to choose careers in primary care and to practice in rural and underserved areas including positive training experiences in rural and underserved communities and rotations in community based practice locations.[91,92] There is evidence that physicians who receive training in community and underserved settings are more likely to practice in similar settings, such as health centers.[93]

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

[86] FY 2022 reflects the post-sequestration amount.
[87] 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.
[88] Health Services and Resources Administration. (2020). Third Quarter of Fiscal Year 2020 Designated HPSA Quarterly Summary. As of June 30, 2020.
[89] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Quarterly. 2005; 83(3):457-502.
[90] 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.
[91] Washko, M, Snyder, J, & Zangaro, G. Where do physicians train? Investigating public and private institutional pipelines. Health Affairs. 2015; 34(5): 852-856.
[92] Connelly M, et al. Variation in Predictors of Primary Care Career Choice by Year and Stage of Training. Journal of General Internal Medicine. 2003; 18(3): 159-69.
[93] Chang C, O'Malley A, Goodman D. Association between Temporal Changes in Primary Care Workforce and Patient Outcomes. Health Services Research. 2017; 52:634–55.

number of these primary care providers. Teaching Health Centers (THCs) specifically have been shown to attract residents from rural and/or disadvantaged backgrounds who are more inclined to practice in underserved areas than those from urban and economically advantaged backgrounds.[94] In a national census of third-year family medicine residents, those who trained in THCs were more likely to plan to work in safety net clinics than residents who did not train in these centers.[95]

Unlike most Federal funding for graduate medical education (GME), THCGME payments support training in community-based ambulatory care settings, as opposed to in-patient care settings in hospitals. Although health centers receive federal funding to improve access to care, they often have difficulty recruiting and retaining primary care professionals.[96] Community health centers are also generally smaller organizations with smaller operating margins compared to teaching hospitals. The THCGME Program is uniquely positioned to meet these recruitment and retention needs by providing funding to support residents training in underserved communities. Without THCGME funding, these additional residency positions would be challenging to maintain, resulting in a decrease in physicians and dentists available to serve 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 ensure 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. Based on recent research demonstrating overall health care cost savings when patients are served in community health centers, the patient care provided by THC residents could yield up to $288 million in Medicaid and Medicare savings between 2019 and 2023. After residency training, evidence demonstrates that physicians who trained in cost-efficient geographic areas continue to provide lower-cost care in their post-residency practice.[97] 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 expanding Americans' overall access to care.

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

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

[95] Bazemore A, Wingrove P, Petterson S, Peterson L, Raffoul M, Phillips RL Jr. Graduates of Teaching Health Centers Are More Likely to Enter Practice in the Primary Care Safety Net. *Am Fam Physician*. 2015;92(10):868.

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

[97] Chen C, Ku L, Regenstein M, Mullan F. Policy Issue Brief 58: Examining the Cost Effectiveness of Teaching Health Centers. March 2019.

In September 2019, HRSA awarded a three-year contract to George Washington University to conduct an updated evaluation of the costs of residency training at THCs, including identifying both direct and indirect expenses. Information and data from this evaluation will provide HRSA with a future methodology to determine appropriate THCGME program payments for direct medical expenses as well as indirect medical expenses.

In Academic Year 2021-2022, HRSA will award to 60 teaching health centers that will support the training of up to 801 resident FTEs. Currently, 45 of the 60 teaching health centers are in Federally Qualified Health Centers (FQHCs) or FQHC Look-alikes.

In Academic Years 2022-2023, HRSA anticipates awarding approximately $220 million appropriated by the American Rescue Plan Act of 2021 to support up to 145 teaching health centers including up to 60 continuation awards, 35 expansion awards, and 50 new awards to establish teaching health centers. These funds will be used to increase the maximum number of approved resident FTE slots to over 1,375. Funding for the additional resident FTE slots is made available through the American Rescue Plan Act of 2021, which will provide support through Fiscal Year 2023. In addition, funds will be used to increase the per resident rate (PRA) payment to THCGME awardees by $10,000, resulting in a total payment of $160,000 per resident FTE starting in FY 2021. Additional awards will be made from the American Rescue Plan Act of 2021 to support the development of new teaching health center programs in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, psychiatry, obstetrics and gynecology, general dentistry, pediatric dentistry, and geriatrics to address the physician workforce shortages and challenges faced by rural and underserved communities.

Once the authorization ends on September 30, 2023, additional funding will be needed to support the training of teaching health center residents beyond Academic Year 2023-2024. Should mandatory base and supplemental THCGME new and expansion funding cease after FY 2023, teaching health centers would not be able to sustain the training of their residents through program completion. As a result, the additional residents supported by supplemental THCGME funding would have their training interrupted, impacting direct patient care and these residents may need to seek out-of-cycle alternate residency opportunities, most likely in non-community based settings. In addition, communities served by teaching health center residents will be impacted by the loss of these additional physician and dental residents.

In Academic Year 2019-2020, the THCGME Program awarded 738[98] resident FTE slots that provided funding to 883 primary care medical and dental residents. While the number of FTE slots just missed the target due to the unexpected loss of two grantees, the program increased the number of FTE slots by 10 and the number of residents funded by 25 over the prior academic year. Nearly all residents (over 99 percent) received training in a primary care setting, providing care during nearly half a million patient encounters and accruing over 600,000 contact hours with these primary care patients. Additionally, most THCGME residents (93 percent) spent a significant part of their training in medically underserved and/or rural communities, providing more than 1.1 million hours of patient care to more than 800,000 patients. Approximately 19

[98] Awarded FTE slots are not the maximum resident FTE cap of up to 801 resident FTEs.

percent of residents reported coming from a financially or educationally disadvantaged background, and 24 percent of them reported a rural background.

In addition to supporting training of individual residents, THCGME recipients also used funding to develop or enhance curricula on topics related to primary care. Programs developed or enhanced and implemented 1,490 courses and training activities during the academic year, impacting over 12,600 healthcare trainees. Over 6,600 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. Among 582 health care delivery sites utilized for residency training, 46 percent provided telehealth services, 30 percent offered substance use treatment services, and 30 percent offered COVID-19 related services. Approximately 80 percent of residents received training in opioid use treatment, 63 percent received training in telehealth, and 60 percent received COVID-19 related training.

Of the 286 residents who completed the program in Academic Year 2019-2020, approximately 60 percent reported intentions to practice in a primary care setting, while 55 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 2020-2021). Of the 213 program completers from the prior academic year for whom employment data was available, most currently practice in a primary care setting (66 percent) and/or in a medically underserved community (55 percent).

Since the THCGME Program began, 1,434 new primary care physicians and dentists have graduated and entered the workforce. As the national average of physicians practicing in primary care specialties is approximately 33 percent, [99] the THCGME Program has evidenced much stronger results. Cumulative follow-up data indicates that 65 percent of graduates are currently practicing in a primary setting and approximately 56 percent of the graduating physicians and dentists are currently practicing in a medically underserved community and/or rural setting. THCGME residents have cumulatively provided over 3.5 million hours of patient care in primary care settings during 3.1 million patient encounters. Residents additionally provided over 5.5 million hours of patient care in medically underserved and rural settings, significantly expanding access to care in these key settings.

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

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

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

Funding History

FY	Amount
FY 2018	$126,500,000
FY 2019	$126,500,000
FY 2020	$126,500,000
FY 2021 Enacted	$126,500,000
FY 2022 President's Budget	$119,290,000[100]

Budget Request

The THCGME program is funded at $126.5 million for each fiscal year through FY 2023. [101] In FY 2022, THCGME mandatory funding will be reduced by $7.2 million through sequestration pursuant to the Balanced Budget and Emergency Deficit Control Act (BBEDCA). Academic Year 2022-2023, the program expects to support up to 801 FTE slots, which is the maximum resident FTE cap at the current funding level. Recoveries and carryover funds in addition to supplemental funds under the American Rescue Plan Act of 2021 will also support this activity.

[100] FY 2022 reflects the post-sequestration amount.
[101] Subject to Sequestration thru FY 2023.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[102]	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
6.I.C.5: Number of resident positions supported by Teaching Health Centers (Cumulative)[103]	FY 2019: 738 Target:750 (Target Not Met)	740	740	Maintain
6.I.C.48: Percent of THCGME-supported residents training in rural and/or underserved communities	FY 2019: 93% Target: 80% (Target Exceeded)	80%	80%	Maintain

Program Activity Data

THCGME Program Outputs	Year and Most Recent Result
Number of primary care residents funded by THCGME residencies[104]	FY 2019: 883
Number of primary care residents completing training	FY 2019: 286
Percent of residents who are from a disadvantaged and/or rural background	FY 2019: 36%
Percent of primary care resident program completers who intend to practice in primary care settings	FY 2019: 60%

[102] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.
[103] Measure captures the number FTEs resident slots awarded and not the maximum possible nor the number of individuals receiving direct financial support through the program. Awardees may use 1 FTE slot to fund two residents at 50 percent time, thus the FTE slot is not a one to one correspondence with number of individuals trained. Number of residents also does not equal the number of graduates as primary care residency programs require one year (Dental and Geriatrics), three years (Family Medicine, Internal Medicine, and Pediatrics), or four years (Ob-Gyn and Psychiatry) of training.
[104] Measure captures the number of individual residents supported, which is different than the FTE slots.

Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	60	60	60
Average Award	$1,923,445	$2,003,550	$1,988,150
Range of Awards	$63,000- $8,175,000	$300,000- $8,175,000	$300,000- $8,175,000

National Practitioner Data Bank

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$18,814,000	$18,814,000	$18,814,000	---
FTE	37	38	38	---

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 2022 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 1.6 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 2020, the NPDB facilitated more than 9.9 million queries from the NPDB to authorized health care providers and entities.
- DPDB has launched attestation initiatives for HRSA's community health centers, hospitals, health plans, medical malpractice payers, all other health care entities, and authorized agents. To date, the attestation completion rate for selected health centers, hospitals, health

plans, medical malpractice payers, all other health care entities, and authorized agents is over 90 percent.

- In FY 2020, NPDB released a publicly available interactive Compliance Results tool[105] that displays the compliance and attestation results for state licensing and certification boards.
- In response to the COVID-19 pandemic, the NPDB temporarily waived query fees. The fee waiver supported health care entities, during this national emergency, to make informed hiring, licensing, and credentialing decisions. As a result, the NPDB waived fees for over 6 million one-time queries, continuous queries, and continuous query renewals between March 1, 2020, and September 30, 2020.

Funding History

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

FY	Amount
FY 2018	$16,922,234
FY 2019	$18,730,776
FY 2020	$10,600,000
FY 2021 Enacted	$18,814,000
FY 2022 President's Budget	$18,814,000

Budget Request

The FY 2022 Budget Request for the National Practitioner Data Bank program of $18.8 million in user fees, is the same as the FY 2021 Enacted level. This is based on HRSA's projections of queries on practitioners and organizations.

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

[105] State Licensing Board Compliance Results

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 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 2020: 4,538,937 Enrolled Practitioners Target: 3,900,000 Enrolled Practitioners (Target Exceeded)	4,200,000	5,300,000	+1,100,000
8.III.B.7: Increase annually the number of disclosures of NPDB reports to health care organizations	FY 2020: 2,022,845 Disclosures Target: 1,980,000 (Target Exceeded)	2,020,000	2,100,000	80,000

Health Workforce Cross-Cutting Performance Measures

The Bureau of Health Workforce (BHW) has tracked and reported on four cross-cutting measures for over 30 of its programs that reported performance data during Academic Year 2019-2020. The cross-cutting measures focus specifically on the diversity of individuals completing specific types of health professions training programs;[106] the rate in which individuals participating in specific types of health professions training programs are trained in medically underserved communities;[107] 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.[108]

During Academic Year 2019-2020, results showed that 50 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.[109]

With regard to the types of settings used to provide training, results showed that 67 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 57 percent. This is a small improvement over last year's result of 65 percent and reflects the Bureau's continued emphasis aimed at increasing service and training in rural and underserved areas. As a result, more health professions trainees are being exposed to training and patient care in medically underserved communities than in prior years.

Results showed that 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. This result surpassed the target of 40 percent.

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[106] 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, 30 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.

[107] 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.

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

[109] 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 71 percent, far exceeding the target of 45 percent. This result is also an improvement over last year's result due to a continued focus on the programmatic emphasis of interprofessional training across programs in the Bureau.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [110]	FY 2021 Target [111]	FY 2022 Target	FY 2022 +/- FY 2021
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 2019: 50% Target: 48% (Target Exceeded)	46%	46%	Maintain
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 2019: 67% Target: 57% (Target Exceeded)	55%	55%	Maintain
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.[112]	FY 2019: 43% Target: 40% (Target Exceeded)	40%	40%	Maintain
6.I.1. Percent of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program.	FY 2019: 71% Target: 45% (Target Exceeded)	50%	55%	+5%

[110] Most recent results are for Academic Year 2019-2020 and funded in FY 2019.
[111] Targets for FY 2021 are maintained or adjusted on certain measures to prepare for inclusion of the CHGME program that year.
[112] 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 2019-2020 based on graduates from Academic Year 2018-2019.

Maternal and Child Health

TAB

MATERNAL AND CHILD HEALTH

Maternal and Child Health Block Grant

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$687,700,000	$712,700,000	$822,700,000	+$110,000,000
FTE	47	53	70	+17

Authorizing Legislation - Social Security Act, Title V

FY 2022 Authorization $850,000,000

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

Program Description and Accomplishments

The Maternal and Child Health (MCH) Block Grant program, authorized under Title V of the Social Security Act, seeks to improve the health of all mothers, children, and their families. The activities authorized as part of the MCH Block Grant program include:
- The **State MCH Block Grant program**, which awards formula grants to 59 states and jurisdictions to address the health needs of mothers, infants, and children, as well as children with special health care needs in their state or jurisdiction;
- **Special Projects of Regional and National Significance (SPRANS)** that address national or regional needs, priorities, or emerging issues (such as opioids, maternal mortality, and COVID-19) 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 other jurisdictions. The MCH Block Grant program enables each state to:
- Assure access to quality maternal and child health care services for mothers and children, especially for those with low-incomes or limited availability of care;
- Reduce infant mortality;

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

State MCH Block Grant Program

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

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

The State MCH Block Grant program 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 through 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.

HRSA works in partnership with the State MCH Block Grant programs to provide technical support, as requested by the state, for addressing their MCH priority needs as well as other performance and programmatic requirements of the MCH Block Grant program. HRSA makes key financial, program, performance, and health indicator data, as reported by states, available to the public through the Title V Information System.[113]

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 60 million pregnant women, infants, and children, including children with special health care needs, benefitted from a service supported by the State MCH Block Grant program in FY 2019. Nationwide, the 59 State MCH Block Grant programs reached approximately 92 percent of pregnant women, 98 percent of infants, and 60 percent of children.
- Access to health services for mothers has improved with support of the State MCH Block Grant program. The percentage of women who received early prenatal care in the first trimester of pregnancy increased from 71.0 percent in 2007 to 77.6 percent in 2019. Recognizing that improving maternal and child health in the United States will require improving women's health before pregnancy, 47 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 22 percent decline in U.S. infant mortality from 7.2 infant deaths per 1,000 live births in 1997 to 5.6 infant deaths per 1,000 in 2019. 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 MCH Block Grant 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 many cases, states have opted to use Title V funds to supplement activities working to address maternal health (see *Maternal mortality* under SPRANS).

Select National Outcome and National Performance Measures in effect from 1997 to 2019 illustrate the program's successes:

[113] Title V Information System (TVIS).

National Outcome or Performance Measures	Percent Change (1997 – 2019 unless otherwise noted)	Data Source
Infant Mortality Rate per 1,000 live births	22% decrease	National Vital Statistics System (NVSS)
Neonatal mortality rate per 1,000 live births	23% decrease	NVSS
Postneonatal mortality rate per 1,000 live births	24% decrease	NVSS
Perinatal mortality rate per 1,000 live births plus fetal deaths	21% decrease	NVSS
Child mortality rate, ages 1 through 9 per 100,000	35% decrease	NVSS
Percent of 19-35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, & Hepatitis B	64% increase (2009-2018)	National Immunization Survey (NIS)
Percentage of children without health insurance	63% decrease	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 (2007-2019)	NVSS

Special Projects of Regional and National Significance (SPRANS)

HRSA awards SPRANS grants to 1) address critical and emerging issues of regional and national significance in maternal and child health, and 2) support collaborative and innovative learning across states so programs can utilize existing best practices and evidence. Of the $139.1 million for SPRANS in FY 2021 Congress set aside approximately 11 percent to address four specific priorities: oral health, epilepsy, sickle cell disease, and Fetal Alcohol Syndrome. In addition, approximately 32 percent of the total SPRANS budget supports specific directives highlighted in the authorizing language, including genetics, hemophilia, training, and research. The remaining approximately 57 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.

SPRANS awards also drive innovation and build capacity to improve systems of care for MCH populations. Funding provides critical programming that complements and ensures the success of State formula-funded activities by improving workforce and system capacity and the ability of programs to utilize best practices and evidence (e.g., through research, data collection, quality improvement and workforce development), as well as enable the Nation to address emerging issues.

Critical and Emerging Issues in Maternal and Child Health

- *Maternal mortality* – HRSA supports a number of investments with SPRANS funding that are integral to HRSA's efforts to promote maternal health and reduce maternal mortality and morbidity. In FY 2021, HRSA continued support for the State Maternal Health Innovation (State MHI) program (9 states), including a focus on access to care via alternative telehealth platforms to address needs resulting from the COVID-19 public health emergency. HRSA has also increased funding for the Alliance for Innovation on Maternal Health (AIM) program with a goal of expanding implementation of the AIM program's maternal safety bundles across all U.S. States, the District of Columbia, and U.S. territories, as well as tribal entities. To date, 41 states and the District of Columbia are enrolled in AIM, with participation from approximately 1,900 birthing facilities. Additional investments related to maternal health include the newly established Maternal Mental Health Hotline and the Women's Preventive Services Initiative.

- *COVID-19* – SPRANS funding has been instrumental in addressing emerging public health issues that impact the MCH population, including COVID-19 response efforts. For example, HRSA launched the Promoting Pediatric Primary Prevention (P4) Challenge in December 2020 to incentivize innovations in pediatric primary care to increase well-child visits and immunizations within primary care settings in light of the COVID-19 pandemic. Innovations will address decreases in these services to prevent the spread of vaccine-preventable diseases such as measles and ensure children receive preventative care, crucial to their growth and development.

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 health care needs. For example, CISS funding supports the Early Childhood Comprehensive Systems (ECCS) program to enhance state-level capacity and infrastructure for integrated maternal and early childhood systems of care that lead to improved children's developmental health, family well-being, and increased family-centered access to care for the prenatal-to-3 year old population. The program provides direct support and technical assistance to up to 20 states to build leadership capacity in early childhood systems, improve cross-sector service coordination and alignment, improve policies and practices across sectors, and advance health equity in early childhood so that more children are thriving at age three and school-ready by age five. The program is re-competing in FY 2021.

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

MCH Activities	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
State MCH Block Grant Awards	$558,308	$563,308	$592,308
SPRANS	$119,116	$139,116	$220,116

MCH Activities	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
CISS	$10,276	$10,276	$10,276
Total	**$687,700**	**$712,700**	**$822,700**

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

MCH SPRANS Set-Aside Programs	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
SPRANS – Other	$106,224	$124,224	$205,224
SPRANS - Oral Health	$5,250	$5,250	$5,250
SPRANS – Epilepsy	$3,642	$3,642	$3,642
SPRANS - Sickle Cell	$3,000	$5,000	$5,000
SPRANS - Fetal Alcohol Syndrome Demo	$1,000	$1,000	$1,000
Total SPRANS	**$119,116**	**$139,116**	**$220,116**

Funding History

FY	Amount
FY 2018	$650,194,233
FY 2019	$674,723,000
FY 2020	$687,700,000
FY 2021 Enacted	$712,700,000
FY 2022 President's Budget	$822,700,000

Budget Request

The FY 2022 Budget Request for the Maternal and Child Health (MCH) Block Grant program of $822.7 million is $110.0 million above the FY 2021 Enacted level. The Budget includes an increase of $29.0 million in funding for formula awards to states to promote and improve the health and well-being of the nation's mothers, children-including children with special needs, and their families. Additionally, the Budget includes an increase of $81.0 million in SPRANS funding for a total of $220.12 million, of which $112.30 million will support HRSA's efforts to improve maternal and child health, including reducing maternal mortality and severe maternal morbidity.

This funding will support the Improving Maternal Health Initiative, which includes new activities and continues support for existing activities, including:

- *State Maternal Health Innovation Grants*: A total of $53.0 million, a $30.0 million increase, to expand the program. This program supports innovation among states to improve maternal health outcomes and address disparities in maternal health. With this funding, states collaborate with maternal health experts to implement state-specific actions plans in order to improve access to maternal care services, identify and address workforce needs, and support postpartum and interconception care services.
- *The Alliance for Innovation on Maternal Health (AIM)*: A total of $14.3 million, an increase of $5.3 million, to expand the reach of AIM's evidence-based models of maternity care to a broader array of providers and health care settings and increase AIM penetration in currently enrolled States. Funding will also ensure the long-term sustainability and impact of AIM by supporting the infrastructure and capacity of health care providers and systems of care to develop and implement AIM-related quality improvement efforts and efforts.
- *Maternal Mental Health Hotline*: A total of $4.0 million, an increase of $1.0 million, to continue and increase support for a maternal mental health hotline, staffed by qualified counselors 24 hours a day. U.S. maternal mortality has not improved in the past decade. Mental health conditions, including those resulting in suicide and unintentional overdose, are a leading cause of pregnancy-related death during pregnancy and the year following delivery.[114] Nearly 1 in 8 women report experiencing depressive symptoms in the postpartum period.[115]
- *Pregnancy Medical Home Demonstration*: A total of $25.0 million to reduce adverse maternal health outcomes and maternal deaths by incentivizing maternal health care providers to provide integral health care services to pregnant women and new mothers. *Early Childhood Development Expert Grants*: A total of $10.0 million in funding to help cities place early childhood development experts in pediatrician offices with a high percentage of Medicaid and Children's Health Insurance Program patients.
- *Implicit Bias Training Grants for Health Providers*: A total of $5.0 million in funding will support new grant awards to train health care providers on implicit bias with the goal of reducing racial disparities.
- *National Academy of Medicine Study*: $1.0 million in funding will support a partnership with the National Academy of Medicine study and make recommendations for incorporating bias recognition in clinical skills testing for accredited schools of allopathic medicine and accredited schools of osteopathic medicine.

The Budget also includes additional SPRANS funding that will support programs to drive innovation and improve systems of care for MCH populations. These programs will address emerging issues relating to disparities in maternal and child health outcomes and gaps in care related to the ongoing impacts of the COVID-19 pandemic on maternal and child health. HRSA anticipates these will continue to be critical issues in FY 2022. 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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[114] Enhancing Reviews and Surveillance to Eliminate Maternal Mortality | CDC Davis NL, Smoots AN, Goodman DA. Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2019.
[115] Bauman BL, Ko, JY, Cox S, et al. Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression — United States, 2018. MMWR Morb Mortal Wkly Rep 2020;69:575–581.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
10.4**:** The percentage of children served by the Maternal and Child Health Block Grant[116] *(Outcome)*	FY 2019: 61% Target: 55% (Target Exceeded)	58%	63%	+5 percentage points
10.5**:** The percentage of pregnant women served by the Maternal and Child Health Block Grant *(Outcome)*	FY 2019: 92% Target: 91% (Baseline)	92%	93%	+1 percentage points
10.IV.B.1**:** Decrease the ratio of the Black infant mortality rate to the White infant mortality rate *(Output)*	FY 2019: 2.3 to 1[117,118] Target: 2 to 1 (Target Not Met)	2 to 1	2 to 1	Maintain
1 the infant mortality rate *(Outcome)*	FY 2019: 5.6 per 1,000 Target: 5.5 per 1,000 (Target Not Met)	5.5 per 1,000	5.4 per 1,000	-0.1 per 1,000
10.III.A.2**:** Reduce the incidence of low birth weight births *(Outcome)*	FY 2019: 8.3% Target: 7.8% (Target Not Met)	8%	8%	Maintain
10.III.A.3**:** Increase percent of pregnant women who received prenatal care in the	FY 2019: 77.6% Target: 79% (Target Not Met but Improved)	80%	80%	Maintain

[116] The term "children" includes both infants and children (0-21) years of age.
[117] Numerator data for infant deaths by race: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database.
[118] Denominator data for live births by race: Centers for Disease Control and Prevention, National Center for Health Statistics. Natality public-use data 2007-2019 on CDC WONDER Online Database.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
first trimester. *(Outcome)*				

Grant Awards Table – Maternal and Child Health Block Grant

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	59	59	59
Average Award	$9,273,962	$9,329,239	$9,806,405
Range of Awards	$147,736-$39,383,025	$148,616-$39,438,661	$156,217-$42,111,522

Grant Awards Table – SPRANS

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	244	295	399
Average Award	$427,761	$408,083	$466,074
Range of Awards	$11,682-$9,948,026	$14,990-$3,457,300	$14,990-$3,500,000

Grant Awards Table – CISS

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	14	21	26
Average Award	$658,601	$319,857	$332,192
Range of Awards	$269,380-$2,687,563	$255,600-$830,000	$255,600-$750,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
FY 2022 Discretionary State/Formula Grants

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant

STATE/TERRITORY	FY 2020 Final[119]	FY 2021 Enacted[120]	FY 2022 President's Budget[121]	FY 2022 +/- FY 2021
Alabama	11,482,727	11,553,054	12,094,214	541,160
Alaska	1,106,794	1,116,678	1,173,246	56,568
Arizona	7,441,320	7,470,719	8,101,269	630,550
Arkansas	6,961,610	7,020,958	7,398,463	377,505
California	39,383,025	39,438,661	42,111,522	2,672,861
Colorado	7,346,989	7,354,540	7,640,473	285,933
Connecticut	4,663,927	4,706,778	4,983,176	276,398
Delaware	2,027,826	2,046,817	2,131,607	84,790
District of Columbia	6,946,124	6,964,088	7,017,950	53,862
Florida	19,841,129	20,071,530	21,800,124	1,728,594
Georgia	17,124,972	17,191,871	18,173,247	981,376
Hawaii	2,143,571	2,142,546	2,253,825	111,279
Idaho	3,297,560	3,306,281	3,415,855	109,574
Illinois	21,173,946	21,202,164	22,180,071	977,907
Indiana	12,312,773	12,366,297	12,841,633	475,336
Iowa	6,520,044	6,559,763	6,762,874	203,111
Kansas	4,734,589	4,747,117	5,022,295	275,178
Kentucky	11,217,257	11,282,885	11,752,650	469,765
Louisiana	12,554,248	12,667,653	13,360,072	692,419
Maine	3,303,836	3,303,846	3,361,013	57,167
Maryland	11,850,506	11,890,449	12,265,211	374,762

[119] The poverty-based allocation for FY 20 uses 3-year poverty data from the American Community Survey, 2015-2017
[120] The poverty-based allocation for FY 21 uses 3-year poverty data from the American Community Survey, 2016-2018
[121] The poverty-based allocation for FY 22 uses 3-year poverty data from the American Community Survey, 2017-2019

STATE/TERRITORY	FY 2020 Final[119]	FY 2021 Enacted[120]	FY 2022 President's Budget[121]	FY 2022 +/- FY 2021
Massachusetts	11,151,272	11,157,180	11,503,173	345,993
Michigan	18,894,032	18,964,938	19,790,177	825,239
Minnesota	9,108,261	9,163,491	9,497,152	333,661
Mississippi	9,278,900	9,319,558	9,764,868	445,310
Missouri	12,242,452	12,327,462	12,867,751	540,289
Montana	2,281,823	2,284,810	2,371,083	86,273
Nebraska	4,029,980	4,020,977	4,130,698	109,721
Nevada	2,141,666	2,173,714	2,451,942	278,228
New Hampshire	1,956,319	1,970,054	2,023,931	53,877
New Jersey	11,679,835	11,734,286	12,257,582	523,296
New Mexico	4,188,189	4,227,065	4,462,079	235,014
New York	38,406,749	38,454,826	40,017,971	1,563,145
North Carolina	17,512,041	17,614,227	18,670,159	1,055,932
North Dakota	1,748,881	1,752,309	1,788,805	36,496
Ohio	22,208,776	22,388,152	23,501,304	1,113,152
Oklahoma	7,215,434	7,333,511	7,759,216	425,705
Oregon	6,207,499	6,196,123	6,430,046	233,923
Pennsylvania	23,928,946	24,005,188	24,999,933	994,745
Rhode Island	1,636,137	1,646,485	1,710,630	64,145
South Carolina	11,510,463	11,642,359	12,157,008	514,649
South Dakota	2,194,925	2,208,988	2,284,302	75,314
Tennessee	11,873,824	12,018,972	12,706,587	687,615
Texas	35,146,148	35,908,010	39,157,382	3,249,372
Utah	6,130,707	6,112,074	6,325,804	213,730
Vermont	1,653,060	1,658,286	1,676,306	18,020
Virginia	12,375,275	12,485,992	13,096,225	610,233
Washington	8,810,592	8,835,717	9,319,781	484,064
West Virginia	6,176,181	6,215,487	6,378,678	163,191
Wisconsin	10,869,001	10,898,800	11,263,980	365,180
Wyoming	1,205,625	1,216,353	1,260,246	43,893

STATE/TERRITORY	FY 2020 Final[119]	FY 2021 Enacted[120]	FY 2022 President's Budget[121]	FY 2022 +/- FY 2021
Subtotal	**527,197,766**	**530,340,089**	**557,465,589**	**27,125,500**
American Samoa	492,447	495,383	520,720	25,337
Guam	760,558	765,092	804,224	39,132
Marshall Islands	229,808	231,177	243,001	11,824
Micronesia	519,806	522,905	549,650	26,745
Northern Mariana Islands	465,091	467,862	491,792	23,930
Palau	147,736	148,616	156,217	7,601
Puerto Rico	15,856,806	15,951,320	16,767,187	815,867
Virgin Islands	1,493,758	1,502,661	1,579,518	76,857
Subtotal	**19,966,010**	**20,085,016**	**21,112,309**	**1,027,293**
TOTAL RESOURCES	**547,163,776**	**550,425,105**	**578,577,898**	**28,152,793**

Autism and Other Developmental Disabilities

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$52,344,000	$53,344,000	$57,344,000	+$4,000,000
FTE	7	7	8	+1

Authorizing Legislation – Public Health Service Act, Section 399BB, as amended by Public Law, 116-60, Section 3

FY 2022 Authorization $50,599,000

Allocation Methods:

- Direct federal/intramural
- Contract
- Competitive grant/co-operative agreement
- Other

Program Description and Accomplishments

The Autism and Other Developmental Disabilities program improves care and outcomes for children, adolescents, and young adults with autism spectrum disorder (ASD) and other developmental disabilities (DDs) through training, advancing best practices, and service. The Autism and Other Developmental Disabilities program began in 2008 as authorized by the Combating Autism Act of 2006. The Autism Collaboration, Accountability, Research, Education and Support, or Autism CARES Act reauthorized the program in 2019. The program supports training programs, research, and state systems grants to:

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

<u>Training Programs</u>
The program has two main training components, the Leadership Education in Neurodevelopmental and Other Related Disabilities (LEND) Training program and the

Developmental-Behavioral Pediatrics (DBP) Training program. LEND programs provide interdisciplinary training to enhance the clinical expertise and leadership skills of professionals dedicated to caring for children with neurodevelopmental and other related disabilities including autism. DBP trains the next generation of leaders in developmental-behavioral pediatrics and provides pediatric practitioners, residents, and medical students with essential biopsychosocial knowledge and clinical expertise. Data from FY 2018 showed that the LEND and DBP programs collectively:

- Provided diagnostic services to confirm or rule out ASD and other DDs to nearly 120,000 children.
- Provided training to over 23,500 trainees in the fields of pediatrics, developmental-behavioral pediatrics, and other health professions.
- Provided nearly 1,600 continuing education events on early screening, diagnosis, and intervention that reached nearly 118,000 pediatricians and other health professionals.

The training programs have an explicit focus on training professionals to provide culturally and linguistically relevant care and to recruit diverse students and professionals into the programs. In FY 2018, over 25% of long-term trainees were from underrepresented racial groups and 10% were Hispanic or Latino. The training programs also include self-advocates and family members as trainees and faculty to enhance exposure to lived experiences and increase the leadership skills of self-advocates and family members as part of an interdisciplinary care team.

Research

To improve the health and well-being of children and adolescents with ASD and other DDs, HRSA supports research networks, single investigator-led autism innovation projects, field-initiated research and secondary data analysis projects. HRSA supports research and development of reliable screening tools and guidelines for ASD and other DD and the implementation of interventions to improve the physical and behavioral health of individuals with ASD and other DDs across the life course. HRSA also funds research to address barriers to diagnosis, access to care, and social determinants of health and health disparities with an explicit focus to recruit participants from underserved populations. For example, the two largest Research Networks, the Autism Intervention Research Network on Physical Health (AIR-P) and the Autism Intervention Research Network on Behavioral Health (AIR-B), recruit diverse research participants with the target of including at least 60 percent of study participants from underserved populations.

Collectively, 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 DD. Accomplishments from the Autism Research Networks and Autism Single Investigator Innovation Programs in FY 2018 include:

- Conducted 76 studies on physical and behavioral health issues related to ASD and other DDs, screening and diagnostic measures, early intervention, and transition to adulthood.
- Forty-nine research sites across the country enrolled 7,696 participants in primary research studies and there were also 228,887 participants included in secondary data analyses.

- Developed 30 peer-reviewed publications in leading scholarly journals.

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 systems grants promote access to more comprehensive coordinated services for ASD by establishing integrated teams of educators, physicians, and social service providers. State grantees:

- Engaged families in program planning, community outreach, and training for providers. In FY 2017, nearly 80,000 individuals received services to facilitate family engagement through family navigation and other family engagement strategies;
- Implemented strategies to reduce disparities in early identification and treatment of ASD. In FY 2017, more than 37,000 individuals were reached by services to promote and facilitate screening and follow-up care.

Funding History

FY	Amount
FY 2018	$48,899,000
FY 2019	$50,377,000
FY 2020	$52,344,000
FY 2021 Enacted	$53,344,000
FY 2022 President's Budget	$57,344,000

Budget Request

The FY 2022 Budget Request for the Autism and Other Developmental Disabilities program of $57.3 million is $4.0 million above the FY 2021 Enacted level. This request will support training programs, research, and state systems with a focus on improving access, quality, and systems of care for underserved children, adolescents, and young adults with ASD or other DDs. According to the Centers for Disease Control and Prevention, approximately 1 in 54 children have ASD based on an in-depth examination of 11 local areas,[122] while parent-reported data from the 2016 National Survey of Children's Health documented that 1 in 40 children aged 3–17 years have a diagnosis of ASD.[123]

The requested funding increase will allow the program to increase access to services for approximately 5,000 additional children, for a total of 125,000 children total. Increased funding for the LEND and DBP programs will address unmet needs and disparities in evaluation, diagnosis, and treatment. Increased funding will support the expansion of the DBP program to 2 additional awardees (14 total) as well as increased fellowship opportunities for existing awardees. Funding will also support additional trainees for existing LEND awardees.

[122] Autism and Developmental Disabilities Monitoring Network (2016 data).
[123] Kogan, et al. (2018) The Prevalence of Parent-Reported Autism Spectrum Disorder Among US Children. Pediatrics 142(6)

The unmet needs are due in part to a shortage of trained providers; as of 2016, only 775 pediatricians were certified by the American Board of Pediatrics as DBPs, resulting in a national average of 109,427 children per DBP.[124] Geographically the shortages are even starker, with one state only having one DBP per 456,248 children, and three states not having any DBPs. There is also wide variability in the age of diagnosis of ASD by state and in many rural communities, children and families face disparities due to distance to subspecialists and a lack of available services.[125] According to the CDC's 2016 Autism and Developmental Disabilities Monitoring Network data there are disparities for Black children in early evaluation and diagnosis of ASD.[126] Hispanic children were identified as having ASD less frequently than White or Black children. A later age of first evaluation for non-Hispanic Black and Hispanic children also points to disparities by race and ethnicity.[127] These disparities may be due to barriers in accessing services, such as services not being available in the family's primary language, limited cultural and linguistic competence among providers and health systems, lack of awareness, and stigma.

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 Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
50.1.A.1: Percent of long-term trainees (LEND, DBP) working with underserved populations, 5 years post-training. *(Outcome)*	FY 2018 LEND Result: 85% (5 years)[128] Target: Maintain prior year of 55.23% (5 years) (Target Exceeded) FY 2018 DBP Result: 92% (5 years) Target: Maintain prior year of 91.67% (5 years) (Target Exceeded) Target: Maintain FY 2017 Result (Target Exceeded)	Not Defined	LEND: 80% DBP: 85%	---

[124] McMillan JA, Land M, Leslie LK. Pediatric Residency Education and the Behavioral and Mental Health Crisis: A Call to Action. Pediatrics. 2017;139(1):e20162141
[125] Ibid.
[126] Autism and Developmental Disabilities Monitoring Network.
[127] Maenner et al. (2020) Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2016. MMWR Surveillance Summary, 69(4).
[128] The data source for this measure is the Discretionary Grants Information System.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
50.I.A.2**:** Percent of long-term trainees (LEND, DBP) who at 2 and 5 years post-training, have worked in an interdisciplinary manner to serve the MCH population. *(Outcome)*	FY 2018 LEND Result: 94% (2 years); 93% (5 years) Target: Maintain prior year of 73.77% (2 years); 73.12% (5 years) (Targets Exceeded) FY 2018 DBP Result: 100% (2 years); 100% (5 years) Target: Maintain prior year of 81.81% (2 years); 45.45% (5 years) (Targets Exceeded) Target: Maintain prior year results (Target Exceeded)	Not Defined	LEND: 75% (2, 5 years) DBP: 85% (2, 5 years)	---
50.I.A.3**:** Percent of MCHB Autism research programs supporting the production of scientific publications. *(Outcome)*	FY 2017: 100%[129] Target: 100% (Baseline)	Discontinued	Discontinued	N/A
50.I.A.4**:** Percent of MCHB Autism research programs with at least two scientific publications in the past year (Outcome and Developmental)	FY 2020: 60%[130] Target: Set Baseline (Pending)	Not Defined	Not Defined	---

[129] The data source for this measure is the Discretionary Grants Information System.
[130] Baseline data reflects reporting by a subset of grantees. Two of the ten grants did not meet the two publication threshold as they were in the first year of funding. The program will identify trends over a three year period as the measure is developmental. Once the trend is analyzed, appropriate targets will be identified and included in the FY 2024 budget justification.

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
LEND	$35,918,857	$36,112,962	$37,388,757
DBP	$2,274,731	$2,284,606	$4,684,606
Research	$6,920,278	$7,525,000	$7,125,000
State Systems	$1,854,316	$1,855,477	$1,855,477
Resource Centers	$896,000	$896,000	$896,000
Number of Awards	81	83	81
Average Award	$590,916	$586,434	$641,356

Sickle Cell Disease Treatment Demonstration Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$5,205,000	$7,205,000	$7,205,000	---
FTE	2	1	1	---

Authorizing Legislation – Public Health Service Act, Section 1106, as amended by Public Law 115-327

FY 2022 Authorization $4,455,000

Allocation Methods:

- Competitive co-operative 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. 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 and telementoring strategies, to educate health professionals on evidence-based treatment of sickle cell disease; and
- Expanding and coordinating patient education, treatment, and care continuity.

The program works to improve health equity by increasing access to evidence-based care provided in the communities in which SCD patients live, increasing access to the latest treatment options, and continuing telehealth support for access to services. The program also fosters partnerships between clinicians and community organizations, partners with communities of practice to improve the quality of care provided to patients with SCD, and educates providers, families, and patients to improve knowledge and capacities, particularly as patient transition into adult health care settings.

A new funding cycle began in FY 2021 with five grants to develop and support Regional Coordinating Centers that cover the United States. The purpose of the SCDTDP is to increase access for individuals with sickle cell disease (SCD) to quality, coordinated, comprehensive care by: 1) increasing the number of clinicians or health professionals knowledgeable about the care of SCD, 2) improving the quality of care provided to individuals with SCD, and 3) improving care coordination with other providers. HRSA expects to strengthen the SCD system of care and support by improving access to quality, coordinated, comprehensive care for individuals with sickle cell disease; increasing the number of clinicians and health professionals knowledgeable about the care of individuals with SCD, including those participating in both telementoring and telemedicine activities; and improving care coordination with other providers.

Funding History

FY	Amount
FY 2018	$4,455,000
FY 2019	$4,435,000
FY 2020	$5,205,000
FY 2021 Enacted	$7,205,000
FY 2022 President's Budget	$7,205,000

Budget Request

The FY 2022 Budget Request for the Sickle Cell Disease Treatment Demonstration Program of $7.21 million is equal to the FY 2021 Enacted level. This request will fund continued support for regional SCD infrastructure, which strengthens the sickle cell disease system of care for individuals with sickle cell disease, their families, and clinicians. The program partners with states to develop and support comprehensive SCD care teams for supporting care across the lifespan; implements telehealth technologies for health care delivery, education, and health information services; increases access to evidence-based care and the latest treatment options; and increases collaboration and care coordination within each region. In response to the COVID-19 global pandemic and needs identified by the sickle cell disease community, funding also supports technical assistance around accessing care via telemedicine; and webinars and educational opportunities to raise awareness about vaccination access and safety.

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 Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
51.1: Number of sickle cell patients served by SCDTDP network providers in the past year (Developmental) (Output)	FY 2019: 25,712[131] Target: Baseline (Target Not in Place)	N/A	N/A	---

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	5	5	5
Average Award	$847,497	$1,000,000	$1,000,000
Range of Awards	$490,000-$1,205,000	$1,000,000	$1,000,000

[131] The data for this measure is collected from provider surveys via the SCDTDP National Coordinating Center. Survey administration was delayed from May until September 2020 due to COVID-19. The program will identify trends over a two year period as the measure is developmental. Once the trend is analyzed, appropriate targets will be identified and included in the FY 2024 budget justification.

Early Hearing Detection and Intervention

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$17,818,000	$17,818,000	$17,818,000	---
FTE	4	4	4	---

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

FY 2022 Authorization $19,522,758

Allocation Methods:

- Competitive grant/co-operative agreement

Program Description and Accomplishments

The Early Hearing Detection and Intervention (EHDI) Program (formerly known as the James T. Walsh Universal Newborn Hearing Screening program), reauthorized in 2017, supports the development of comprehensive and coordinated state and territory EHDI systems of care. EHDI assures that families with newborns, infants, and young children up to three years of age that are deaf or hard of hearing receive appropriate and timely services that include hearing screening, diagnosis, and early intervention. This program focuses on:

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

The EHDI Program funds 59 competitive grants to states and territories to develop comprehensive and coordinated statewide EHDI systems of care as well as two technical resource centers that support these efforts in addition to empowering families to serve as leaders in the EHDI system. To address health equity, grantees are required to develop plans to address diversity and inclusion in the EHDI system by the end of FY 2021 to ensure their activities are inclusive of and address the needs of the populations they serve.

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 who are deaf or hard of hearing.

In 2018, 98.3% of births had hearing screening before 1 year of age.[132] Additionally, the EHDI Program continues to work with states to meet the Healthy People 2020 objectives of screening no later than one month of age, conducting audiologic evaluations no later than 3 months of age, and enrollment in early intervention services no later than 6 months of age (1-3-6 objectives). In 2018, 97.0% of infants were screened before one month of age, 77.1% were diagnosed before 3 months of age, and 70.1% were enrolled in early intervention before six months of age.[133] A lack of comprehensive data reporting requirements for service providers in states and variability across states in timely access to such providers, among other factors, continues to be a challenge.

The EHDI Program continues to focus on supporting early screening and diagnosis as recommended by Healthy People 2030. Overall system improvements have led to more infants being screened and identified as deaf or hard of hearing and fewer infants being lost to follow-up (when an infant does not receive the recommended follow-up services) or lost to documentation (when an infant has received services, but results have not been reported to the EHDI Program and, therefore, cannot be documented). In addition, the EHDI Program encourages grantees to develop an integrated EHDI health information system that allows communication and protected data sharing among health care providers to ensure that newborns, infants, and young children up to three years of age receive pertinent screenings and follow-up services.

In response to the COVID-19 pandemic, 55 grantees and the two technical resource centers used program funding to strengthen telehealth capacities at the state level. Example activities include promoting remote screening and follow-up via tele-audiology and access to teleintervention and support for families.

Funding History

FY	Amount
FY 2018	$17,818,000
FY 2019	$17,740,000
FY 2020	$17,818,000
FY 2021 Enacted	$17,818,000
FY 2022 President's Budget	$17,818,000

Budget Request

The FY 2022 Budget Request for the Early Hearing Detection and Intervention Program of $17.8 million is equal to the FY 2021 Enacted Level. The Budget Request will continue to support 59 competitive grants to states and territories, in addition to two technical resource centers and supplemental awards to 12 Leadership Education in Neurodevelopmental and Related Disabilities training programs to train future leaders in pediatric audiology.

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.

[132] 2018 CDC EHDI Hearing Screening & Follow-up Survey (HSFS) data.
[133] Ibid

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
13.III.A.3**:** Percentage of infants screened for hearing loss prior to one month of age. *(Output)*	FY 2018: 97%[134] Target: 98% (Target Not Met)	98%	98%	Maintain
13.III.A.1**:** Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by three months of age.[135] *(Output)*	FY 2018: 75.4%[136] Target: 77% (Target Not Met)	77%	77%	Maintain
13.2**:** Increase the percentage of infants with hearing loss enrolled in early intervention before six months of age.[137] *(Output)*	FY 2018: 70.1%[138] Target: 72% (Target Not Met but Improved)	72%	72%	Maintain

[134] 2018 CDC EHDI Hearing Screening & Follow-up Survey (HSFS): The CDC has been collecting data annually since 2005.
[135] "Confirmed" diagnosis refers to a "documented" diagnosis which is consistent with newborn hearing screening programs.
[136] Ibid.
[137] This measure is to be tracked annually under Part C of the Individuals with Disabilities Act (IDEA) regulations that mandate collaboration with Title V programs and newborn hearing screening programs.
[138] Ibid.

Grant Awards Table[139]

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	59	59	59
Average Award	$226,577	$219,149	$235,000
Range of Awards	$84,035-$245,000	$23,355-$235,000	$235,000

[139] Does not include EHDI National Technical Resource Center cooperative agreement ($1.05M in FY 2020; $0.85M in FY 2021 and $0.85M in FY 2022), LEND supplements ($0.9M), Family Leadership in Language and Learning Center ($0.45M), and Advancing Systems of Services for Children and Youth with Special Health Care Needs ($154K) and Cares National Interdisciplinary Training Resources Center ($150K).

Emergency Medical Services for Children

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$22,334,000	$22,334,000	$28,134,000	+$5,800,000
FTE	5	5	6	+1

Authorizing Legislation – Public Health Service Act, Section 1910, as amended by Public Law 116-49

FY 2022 Authorization $22,334,000

Allocation Method
- Competitive grant/co-operative agreement
- Contract

Program Description and Accomplishments

Children have unique emergency care needs, especially during serious or life-threatening emergency situations. The majority of the nation's children are treated in community and rural emergency departments (EDs) close to where they live, rather than in specialized pediatric medical care centers. In addition, emergency medical services (EMS) agencies and hospital EDs often lack the necessary equipment and resources to treat children adequately.

The Emergency Medical Services for Children (EMSC) program, reauthorized under the EMSC Reauthorization Act of 2019, is the only federal grant program specifically focused on ensuring that seriously ill or injured children have access to high-quality pediatric emergency care, no matter where they live in the United States. The EMSC Program aims to ensure that all EMS agencies and hospital EDs are equipped to provide appropriate medical care for children, including access to pediatric-specific equipment, medications, and transportation (e.g., ambulances). In addition, EMS personnel must be knowledgeable and skilled in carrying out pediatric emergency care and have access to pediatric transport guidelines. It is critical that EMS systems are optimally prepared to provide high-quality pediatric care in both prehospital and hospital settings.

In recent years, the EMSC Program has invested in:
- The EMSC State Partnership Program which aims to improve pediatric emergency care across 59 states and jurisdictions;
- The Pediatric Emergency Care Applied Research Network (PECARN) Program and Targeted Issues grants, which aim to carry out rigorous clinical research to develop evidence-based optimal pediatric emergency care guidelines;

- The EMSC Innovation and Improvement Center, which provides guidance to EMSC State Partners and other EMS stakeholders to disseminate and increase uptake of evidence-based approaches to pediatric emergency care in each state and territory; and
- The EMSC Data Center, which tracks performance improvement efforts across all funded states and territories and serves as a central data coordinating entity for ongoing PECARN research.

Notable accomplishments of the EMSC Program include:

- **Increased the Institutionalization of Pediatric Guidelines in Hospitals:** Between 2013 and 2018, the proportion of hospitals with written interfacility transfer guidelines covering pediatric patients increased from 50% to 58%.[140]
- **Increased Efforts to Drive Pediatric Quality Improvement in Hospitals:** Between 2006 and 2020, the number of states that established a pediatric medical facility recognition program, which acknowledges organizations that invest and demonstrate their capacity to provide high quality pediatric emergency services, increased from five to 17 states.[141]
- **Improved the Coordination and Management of Pediatric Mental Health Care in the Emergency Department:** In 2019, in partnership with the Federal Office of Rural Health Policy (FORHP), MCHB developed the Critical Crossroads: Pediatric Mental Health Care in the Emergency Department Pathways Toolkit. This toolkit helps hospital EDs identify, manage, and ensure continuity of care for children and adolescents in mental health crisis.[142]
- **Increased Pediatric Workforce Oversight in Prehospital EMS Agencies:** The proportion of EMS agencies with a pediatric emergency care coordinator (PECC) increased significantly from 23% in 2018 to 30% in 2020.[143]
- **Advanced EMSC Science and Clinical Practice:** In 2019, PECARN developed a new guideline to evaluate the half million infants less than 2 months of age who present to the emergency department with fever. This helps to decrease physical and emotional risks for infants and their families and reduce health care costs.[144]
- **Advanced Prehospital Emergency Services**: In 2019, Targeted Issues grants advanced our understanding of pediatric patient safety dosing errors, highlighting the need for expanded prehospital emergency services education.[145] This work has been included in the American Board of EMS core content for pediatric patient safety continuing medical education.

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[140] Data from interfacility transfer guidelines items from the National Pediatric Readiness Assessment, fielded and reported by the EMSC Data Center Data. The 2020 National Pediatric Readiness Assessment was delayed due to COVID-19 until summer 2021, delaying FY20 reporting.
[141] Data reported by EMSC State Partnership performance reports.
[142] Critical Crossroads: Pediatric Mental Health Care in the Emergency Department.
[143] Data reported by EMSC State Partnership performance reports.
[144] Kuppermann, N., Dayan, P. S., Levine, D. A., Vitale, M., Tzimenatos, L., Tunik, M. G., ... & Mahajan, P. (2019). A clinical prediction rule to identify febrile infants 60 days and younger at low risk for serious bacterial infections. JAMA pediatrics, 173(4), 342-351.
[145] Hoyle Jr JD, Ekblad G, Hover T, Woodwyk A, Brandt R, Fales B, Lammers RL. Dosing errors made by paramedics during pediatric patient simulations after implementation of a state-wide pediatric drug dosing reference. Prehospital Emergency Care. 2019 Jun 10.

- **Advanced EMSC Health Equity Research and Care**: In 2020, PECARN increased understanding of and approaches to remediating racial inequities in pain management for pediatric emergency patients.[146,147]

Funding History

FY	Amount
FY 2018	$22,134,000
FY 2019	$22,236,000
FY 2020	$22,334,000
FY 2021 Enacted	$22,334,000
FY 2022 President's Budget	$28,134,000

Budget Request

The FY 2022 Budget Request for the Emergency Medical Services for Children (EMSC) program of $28.13 is $5.8 million above the FY 2021 Enacted Level. This increase in funding will provide additional funding to states to address critical gaps that remain for access to high quality emergency and trauma care, including pre-hospital and hospital emergency medical services, for children across the country.

EMSC agencies are a critical resource in responding to childhood trauma, youth suicide (now the second leading cause of death for people aged 10-34[148]) and the health and social/emotional impact of the COVID-19 pandemic on children. Currently, only 26% of EMS agencies require demonstration of effective use of pediatric equipment, less than a third of EMS agencies have dedicated pediatric emergency care coordinators, and only 58% of hospitals have inter-facility transfer guidelines, all of which are critical for improving pediatric readiness and improving outcomes.[149] Additional funding to states will help to increase readiness in EMS agencies and hospitals across the country through additional personnel and quality/training supports.

Funding will also support State EMSC programs to build mental health capacity for children in emergency departments. This growing issue is particularly important from an equity standpoint—black children had 1.5 times the rate of mental health diagnoses in the emergency department compared to white children, and the rate of ED visits is increasing faster for black

[146] Goyal MK, Johnson TJ, Chamberlain JM, Cook L, Webb M, Drendel AL, Alessandrini E, Bajaj L, Lorch S, Grundmeier RW, Alpern ER. Racial and ethnic differences in emergency department pain management of children with fractures. Pediatrics. 2020 May 1;145(5).
[147] Brousseau DC, Alpern ER, Chamberlain JM, Ellison AM, Bajaj L, Cohen DM, Hariharan S, Cook LJ, Harding M, Panepinto J, Pediatric Emergency Care Applied Research Network. A Multiyear Cross-sectional Study of Guideline Adherence for the Timeliness of Opioid Administration in Children With Sickle Cell Pain Crisis. Annals of Emergency Medicine. 2020 Sep 1;76(3):S6-11.
[148] CDC. Web-based Injury Statistics Query and Reporting System (WISQARS). (2020) Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
[149] Data reported by EMSC State Partnership performance reports.

children compared to white children.[150] Funding will provide additional support to EMS agencies and emergency departments for training to appropriately respond to these diagnoses.

The funding request also includes costs associated with data coordination activities, grant reviews, follow-up performance reviews, 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 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
14.3**:** The percentage of responding EMS agencies nationwide that have a designated individual who coordinates pediatric emergency care. *(Outcome)*	FY 2019: 30%[151] Target: 24% (Target Exceeded)	Not Defined	32%	N/A
14.4**:** Percent of responding hospitals nationwide that have written interfacility transfer guidelines that cover pediatric patients and that include specific components of transfer. *(Outcome)*	FY 2018: 58%[152] Target: Baseline (Target Not In Place)	Not Defined	61%	N/A

[150] Abrams, M. Pediatrics August 2019, 144 2 Racial Disparities in Pediatric Mental Health-Related Emergency Department Visits: A Five-Year Multi-Institutional Study

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

[152] The data source for this measure is from interfacility transfer guidelines items fielded separately from the full National Pediatric Readiness Assessment, fielded and reported by the EMSC Data Center. The 2020 National Pediatric Readiness Assessment was delayed due to COVID-19 until summer 2021, delaying FY20 reporting.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
14.5**:** Number of children enrolled in Pediatric Emergency Care Applied Research Network (PECARN) studies. *(Outcome)*	FY 2020: 133,471[153] Target: 126,009 (Target Exceeded)	Not Defined	126,009	N/A

Grant Awards Table

	FY 2020 Final	**FY 2021 Enacted**	**FY 2022 President's Budget**
Number of Awards	72	72	72
Average Award	$270,995	$272,740	$347,273
Range of Awards	$130,000-$3,067,473	$130,000-$3,000,000	$223,255-$3,000,000

[153] The data source for this measure is the Data Coordinating Center.

Healthy Start

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$125,500,000	$128,000,000	$128,000,000	---
FTE	14	19	19	---

Authorizing Legislation – Public Health Service Act, Section 330H as amended by Public Law 116-36, Section 3225

FY 2022 Authorization $125,500,000

Allocation Method:

- Competitive grant/co-operative 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 U.S. infant mortality rate declined nearly 18 percent overall and 20 percent for non-Hispanic Black infants between 2005 and 2019. 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 in the U.S. include birth defects, preterm birth and low birthweight, maternal pregnancy complications, sudden infant death syndrome, and injuries. There is a potential for reducing each of these causes of death, particularly among low-income families and communities. Preterm birth (defined as birth at less than 37 completed weeks of gestation) is a key risk factor for infant death. More than two-thirds of all infant deaths occur among infants born preterm. After declining from 2007 to 2014, the U.S. preterm birth rate increased nearly 6.9 percent from 9.57 percent in 2014 to 10.23 percent in 2019. Non-Hispanic Black women continue to be more likely to experience preterm birth than non-Hispanic white women (14.38 and 9.26 percent, respectively, in 2019). 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.

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. In FY 2021, Healthy Start funded 101 competitive grants in 34 States, the District of Columbia, and Puerto Rico.

Healthy Start grantees use four approaches to reduce infant mortality through individual services and community support to women, infants, and families:

- Improve women's health before, during, and between pregnancies;
- Improve family health and wellness to improve infant health and development;
- Promote systems change to maximize opportunities for community action to address social determinants of health; and
- Assure impact and effectiveness by conducting ongoing HS workforce development, data collection, quality improvement, performance monitoring, and evaluation.

Healthy Start implements community-based interventions and helps to ensure a well-prepared quality workforce; establishes an information system for client services coordination; and supports ongoing evaluation and quality improvement at the local and national levels. The Healthy Start service delivery model engages the entire family, working with women and their families before, during, and after pregnancy, and through the first 18 months after birth. With the recent emphasis on including the partners of enrolled women, the program has begun actively recruiting fathers/males in education, activities, services, and events. Service provision begins with direct outreach by Healthy Start community health workers to women who are at an increased risk of adverse maternal health outcomes. Each enrolled Healthy Start family receives a standardized, comprehensive assessment that considers physical and behavioral health, employment, housing, intimate partner violence risks, and more. Case managers link women and families to appropriate services and a medical home. Healthy Start delivers services using a range of approaches, including on-site provider/program locations, in-home visits, and community locations/events. Services incorporate:

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

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

Healthy Start projects collaborate with federal, state, and local programs, including but not limited to: the Maternal, Infant, and Early Childhood Home Visiting Program; Special

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

Regular collection of program data enables HRSA and grantees to monitor and evaluate ongoing activities, as well as to identify technical assistance needs. HRSA is launching two new data systems to streamline and improve data collection and reporting efforts. The Healthy Start Monitoring and Evaluation Data System will enable grantees to more efficiently submit reports to HRSA and will facilitate monitoring of grantee data. Additionally, HRSA is adapting CAREWare for voluntary use by Healthy Start grantees. This system will serve as a site-level data and case management system. HRSA supports ongoing technical assistance, training, and education for grantees through the Healthy Start EPIC Center (www.healthystartepic.org). EPIC Center services include strengthening staff skills to implement evidence-based practices in maternal and child health; facilitating grantee-to-grantee sharing of expertise and lessons from the field; and sharing resources for effective program delivery.

The EPIC center has been instrumental in providing COVID-19-related training to Healthy Start grantees whose programs and program participants have been impacted by the COVID-19 public health emergency. Information gathered through grantee listening sessions conducted through the EPIC Center has informed trainings for grantees on how to adapt in-person services to remote or virtual services to protect the health and safety of their clients and staff. Grantee reports indicate mental and behavioral needs have increased during the COVID-19 public health emergency, including those needs linked to anxiety, depression, stress, trauma, suicidality, and substance use. Healthy Start program participants are also experiencing challenges such as job loss, food insecurity, and housing instability. HRSA anticipates the need for additional programmatic TA to help grantees meet these challenges will continue to grow.

In FY 2019, Healthy Start began supporting 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. In FYs 2020 and 2021, HRSA used $15 million to support these activities within existing Healthy Start grants. To date, 92 grantees have received clinician funding.

Program Accomplishments

In CY 2019 there was a change in the composition of grantees funded by HRSA due to a re-competition of the program and new awards were made in April 2019 for the five-year period of 2019-2024. As a result of the re-competition in FY 2019, Healthy Start began funding 18 new grantees and stopped funding 17 grantees of the original cohort. The re-competition and funding of new grantees has had an impact on the overall data collected for FY 2019; new grantees, who

comprise 20 percent of the new cohort, will need additional time to demonstrate improvements in key indicators. For example, a number of program performance measures did not meet targets after having been relatively stable for several years prior.

The infant mortality rate in the United States for 2017-2018 (two-year average) was 5.73 per 1,000 live births. The 2017-2019 (three-year average) infant mortality rate among Healthy Start participants was 7.98 per 1,000 live births, which reflects the high risk populations targeted by the program.[154] This is the second year in which the program is monitoring and reporting a multi-year infant mortality rate among the Healthy Start participants.

Healthy Start is committed to data-driven and evidence-based decision-making. HRSA is investing in a one-year contract to design the next evaluation plan for the Healthy Start program with the secondary purpose of assessing grantee data collection and evaluation capacity. These efforts are building from evaluation work that began in 2017 when Healthy Start initiated a national evaluation to explore associations between program participation and participant-level characteristics. Findings from the evaluation showed positive outcomes related to program goals.[155] These include earlier and more-frequent prenatal care, greater engagement in infant safe sleep practices, and lower rates of low birth weight. HS participants also met or exceeded targets with respect to usual source of care and depression screening.

Funding History

FY	Amount
FY 2018	$110,300,000
FY 2019	$121,962,000
FY 2020	$125,500,000
FY 2021 Enacted	$128,000,000
FY 2022 President's Budget	$128,000,000

Budget Request

The FY 2022 Budget Request for the Healthy Start program of $128.0 million is equal to the FY 2021 Enacted Level. Within this total, funding is also continued at $15.0 million to allow grantees to hire clinical service providers at Healthy Start sites to provide direct access to well woman care and maternity care services. This will reduce barriers to care and better address

[154] A multi-year infant mortality rate (IMR) is reported for 2017-2019. This allows the Healthy Start program to track infant mortality while taking into consideration that infant death is a rare event and when calculated within small populations, such as the Healthy Start program population, IMRs can appear to change substantially if there is even a small difference in the number of deaths within a single year. Such changes may be due to normal variation and are not necessarily caused by actual change in the underlying risk. The IMRs for the single years 2017 to 2019 are as follows:
2017: Healthy Start 9.47 per 1,000 live births, United States 5.79 per 1,000 live births
2018: Healthy Start 6.26 per 1,000 live births, United States 5.67 per 1,000 live births
2019: Healthy Start 8.05 per 1,000 live births, United States (2019 data not yet available from CDC/National Center for Health Statistics (NCHS)

[155] Abt Associates (2020). Evaluation of the Implementation and Outcomes of the Maternal & Child Health Bureau's Federal Healthy Start Program.

health disparities among high-risk and underserved women. In FY 2022, the program will continue to serve women and families across the nation through the 101 grants awarded in the FY 2019 funding cycle. Healthy Start expects to serve at least 80,000 participants in FY 2022 with case management services. Recognizing that improving birth outcomes begins with improving women's health before, during, and between pregnancies, funding will continue to improve access to quality healthcare and support services for women and children throughout the prenatal, postpartum, and interconception periods.

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. 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[156,157]

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
12.III.A.1**:** The percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester. *(Outcome)*	FY 2019: 66.6% Target: 75% (Target Not Met)	80%	80%	Maintain
12.III.A.2**:** Percent of singleton births weighing less than 2,500 grams (low birthweight) *(Outcome)*	FY 2019: 11.2% Target: 9.6% (Target Not Met)	9.6%	9.6%	Maintain

[156] Fiscal year targets reflect calendar year data. Awards are made annually in April, thus the bulk of the data coincides with the fiscal year.
[157] Due to a re-competition of Healthy Start (HS) program in April 2019 that resulted in changes in the cohort of HS grantees, CY 2019 data and outcomes did not meet the levels of achievement previously reported. New HS grantees, who comprise approximately 20% of the new cohort, require several months to hire staff, establish referral networks and partnerships, and start demonstrating improvements in key indicators.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
12.E.2**:** The number of persons case managed in the Healthy Start Program. *(Developmental)*	FY 2019: 59,709[158] Target: 69,000[159] (Target Not Met)	75,000	80,000	+5,000

Grant Awards Table[160]

	FY 2020 Final	**FY 2021 Enacted**	**FY 2022 President's Budget**
Number of Awards	101	101	101
Average Award	$1,106,159	$1,125,422	$1,124,185
Range of Awards	$712,219-$1,144,121	$623,477-$1,144,121	$623,477-$1,144,121

[158] The HS Program served fewer participants in CY 2019 than it did in CY 2018 due to a re-competition of the HS grantee cohort in CY 2019.

[159] Target adjusted from 74,000 as set in the FY 2018 Congressional Justification to reflect FY 2018 Annualized CR funding levels.

[160] FY 2020 and FY 2021 reflect post-offset awards. Does not include $4M for the Supporting Healthy Start Performance Project.

Heritable Disorders in Newborns and Children

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$17,883,000	$18,883,000	$18,883,000	---
FTE	2	5	5	---

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

FY 2022 Authorization……Expired

Allocation Methods:

- Contract
- Competitive grant/co-operative 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 30 of the 35 core conditions on the Recommended Uniform Screening Panel (RUSP), a list of conditions recommended by the Secretary of HHS for state newborn screening programs. Babies testing positive for one of these conditions receive early intervention and treatment to prevent serious problems such as brain damage, organ damage, and even death. Newborn screening saves or improves the lives of more than 12,000 babies in the United States each year.

The program is composed of six different projects.

- The **Newborn Screening Data Repository and Technical Assistance Program** seeks to enhance, improve, and expand the newborn screening system by supporting state public health newborn screening programs, public health professionals, and primary and specialty care providers. The program also tracks and estimates the incidence of screened conditions. These data help the program assist states and territories to implement quality improvement activities, evaluate newborn screening program impact, and address gaps in newborn screening follow-up. In addition, the program supports states with implementing conditions recently added to the RUSP.
- The **Quality Improvement in Newborn Screening Program** supports states to improve the outcomes of newborns with conditions identified through newborn screening by improving:
    - The amount of time it takes to identify infants at high risk for having one of these conditions;

    - The processes used for detecting out-of-range results and 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.
- 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.
- **Long-Term Follow-Up for Severe Combined Immunodeficiency (SCID) Implementation and Other Newborn Screening Conditions Program**: The purpose of this program is to support comprehensive models of long-term follow-up that demonstrate collaborations between clinicians, public health agencies, and families. The program works to ensure that newborns and children identified through newborn screening achieve the best possible outcomes by expanding the ability of state public health agencies to provide screening, counseling, and services to these newborns and children. The program also supports collaboration with clinicians, public health agencies, and families to create a system of care that can assess and coordinate follow-up and treatment of SCID and/or other newborn screening conditions.
- **The Newborn Screening Interoperability Program**: The purpose of this program is to provide state newborn screening programs with expertise, training, and education in informatics and to support programs in the development and implementation of comprehensive data interoperability plans. The aim is to ensure accurate and timely data sharing between entities involved in the newborn screening system, including hospitals, providers, laboratories, registries, vital records and other state programs. The overall goal is to improve outcomes for newborns and children affected by a condition identified through newborn screening.

In FY 2020, the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children was re-established as a discretionary committee. The Committee continues to provide national newborn screening guidance and standards as well as advise the Secretary on reducing mortality or morbidity from heritable disorders, conduct evidence-based reviews of conditions to recommend updates to the RUSP, and consider 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 Newborn Screening Information Center 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.

In response to the COVID-19 global pandemic and needs expressed by newborn screening programs across the nation, NewSTEPs, the Newborn Screening Family Education Program, and the regional genetics networks provided technical assistance to states around laboratory supply and support needs; emergency and contingency planning tools and resources, including information about access to care through telehealth; and educational materials to their constituents and stakeholders.

The program addresses health equity through the Regional Genetics Networks and the Newborn Screening Education program, which aim to increase access to genetic services and information for underserved populations. Additionally, The Western States Regional Genetics Network has developed a national minority genetics professional network to support and encourage increased diversity across all genetics professions.

Funding History

FY	Amount
FY 2018	$15,788,085
FY 2019	$16,311,000
FY 2020	$17,883,000
FY 2021 Enacted	$18,883,000
FY 2022 President's Budget	$18,883,000

Budget Request

The FY 2022 Budget Request for the Heritable Disorders in Newborns and Children program of $18.88 million is equal to the FY 2021 Enacted Level. This request will invest $18.88 million to continue support of the six projects and associated awards that comprise the Heritable Disorders in Newborns and Children program. This includes continued support of state and local public health agencies, public health professionals, and primary and specialty care providers in their ability to provide screening, counseling, and health care services to reduce morbidity and mortality caused by heritable disorders in newborns and children. The program will continue to fund efforts to increase awareness, knowledge and understanding of newborn screening and enhance, improve, or expand access to screening, counseling, and health care services for newborns and children having or at risk for genetic disorders.

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 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	18	16	16
Average Award	$818,220	$891,828	$902,745
Range of Awards	$47,000-$3,300,000	$133,333-$3,300,000	$133,333-$3,300,000

Pediatric Mental Health Care Access

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$10,000,000	$10,000,000	$10,000,000	---
FTE	2	2	5	+3

Authorizing Legislation – Public Health Service Act, Section 330M, as added by Public Law 114-255

FY 2022 Authorization……$9,000,000

Allocation Method

- Competitive co-operative agreement

Program Description and Accomplishments

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

Approximately 22.1 percent of children ages 17 and under living in the U.S. experience at least one mental disorder in a given year.[161] Of those, only 53.5 percent received mental health treatment or counseling in the past year.[162] Significant disparities exist in access to behavioral health care. A 2019 study of racial/ethnic disparities in mental health related emergency department visits among children found that Non-Hispanic Black children have more frequent emergency department visits for mental health than Non-Hispanic White children.[163] Compounding this, approximately 36.2 percent of the U.S population lives in a designated Mental Health Professional Shortage Area (HPSAs) and only 26.8 percent of the need for mental

[161] NCHS, 2018-2019 National Survey of Children's Health, Indicator 2.10: Does this child have a mental, emotional, developmental or behavioral (MEDB) problem, age 3-17 years?.
[162] Ghandour RM, Sherman LJ, Vladutiu CJ, Ali MM, Lynch SE, Bitsko RH, Blumberg SJ. Prevalence and treatment of depression, anxiety, and conduct problems in U.S. children. *The Journal of Pediatrics*, 2018. Published online before print, October 12, 2018. Data and Statistics on Children's Mental Health.
[163] Abrams, M. Pediatrics August 2019, 144 2 Racial Disparities in Pediatric Mental Health-Related Emergency Department Visits: A Five-Year Multi-Institutional Study

health care in these HPSAs has been met.[164] Often, pediatric primary care providers are the first responders in behavioral disorder identification and service provision. However, they may not have the knowledge and training to screen, diagnose, and treat behavioral disorders and patients may lack access to needed services, leading 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 will be shared with the field and scaled up as feasible and appropriate.

PMHCA programs are addressing increases in behavioral health concerns among children and adolescents related to the COVID-19 pandemic, including increased reports of anxiety, depression, and suicidal ideation and attempts. PMHCA programs are also supporting resilience strategies among families and clinicians.

Section 2712 of the American Rescue Plan Act of 2021 (P.L. 117-2) (ARP) provides $80 million in funding to support pediatric mental health care access, promoting behavioral health integration into pediatric primary care by supporting state or regional networks of pediatric mental health care teams. HRSA plans to support up to 32 additional PMHCA projects in areas without current HRSA-funded programs. This will bring the total number of PMHCA awards to 53. ARP funds also will be used to establish a new PMHCA Innovation Center to provide technical expertise and assistance to state PMHCA programs and to expand evaluation efforts to include newly-funded PMHCA projects.

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

Funding History

FY	Amount
FY 2018	$10,000,000
FY 2019	$9,956,000
FY 2020	$10,000,000
FY 2021 Enacted	$10,000,000
FY 2022 President's Budget	$10,000,000

[164] Health Resources and Services Administration. Bureau of Health Workforce. Designated Health Professional Shortage Areas Statistics (September 30, 2020). Retrieved 04/2021.

Budget Request

The FY 2022 Budget Request for the Pediatric Mental Health Care Access program of $10.0 million is equal to the FY 2021 Enacted Level. The Budget Request will continue to support 21 statewide or regional pediatric mental health care telehealth access programs providing tele-consultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat and refer children with behavioral health conditions.

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[165,166]

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
52.1**:** Number of primary care providers enrolled in a statewide or regional pediatric mental health care access program. *(Output)*	FY 2018: 1,983 Target: 1,983 (Baseline)	2,300	2,500	+200
52.2**:** Percentage of primary care providers enrolled in a statewide or regional pediatric mental health care access program who receive tele-consultation on behavioral health conditions. *(Output)*	FY 2018: 19.8% Target: 19.8% (Baseline)	25%	30%	+5 percentage points
52.3**:** Number of children and adolescents, 0-21 years of age, seen by primary care providers enrolled in a statewide or regional pediatric mental health care access program, who received at least one screening for a behavioral health condition using a standardized validated tool. *(Intermediate Outcome)*	Baseline and FY 2019 data will be available in Fall FY 2022	Not Defined	TBD	---

[165] FY 2018 data includes reporting from 18 PMHCA programs. The additional 3 PMHCA programs were awarded in FY 2019.
[166] Due to data reporting issues, baseline data for measures 52.3, 52.4, and 52.5 will not be presented until FY 2022

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
52.4**:** Among children and adolescents, 0-21 years of age, seen by primary care providers enrolled in a statewide or regional pediatric mental health care access program and who received at least one screening for a behavioral health condition using a standardized validated tool, the percentage who screened positive for a behavioral health condition. *(Intermediate Outcome)*	Baseline and FY 2019 data will be available in Fall FY 2022	Not Defined	TBD	---
52.5**:** Among children and adolescents, 0-21 years of age, seen by primary care providers enrolled in a statewide or regional pediatric mental health care access program, who screened positive for a behavioral health condition, the percentage who received treatment from the primary care providers or a referral to a behavioral clinician *(Outcome)*	Baseline and FY 2019 data will be available in Fall FY 2022	Not Defined	TBD	---

Grant Awards Table

	FY 2020 Final	**FY 2021 Enacted**	**FY 2022 President's Budget**
Number of Awards	21	21	21
Average Award	$440,569	$442,283	$444,202
Range of Awards	$403,104 – $445,000	$425,000 - $522,698	$425,000 - $522,698

Screening and Treatment for Maternal Depression and Related Behavioral Disorders

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$5,000,000	$5,000,000	$10,000,000	+$5,000,000
FTE	1	1	2	+1

Authorizing Legislation – Public Health Service Act, Section 317L-1, as added by Public Law 114-255

FY 2022 Authorization……$5,000,000

Allocation Method

- Competitive co-operative agreement

Program Description and Accomplishments

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

This program improves the mental health and well-being of pregnant and postpartum women and the social and emotional development of their infants. There are approximately 64 million U.S. women of childbearing age in the U.S and approximately 4 million women give birth in the United States each year. Despite advances in medical care and investments in improving access to care, the maternal mortality rate has continued to rise, most recently reported as 17.4 maternal deaths per 100,000 live births in 2018.[167] Depression is one of the most common complication of pregnancy, experienced by one in seven women.[168, 169] CDC data indicate that the rate of depression diagnoses at delivery among pregnant women increased by seven times from 2000-2015. Additionally, substance misuse can co-occur with mental disorders and is at least as common as many of the other medical conditions typically screened for and managed during

[167] Maternal Mortality

[168] American College of Obstetricians and Gynecologists 2018 committee opinion. No. 757, Screening for Perinatal Depression. Retrieved 6/2020

[169] Fawcett EJ, Fairbrother N, Cox ML, White IR, Fawcett JM. The Prevalence of Anxiety Disorders During Pregnancy and the Postpartum Period: A Multivariate Bayesian Meta-Analysis. *J Clin Psychiatry*. 2019;80(4):18r12527. Published 2019 Jul 23. doi:10.4088/JCP.18r12527

pregnancy.[170] 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 effects.

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

The Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program addresses these gaps by employing a myriad of strategies, including:

- Providing front-line health care providers with real-time psychiatric consultation and care coordination support, as well as training on evidence-based and culturally and linguistically appropriate screening, assessment, and treatment protocols;
- Increasing universal screening in project areas; and
- Improving access to treatment and referral for maternal depression and related behavioral health disorders, such as anxiety and substance use disorder, for pregnant and postpartum women.

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

Funding History

FY	Amount
FY 2018	$5,000,000
FY 2019	$4,978,000
FY 2020	$5,000,000
FY 2021 Enacted	$5,000,000
FY 2022 President's Budget	$10,000,000

Budget Request

The FY 2022 Budget Request for the Screening and Treatment for Maternal Depression and Related Behavioral Disorders program of $10.0 million is $5.0 million above the FY 2021 Enacted Level. This request supports the Improving Maternal Health Initiative and will expand the Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program to increase access for women of reproductive age to mental and behavioral health care. This effort will support use of telehealth and psychiatric teleconsultation to expand front-line health care provider capacity to screen, assess, treat, and refer pregnant and postpartum women

[170] 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.

for maternal depression and related behavioral health disorders, including in rural and medically underserved areas. This funding will help states address an anticipated increase in the need for maternal behavioral and mental health support as a result of the impact of COVID-19 on pregnant and postpartum women.

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 Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
53.1**:** Percent of pregnant and postpartum women at participating practices who received at least one screening for substance use using a standardized validated tool conducted by participating practices during pregnancy or the first 12 months after delivery *(Developmental)*	FY 2019: 52%[171] Target: N/A (Baseline)	Not Defined	Not Defined	---
53.2**:** Percent of pregnant and postpartum women at participating practices who received at least one screening for anxiety using a standardized validated tool conducted by participating practices during pregnancy or the first 12 months after delivery *(Developmental)*	FY 2019: 36% Target: N/A (Baseline)	Not Defined	Not Defined	---
53.3**:** Percent of pregnant and postpartum women at participating practices who received at least one screening for depression using a standardized validated tool conducted by participating practices during pregnancy or the first 12 months after delivery *(Developmental)*	FY 2019: 54% Target: N/A (Baseline)	Not Defined	Not Defined	---

[171] Baseline data reflects reporting by a subset of grantees. The program will identify trends over a three year period as the measure is developmental. Once the trend is analyzed, appropriate targets will be identified and included in the FY 2023 budget justification.

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	7	7	14
Average Award	$646,379	$646,516	$648,233
Range of Awards	$627,525-$650,000	$627,525-$650,000	$627,525-$650,000

Family-To-Family Health Information Centers

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Current Law Mandatory Funding	$6,000,000	$5,658,000[172]	$5,658,000[173]	---
FTE	1	1	1	---

Authorizing Legislation - Social Security Act, Title V, Section 501(c)(1)(A) of the, as amended by Public Law 116-39, Section 5

FY 2022 Authorization……$6,000,000

Allocation Method:

- Competitive grant/co-operative agreement

Program Description and Accomplishments

The Family-to-Family Health Information Centers (F2F HICs) Program assists families of children and youth with special health care needs (CYSHCN) to be partners in health care decision making. Staffed by family members who have first-hand experience using health care services and programs for CYSHCN, F2F HICs promote cost-effective, quality health care by providing patient-centered information, education, technical assistance, and peer support to families of CYSHCN and health professionals. Initially authorized by the Deficit Reduction Act of 2005, the program funded one health information center in each of the 50 states and the District of Columbia. Since then, F2F HICs have been developed in all territories and also for Indian tribes. Most recently, the Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39) reauthorized the program through FY 2024.

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

- Helping families gain the knowledge and skills to make informed health care choices that promote good treatment decisions, cost effectiveness, and improved health outcomes;
- Developing models for building working relationships between families and health professionals to assist in providing appropriate services and information;
- Providing training and guidance to health professionals on the care of CYSHCN;
- Conducting outreach activities to families, health professionals, schools, and other appropriate entities to increase their knowledge of F2F HICs and the resources available for CYSHCN and their families; and
- Enlisting families of CYSHCN and health professionals to staff these efforts.

[172] FY 2021 reflects the post-sequestration funding amount.
[173] FY 2022 reflects the post-sequestration funding amount

Research supports the effectiveness of the F2F HIC strategy.[174] 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.[175] 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 2019 F2F HICs provided services to 208,318 families, which exceeded the target of 174,300 families. In addition, in FY 2019, F2F HICs trained and provided information, resources, and referrals to 110,023 health professionals who serve CYSHCN and their families within community and state public health agencies, managed care and insurance organizations, medical practices, children's hospitals, universities, Federally Qualified Health Centers, and more.

Funding History

FY	Amount
FY 2018	$6,000,000
FY 2019	$6,000,000
FY 2020	$6,000,000
FY 2021 Enacted	$5,658,000[176]
FY 2022 President's Budget	$5,658,000[177]

Budget Request

The Family-to-Family Health Information Centers (F2F HICs) program is funded at $6.0 million for each fiscal year through FY 2024.[178] In FY 2022, F2F HICs will be reduced by $342,000 through sequestration pursuant to the Balanced Budget and Emergency Deficit Control Act (BBEDCA).

FY 2022 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

[174] 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
[175] 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).
[176] Reflects the post-sequestration amount.
[177] Reflects the post-sequestration amount.
[178] Funding is subject to sequestration.

cost-savings for families. The FY 2022 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.

To address health equity, an objective of the F2F program is to increase the number of individuals from underrepresented and diverse communities trained to partner with families at all levels of decision making. The F2Fs are doing this through targeted outreach and leadership development to specific populations. Additionally, F2Fs participated in community forums and town halls led by Family Voices to address the impact of racism on CYSHCN and their families.

To address the impact of COVID-19, in FY 2020, 56 grantees received funding through the CARES Act to help prepare families to access services through telehealth, especially those in underserved communities.

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 Table[179]

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
15.III.C.1**:** Number of families with CSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers (Outcome)	FY 2019: 208,318[180] Target: 174,300 (Target Exceeded)	195,000	195,000	Maintain
15.III.C.2**:** Number of professionals who serve CSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers *(Output and Developmental)*	FY 2019: 110,023[181] Target: 110,023 (Baseline)	100,000	100,000	Maintain :

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
15.III.C.3**:** Percentage of families with CSHCN 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 *(Outcome and Developmental)*	FY 2019: 87%[182] Target: Set Baseline (Pending)	Not Defined	90%	Maintain
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 CSHCN and/or others who serve CSHCN *(Outcome and Developmental)*	FY 2019: 94%[183] Target: Set Baseline (Pending)	Not Defined	95%	Maintain

Grant Awards Table[184]

	FY 2020 Final	**FY 2021 Enacted**	**FY 2022 President's Budget**
Number of Awards	59	59	59
Average Award	$89,111	$89,293	$89,293
Range of Awards	$49,000-$96,750	$49,000-$96,750	$49,000-$96,750

[182] The data for this measure is collected from grantee surveys.
[183] Ibid.
[184] Does not include carryover funding. FY 2021 and FY 2022 reflect post-sequestration funding.

Maternal, Infant, and Early Childhood Home Visiting Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Current Law Mandatory Funding	$376,400,000[185]	$377,200,000[186]	$377,200,000[187]	---
FTE	38	45	53	+8

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

FY 2022 Authorization $400,000,000

Allocation Methods:

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

Program Description

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry living in at-risk communities. 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.[188]

[185] FY 2020 reflects the post-sequestration funding amount.
[186] FY 2021 reflects the post-sequestration funding amount.
[187] FY 2022 reflects the post-sequestration funding amount.
[188] 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.[189]

Grantees deliver services by implementing one or more of 19 evidence-based home visiting models, selected by the grantee, which meet HHS established evidence of effectiveness criteria and MIECHV criteria for implementation. Administered by the Administration for Children and Families (ACF), the Home Visiting Evidence of Effectiveness review (HomVEE) 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 19 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 conducted needs assessments, which were updated by October 1, 2020, as required under the Bipartisan Budget Act of 2018, to identify eligible at-risk communities, determine priority populations, and choose which approved evidence-based models or promising approaches for home visiting will be used.

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

[189] 42 U.S.C. § 711(b)(1)(A).

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.

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

Formula grants to states and territories

In FY 2020, HRSA awarded $341 million in MIECHV formula grants to 56 states, territories, and nonprofit organizations.[190] 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 2020, three states implemented and evaluated three promising approaches to better address the needs of their communities.

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

Three percent of funding ($12 million) is set aside for five-year competitive awards available to tribal entities. As of FY 2020, 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).

Section 9101 of the American Rescue Plan Act of 2021 (P.L. 117-2) (ARP) appropriated $150 million to enable MIECHV Program recipients to address the needs of expectant parents and families with young children during the COVID-19 public health emergency. HRSA will make formula-based awards to all current MIECHV recipients to support direct COVID-related costs (e.g., costs associated with shifting to virtual service including the provision of technology-related items, basic supplies such as formula, diapers, and groceries to families, and hazard pay

[190] In FY 2020, North Dakota was awarded one dollar, which allows them to apply for future funding. Further funding for North Dakota will be determined upon satisfactory compliance with established HRSA programmatic and financial requirements for previous HRSA grants representing multiple fiscal years.

and other supports for staff) and expand services to families in communities at risk for poor maternal and child health outcomes. HRSA will make competitive awards to current MIECHV awardees to document and evaluate programmatic innovations intended to enable MIECHV awardees to better serve families in response to the COVID-19 pandemic. In addition, funds will be used to support current MIECHV recipients serving tribal communities and for administration of the program.

Program Accomplishments

MIECHV state and territory grantees provided over 7.1 million visits from FY 2012 through FY 2020. In FY 2020 states reported serving more than 140,000 parents and children in 1,054 counties across all 50 states, the District of Columbia, and five territories. This is more than a 300 percent increase in the number of participants served since FY 2012 (see Tables 1 and 2 below). Tribal grantees provided over 123,000 home visits from FY 2012 to FY 2020 and served over 3,315 parents and children in FY 2020.

Table 1: Number of State/Territory Participants (FY 2012 – FY 2020)[191]

Fiscal Year	Number of Participants
2012	34,180
2013	75,970
2014	115,545
2015	145,561
2016	160,374
2017[192,193]	156,297
2018[194]	150,291
2019	154,496
2020	140,606

[191] 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).
[192] 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.
[193] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.
[194] Does not include data from the Commonwealth of the Northern Mariana Islands due to reporting delays caused by Super Typhoon Yutu.

Table 2: Number of Home Visits by State/Territory Grantees (FY 2012 – FY 2020)

Fiscal Year	Number of Home Visits
2012	174,257
2013	489,363
2014	746,303
2015	894,347
2016	979,521
2017[195,196]	942,676
2018[197]	930,595
2019	1,015,217
2020	928,130

MIECHV serves many at-risk families. In FY 2020:

- 70 percent of participating families had household incomes at or below 100 percent of the federal poverty guidelines ($26,000 for a family of four), and 41 percent were at or below 50 percent of those guidelines;
- 25 percent of adult program participants had less than a high school education, and 38 percent had only a high school degree or equivalent; and
- 10 percent of households included pregnant teens; 21 percent of households reported a history of child abuse and maltreatment; and 15 percent of households reported substance abuse.

Performance data collected to fulfill the statutory requirement of a three-year assessment of improvement[198] were most recently updated in FY 2016. These data indicate that 98 percent of states, territories, and non-profit grantees demonstrated improvement in at least four of the six benchmark areas for demonstrating program improvements as outlined in the legislation:

- Improving maternal and newborn health;
- Preventing child injuries, maltreatment, and emergency department visits;
- Improving school readiness and achievement;
- Reducing crime or domestic violence;
- Improving family economic self-sufficiency; and
- Improving service coordination and referrals for other community resources and supports.

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. Released in November 2018,[199] 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 as intended by the program; most home visitors were well educated, trained and experienced; local programs focused on improving parenting and child development outcomes; and the tailoring of services to families' needs was especially evident in areas of substance use, mental health, and intimate partner violence. The MIHOPE Impact Report, released in January 2019,[200] presents evidence that MIECHV-funded home visiting services had positive effects for the families that participated in services, including in the quality of the home environment and the frequency of psychological aggression towards the child. The study provides evidence that differences in effects among the evidence-based models that were included in the study are generally consistent with the models' focuses.

Funding History

FY	Amount[201]
FY 2018	$400,000,000
FY 2019	$400,000,000
FY 2020	$376,400,000
FY 2021 Enacted	$377,200,000
FY 2022 President's Budget	$377,200,000

Budget Request

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is funded at $400.0 million for each fiscal year through FY 2022.[202] In FY 2022, MIECHV will be reduced by $22.8 million through sequestration pursuant to the Balanced Budget and Emergency Deficit Control Act (BBEDCA). FY 2022 funding will support the state, territory, and tribal administration of locally run voluntary, evidence-based home visiting services for at-risk families that have been proven to help prevent child abuse and neglect, encourage positive

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

[200] Michalopoulos, Charles, Kristen Faucetta, Carolyn J. Hill, Ximena A. Portilla, Lori Burrell, Helen Lee, Anne Duggan, and Virginia Knox. 2019. *Impacts on Family Outcomes of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation.* OPRE Report 2019-07. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[201] Reflects post-sequestration amounts in FY 2020, FY 2021, and FY 2022.

[202] FY 2020, FY 2021, and FY 2022 are subject to sequestration.

parenting, and promote child development and school readiness. This level of funding will provide:

- Awards to 53 state and territory grantees and three non-profit organizations;
- Awards to 23 tribal entities; and
- Support for research, evaluation, and technical assistance for both corrective action and program improvement for state, territory, and tribal MIECHV grantees.

Funds will continue to support the statutory directive for an ongoing portfolio of research and evaluation on home visiting, which includes the MIHOPE Long-Term Follow-Up evaluation, the Home Visiting Research and Development Platform, the Home Visiting Collaborative Improvement and Innovation Network, a multi-site implementation study of Tribal Home Visiting, and a tribal early childhood research center.

Technical assistance to grantees is of vital importance to ensure that home visiting services are provided with quality and fidelity to evidence-based and promising approach home visiting service delivery models. The funding will support contracts for technical assistance to state, territory, and tribal grantees for performance measurement, implementation, data systems, quality improvement, and research and evaluation to help grantees enhance the efficiency and effectiveness of their home visiting programs.

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

Outcomes and Outputs Tables[203]

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
37.1**:** Number of home visits to families receiving services under the MIECHV program.[204] *(Output)*	FY 2020: 945,259[205] Target: 1,033,000 (Target Not Met)	1,033,000	945,000[206]	-88,000
37.2**:** Number and percent of grantees that meet benchmark area data requirements for demonstrating improvement. *(Outcome)*	State/Territory FY 2016: 55 (98%)[207] Target: 53 (95%) (Target Exceeded) Tribal FY 2020: 14 (74%) Target: 20 (80%) (Target Not Met)	State/Territory: 55 (98%), Tribal: 22 (88%)	State/Territory: 47 (84%), Tribal 22 (88%)	N/A
37.3**:** Number of participants served by the MIECHV Program *(Outcome)*	FY 2020: 143,921[208] Target: 160,000 (Target Not Met)	160,000	144,000[209]	-16,000

[203] In 2020, the COVID-19 pandemic negatively impacted new enrollment of families in Q3 and continuing enrollment of families in Q4.
[204] 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.
[205] The data source for this measure is the Home Visiting Information System (HVIS). Results reflect the most recent data available, which include FY 2020 data for state, territory, and Tribal grants. The most recent data available are from 2016 and will be updated when more recent data become available.
[206] FY2022 Target reflects FY2020 results impacted by sequestration, COVID-19, and a reporting error in one state.
[207] Ibid. Per statute, an initial assessment of improvement occurred after three years of program implementation. Current statute requires the next assessment of improvement following FY 2020, and every 3 years thereafter.
[208] Ibid. Results reflect the most recent data available, which includes FY 2020 data for state, territory, and Tribal grants.
[209] FY2022 Target reflects FY2020 results impacted by sequestration, COVID-19, and a reporting error in one state.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
37.4**:** Percent of children enrolled in MIECHV who received daily early language and literacy support from a family member *(Outcome and Developmental)*	FY 2020: 77.5%[210] Target: 65.4%[211] (Target Exceeded)	Not Defined	65.4%	N/A
37.5**:** Percent of parents enrolled in MIECHV who were screened for depression after enrollment or after giving birth *(Outcome and Developmental)*	FY 2020: 81%[212] Target: 76.5%[213] (Target Exceeded)	Not Defined	76.5%	N/A

Grant Awards Tables[214]

	FY 2020 Final	**FY 2021 Enacted**	**FY 2022 President's Budget**
Number of Awards	79	79	79
Average Award	$4,282,442	$4,305,808	$4,305,808
Range of Awards	$300,000-$19,610,292	$300,000-$19,397,203	$300,000-$19,397,203

[210] Ibid. Results reflect state and territory grants only and reflect a two-year average from FY 2019 and FY 2020.
[211] Ibid. Results reflect state and territory grants only and reflect a two-year average from FY 2017 and FY 2018.
[212] Ibid. Results reflect state and territory grants only and reflect a two-year average from FY 2019 and FY 2020.
[213] Ibid. Results reflect state and territory grants only and reflect a two-year average from FY 2017 and FY 2018.
[214] Does not include carryover funding. FY 2020, FY 2021, and FY 2022 reflect post-sequestration funding.

RYAN WHITE HIV/AIDS TAB

RYAN WHITE HIV/AIDS

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) funds and coordinates with cities, states, and local clinics/community-based organizations to deliver efficient and effective HIV care, treatment, and support to low-income people with HIV. Nearly sixty one percent of clients (patients) live at or below 100 percent of the federal poverty level and approximately three-quarters of RWHAP clients are racial and ethnic minorities. The RWHAP statute requires that the program is the "payor of last resort," meaning RWHAP funds can only be used for allowable services not covered by other federal or state programs, or private insurance. Since 1990, RWHAP has developed a comprehensive system of safety net providers who deliver high quality direct health care and support services to over half a million people with HIV[215] – more than 50 percent of all people with diagnosed HIV in the United States.[216] This is one of the many reasons why the Health Resources and Services Administration (HRSA) is leading key components of the *Ending the HIV Epidemic in the U.S.* initiative.

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

The RWHAP provides HIV care and treatment services to a higher proportion of certain populations with HIV than their representation in the epidemic nationally. For example, according to the most recent Centers for Disease Control and Prevention (CDC) data, 71 percent of people with diagnosed HIV in the United States are racial and ethnic minorities, while 73 percent of RWHAP clients are racial and ethnic minorities, meeting the target of not being lower than 3 percentage points of the national HIV prevalence data as reported by CDC HIV prevalence data as reported by CDC.[217] Similarly, 24 percent of people with diagnosed HIV in the United States are women, while 26 percent of RWHAP clients are women, meeting the target of not being lower than 3 percentage points of the national HIV prevalence data as reported by CDC.

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 optimal health outcomes of people with HIV but to preventing

[215] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019. Published December 2020. Accessed March 26, 2021.
[216] Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Updated); vol. 31. Published May 2020. Accessed March 26, 2021.
[217] Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Updated); vol. 31. Published November 2019. Accessed March 26, 2021.

further transmission of the virus,[218] which furthers the public health goal of ending the HIV epidemic in the United States.[219] Research studies demonstrate that people with HIV who take HIV medications daily as prescribed, and achieve and then maintain an undetectable viral load, have effectively no risk of sexually transmitting the virus to an HIV uninfected partner.[220,221] In the RWHAP, 88.1 percent of patients receiving RWHAP medical care are virally suppressed[222] compared to the general population of people with diagnosed HIV, who have a viral suppression of 64.7 percent[223,224] - an outcome measure that demonstrates the success of the program and results in major public health benefits.

According to a *Clinical Infectious Diseases* study, clients receiving care and support at RWHAP-funded facilities are associated with improved outcomes (such as viral suppression), compared to those not served by the RWHAP.[225] Furthermore, RWHAP patients are more likely to reach viral suppression regardless of other health care coverage (e.g., uninsured, Medicaid, Medicare, or private insurance). Not only do improved viral suppression rates reduce the transmission of HIV, they also result in significant cost-savings to the health care system.[226]

The RWHAP has made tremendous progress toward ending the HIV epidemic in the United States: from 2010 to 2019, HIV viral suppression among RWHAP patients has increased from 69.5 percent to 88.1 percent, and racial and ethnic, age-based, and regional disparities have decreased.[227] 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

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[218] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2014–2018. HIV Surveillance Supplemental Report, 2020; vol. 25 Published May 2020. Accessed March 2021.
[219] The goal of HIV treatment is to decrease viral load in people with HIV, ideally to an undetectable level, known as viral suppression. When viral suppression is achieved and maintained, the risk of transmitting HIV is reduced.
[220] 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]. NLM Identifier: NCT00074581.
[221] 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.
[222] HIV viral suppression was based on data for RWHAP clients who had at least one 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.
[223] Harris NS, Johnson AS, Huang YA, et al. *Vital Signs:* Status of Human Immunodeficiency Virus Testing, Viral Suppression, and HIV Preexposure Prophylaxis — United States, 2013–2018. MMWR Morb Mortal Wkly Rep 2019;68:1117–1123.
[224] Centers for Disease Control and Prevention. Social determinants of health among adults with diagnosed HIV infection, 2018. HIV Surveillance Supplemental Report 2020;25 (No. 3). Published November 2020. Accessed March 2021.
[225] 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.
[226]Schackman BR, Fleishman JA, Su AE, et al. The lifetime medical cost savings from preventing HIV in the United States. Med Care. 2015;53(4):293-301. doi:10.1097/MLR.0000000000000308.
[227] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019. Published December 2020. Accessed March 2021.

the United States have HIV, and 1 in 7 are unaware of their HIV.[228] In addition, approximately 40,000 HIV diagnoses occur every year.[229]

Coronavirus Pandemic

On April 15, 2020, the U.S. Department of Health and Human Services (HHS), through HRSA, awarded $90 million for RWHAP recipients across the country to prevent, prepare for, and respond to coronavirus disease 2019 (COVID-19). The Coronavirus Aid, Relief and Economic Security (CARES) Act, which was signed into law on Friday, March 27, 2020, provided this funding.

The FY 2020 CARES Act funding supports RWHAP Parts A-D and the RWHAP AIDS Education and Training Centers (AETC) recipients to prepare for, prevent, and respond to the COVID-19 pandemic. HRSA continues to closely monitor the impact of COVID-19 on the RWHAP. As states, cities, clinics, and community-based organizations adjusted to the rapidly changing health care environment, HRSA worked to more fully understand the impact that these adjustments, including transitioning to telehealth, diverting staff to work on COVID-19, etc., would have on program implementation, access to care and support services, and patient health outcomes. The Consolidated Appropriations Act, 2021, Pub. L. 116-260, Division M, § 307 included language which allowed flexibilities related to penalties and administrative requirements that the Secretary could exercise to provide relief to RWHAP recipients. After careful review of RWHAP penalties and requirements, HRSA responded by providing opportunities to reduce or delay requirements without compromising the integrity, scope, and implementation of the RWHAP. Given the on-going nature of the pandemic, the Budget proposes to extend this language in FY 2022 to allow continued flexibilities.

Ending the HIV Epidemic in the U.S.

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

In FY 2021, HRSA awarded funds to the 39 RWHAP Part A recipients and 8 Part B recipients that encompass the 48 counties, Washington, D.C., San Juan (PR), as well as 7 states that have a substantial rural HIV burden. Jurisdictions will utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. In total, $99 million was awarded to these 39 recipients, two

[228] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2014–2018. HIV Surveillance Supplemental Report 2020;25(No. 1). Published May 2020. Accessed March 2021..
[229] Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Updated); vol. 31. Published May 2020. Accessed March 2021.

technical assistance providers, and 12 RWHAP AETC Program recipients.[230] Strategies for implementation are:

- Implementing evidence-informed and emerging strategies shown to increase linkage, engagement, and retention in care targeted to those not yet diagnosed, those diagnosed but not in HIV care, and those who are in HIV care but not yet virally suppressed;
- Re-engaging people with HIV who were in care, but are no longer in ongoing care and are not virally suppressed.
- Providing technical assistance and systems coordination to support effective strategic plans and activities to successfully implement the new initiative; and
- Expanding workforce capacity through the efforts of the AIDS Education and Training Centers (AETCs).

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

Additional Priorities and Collaborative Efforts

In FY 2022, the HRSA RWHAP will continue to ensure effective use of resources and a coordinated and focused public health response to HIV. HRSA will also continue to coordinate and collaborate with other federal, state, and local entities as well as national HIV organizations to further leverage and promote efforts to address the unmet care and treatment needs of people with HIV who are uninsured and underserved. These efforts help to align priorities, policies, and 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 Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), the Indian Health Service (IHS), the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), the Department of Housing and Urban Development (HUD), the Department of Veterans Affairs (VA), and the Department of Justice (DOJ), as well as other HRSA-funded programs, such as the Health Center Program. With many clients in common, HRSA RWHAP will also coordinate with the Administration for Community Living (ACL) to leverage existing resources in both programs to advance the health outcomes of older adults living with HIV.

The HIV National Strategic Plan: A Roadmap to End the HIV Epidemic for the United States (2021 – 2025: HIV Plan): The HIV Plan builds on the targets for ending the HIV epidemic in the United States by 2030. For stakeholders across the nation, the HIV Plan articulates goals, objectives, and strategies to prevent new infections, treat people with HIV to improve health outcomes, reduce HIV-related disparities, and better integrate and coordinate the efforts of all partners to achieve the bold targets for ending the HIV epidemic in the United States. The RWHAP will continue to coordinate with other federal partners, grant recipients, and other partners to work towards achieving these four goals.

[230] HRSA Press Release. FY 2021 Ending the HIV Epidemic Awards. Date accessed: March 2021.

The HRSA RWHAP will also coordinate with federal partners, grant recipients, and other partners to address the syndemics of HIV, viral hepatitis, STIs, and substance use disorders through the following HHS efforts:

- *Sexually Transmitted Infections (STI) National Strategic Plan for the United States: A Roadmap to Elimination 2021-2025:* The STI plan will develop, enhance and expand STI prevention and care programs over the next five years. The aim is to reverse the recent dramatic rise in STIs in the United States. The STI Plan includes a set of goals, objectives, and strategies to respond to this STI epidemic and includes indicators with measurable targets to track progress.

- *Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination 2021-2025:* The Viral Hepatitis Plan is intended to serve as a comprehensive, data-driven roadmap for federal and other stakeholders to reverse the rates of viral hepatitis, prevent new infections, improve care and treatment and ultimately eliminate viral hepatitis as a public health threat in the United States.

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

Measuring Future Performance

Together, in FY 2022 RWHAP Parts A-D programs are anticipated to achieve the following performance goals:

- In FY 2022, the RWHAP will serve racial and ethnic minorities at a proportion not lower than three percentage points of national HIV prevalence data as reported by CDC.
- In FY 2022, the RWHAP will serve women at a proportion that is not lower than three percentage points of national HIV prevalence data as reported by CDC.
- In FY 2022, 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 2021 Target	FY 2022 Target	FY 2021 +/- FY 2022
16.I.A.1: Percentage of people with diagnosed HIV served by the Ryan White HIV/AIDS Program who are racial and ethnic minorities.*(Output)*	2019: 73% Target: Not lower than 3 percentage points of CDC data or 71% (Target Met)	Not lower than 3 percentage points of CDC data	Not lower than 3 percentage points of CDC data	Maintain
16.I.A.2: Percentage of people with diagnosed HIV served by the Ryan White HIV/AIDS Program who are women.*(Output)*	2019: 26% Target: Not lower than 3 percentage points of CDC data or 24% (Target Met)	Not lower than 3 percentage points of CDC data	Not lower than 3 percentage points of CDC data	Maintain
16.III.A.4: Percentage of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test who are virally suppressed. *(Outcome)*	2019: 88% Target: 83% (Target Exceeded)	83%	83%	Maintain

RWHAP Part A - Emergency Relief Grants

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$655,876,000	$655,876,000	$665,876,000	+$10,000,000
MAI (non add)	$54,105,000	$54,105,000	$54,105,000	---
Total Funding	$655,876,000	$655,876,000	$665,876,000	+$10,000,000
FTE	45	48	48	---

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

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

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

Ryan White HIV/AIDS Program (RWHAP) Part A provides grants to cities with a population of at least 50,000, which are areas severely affected by the HIV epidemic. These jurisdictions are funded as either an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA), depending on the severity of the epidemic in their jurisdiction. Seventy-one percent of all people with diagnosed HIV reside in a RWHAP Part A EMA or TGA. [231,232]

Formula and supplemental grants assist eligible areas in developing and enhancing access to a comprehensive continuum of high quality, community-based care for low-income people with HIV. The RWHAP requires EMAs and TGAs to utilize local needs assessments and planning processes to develop coordinated systems of HIV care in order to improve health outcomes for low-income people with HIV, thereby reducing transmission of HIV.

RWHAP Part A prioritizes primary medical care, access to antiretroviral treatment, and other core medical and supportive services in order to engage and retain people with HIV in care. These grants fund systems of care to provide services for people with HIV in 24 EMAs and 28 TGAs. EMAs are jurisdictions with 2,000 or more AIDS cases over the last five years, whereas TGAs are jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases over the last five

[231] Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Updated); vol. 31. Published May 2020. Accessed March 2021.
[232] Centers for Disease Control and Prevention. HIV/AIDS data through December 2018 provided for the Ryan White HIV/AIDS Program, for fiscal year 2020. *HIV Surveillance Supplemental Report 2020*;25(No. 4). Published December 2020. Accessed March 2021.

years as reported to the Centers for Disease Control and Prevention. Two-thirds of the funds available for EMAs and TGAs are awarded according to a formula, based on the number of people with diagnosed HIV in the EMAs and TGAs.

The remaining funds are awarded as discretionary supplemental grants based on the demonstration of additional need by the eligible EMAs and TGAs, and as Minority AIDS Initiative (MAI) grants. The MAI funds are a statutory set-aside funding component for RWHAP Parts A – D, and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. MAI funds are also awarded based on a formula utilizing the number of minorities with diagnosed HIV and AIDS in a jurisdiction and support HIV care, treatment, and support services to racial and ethnic minorities.

The RWHAP Part A funds are awarded to the Chief Elected Official who is required to establish a local Planning Council/Body that determines the allocation of RWHAP resources based on local needs assessments. Seventy-five percent of RWHAP Part A funds must be used to support core medical services. Eligible sub-recipients are community health centers, health departments, ambulatory care facilities, and other non-profit organizations providing services for people with HIV.

In 2019, 78 percent of RWHAP Part A clients were racial and ethnic minorities and 26 percent were women. In 2019, RWHAP Part A funded sites provided nearly 3.3 million core medical service visits for health-related care utilizing a combination of RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of RWHAP Part A in delivering primary care and related services for people with HIV by increasing the availability and accessibility of care.

Ending the HIV Epidemic in the U.S. - RWHAP Part A Jurisdictions

Thirty nine of the RWHAP Part A jurisdictions received a cooperative agreement to implement EHE initiative activities related to Pillar Two (Treat) and Pillar Four (Respond) in FY 2021. This initiative is now in its second year and jurisdictions will utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. See the final pages of the RWHAP section for more information on the EHE initiative.

RWHAP Part A Funding History

FY	Amount
FY 2012	$666,071,000
FY 2013	$624,262,000
FY 2014	$649,373,000
FY 2015	$655,220,000
FY 2016	$655,876,000
FY 2017	$654,296,000
FY 2018	$655,876,000
FY 2019	$655,876,000
FY 2020	$655,876,000
FY 2021 Enacted	$655,876,000
FY 2022 President's Budget	$665,876,000

Budget Request

The FY 2022 President's Budget request for the Ryan White HIV/AIDS Program (RWHAP) Part A of $665.9 million is $10.0 million above the FY 2021 Enacted Level. The President's Budget request will support the provision of core medical and support services for people with HIV in the 24 EMAs and 28 TGAs.

The RWHAP has seen a significant increase in utilization during the COVID-19 pandemic due to people with HIV losing other sources of health coverage (such as employer insurance), and state governments' revenue dropping, resulting in state funding cuts. The Budget requests an additional $10.0 million for the RWHAP Part A program to expand services for significantly impacted populations, particularly racial and ethnic minorities. RWHAP Part A jurisdictions encompass over 70 percent of all HIV cases in the US, therefore an increase in funding will help meet this need driven by the pandemic.

In 2019, 65 percent of all RWHAP clients were served by one of the 52 metropolitan areas funded under the RWHAP Part A. Nearly 71 percent of all people with diagnosed HIV reside within these metropolitan areas. The RWHAP serves populations that are diverse with multiple structural barriers to care (e.g., people with HIV at or below 100 percent of the federal poverty level and/or those who are homeless).

The FY 2022 funding request will support the RWHAP Part A in achieving its target of providing 3.3 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 2022 targets for performance goals that relate to cross-cutting activities, such as the percentage of racial and 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 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
17.I.A.2: Number of RWHAP Part A visits for health-related care. *(Output)*	2019: 3.3M Target: 3.7M (Target Not Met)	3.6M	3.3M	Maintain

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	52	52	52
Average Award	$12,055,968	$11,950,579	$12,142,887
Range of Awards	$2,805,373 - $92,902,442	$2,774,766 - $90,652,054	$2,815,698 - $92,445,460

RWHAP Part A – FY 2020 Formula, Supplemental & MAI Grants[233]

Table 1. Eligible Metropolitan Areas

EMAs	Formula	Supplemental	MAI	Total
Atlanta, GA	$17,143,377	$8,389,247	$2,700,856	$28,233,480
Baltimore, MD	$9,547,056	$5,236,147	$1,601,774	$16,384,977
Boston, MA	$9,293,553	$4,547,874	$1,053,337	$14,894,764
Chicago, IL	$16,844,533	$8,509,007	$2,471,630	$27,825,170
Dallas, TX	$11,401,953	$5,262,235	$1,522,122	$18,186,310
Detroit, MI	$5,766,671	$2,962,398	$844,676	$9,573,745
Ft. Lauderdale, FL	$9,584,154	$5,002,985	$1,299,316	$15,886,455
Houston, TX	$14,926,259	$7,382,752	$2,322,959	$24,631,970
Los Angeles, CA	$27,124,273	$13,447,307	$3,768,137	$44,339,717
Miami, FL	$15,612,056	$8,309,536	$2,711,490	$26,633,082
Nassau-Suffolk, NY	$3,212,580	$1,652,586	$444,909	$5,310,075
New Haven, CT	$3,193,000	$1,775,202	$452,333	$5,420,535
New Orleans, LA	$4,631,577	$2,615,120	$654,674	$7,901,371
New York, NY	$54,062,543	$30,054,269	$8,785,630	$92,902,442
Newark, NJ	$7,253,165	$4,040,146	$1,263,202	$12,556,513
Orlando, FL	$6,382,394	$3,108,576	$851,196	$10,342,166
Philadelphia, PA	$13,122,886	$7,238,728	$1,992,813	$22,354,427
Phoenix, AZ	$6,133,013	$3,040,543	$619,161	$9,792,717
San Diego, CA	$7,201,641	$3,439,807	$773,149	$11,414,597
San Francisco, CA	$9,219,872	$4,979,611	$791,006	$14,990,489
San Juan, PR	$6,085,610	$3,337,085	$1,183,349	$10,606,044
Tampa-St. Petersburg, FL	$6,332,930	$3,449,525	$701,924	$10,484,379
Washington, DC-MD-VA-WV	$18,265,075	$10,114,538	$2,924,063	$31,303,676
West Palm Beach, FL	$4,355,403	$2,442,612	$660,793	$7,458,808
Subtotal EMAs	**$286,695,574**	**$150,337,836**	**$42,394,499**	**$479,427,909**

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

Table 2. Transitional Grant Areas

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$3,189,968	$1,608,721	$370,173	$5,168,862
Baton Rouge, LA	$2,710,457	$1,323,952	$457,549	$4,491,958
Bergen-Passaic, NJ	$2,374,190	$1,283,276	$355,426	$4,012,892
Charlotte-Gastonia, NC-SC	$3,856,916	$1,865,344	$597,693	$6,319,953
Cleveland, OH	$2,885,194	$1,436,559	$389,835	$4,711,588
Columbus, OH	$2,951,737	$1,424,569	$302,358	$4,678,664
Denver, CO	$4,849,971	$2,420,254	$400,168	$7,670,393
Fort Worth, TX	$2,924,307	$1,420,687	$388,029	$4,733,023
Hartford, CT	$1,831,184	$1,014,327	$259,021	$3,104,532
Indianapolis, IN	$2,782,079	$1,398,781	$313,794	$4,494,654
Jacksonville, FL	$3,631,383	$1,717,539	$522,656	$5,871,578
Jersey City, NJ	$2,912,116	$1,616,180	$471,895	$5,000,191
Kansas City, MO	$2,665,249	$1,340,582	$281,793	$4,287,624
Las Vegas, NV	$4,062,638	$1,861,057	$476,510	$6,400,205
Memphis, TN	$4,067,718	$1,905,527	$704,933	$6,678,178
Middlesex-Somerset-Hunterdon, NJ	$1,666,606	$894,894	$243,873	$2,805,373
Minneapolis-St. Paul, MN	$3,671,511	$1,810,358	$384,317	$5,866,186
Nashville, TN	$2,768,872	$1,291,035	$314,597	$4,374,504
Norfolk, VA	$3,540,967	$1,705,526	$543,221	$5,789,714
Oakland, CA	$4,353,189	$2,120,615	$586,257	$7,060,061
Orange County, CA	$3,938,189	$1,947,252	$464,271	$6,349,712
Portland, OR	$2,584,484	$1,288,145	$148,470	$4,021,099
Riverside-San Bernardino, CA	$5,034,869	$2,422,259	$568,501	$8,025,629
Sacramento, CA	$2,142,054	$1,069,699	$208,962	$3,420,715
Saint Louis, MO	$3,871,646	$1,913,367	$488,046	$6,273,059
San Antonio, TX	$3,423,629	$1,685,349	$538,406	$5,647,384
San Jose, CA	$1,967,825	$989,588	$251,798	$3,209,211
Seattle, WA	$4,473,067	$2,167,653	$374,787	$7,015,507
Subtotal TGAs	**$91,132,015**	**$44,943,095**	**$11,407,339**	**$147,482,449**
Subtotal EMAs/TGAs	**$377,827,589**	**$195,280,931**	**$53,801,838**	**$626,910,358**

RWHAP Part B - HIV Care Grants to States

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$1,315,005,000	$1,315,005,000	$1,345,005,000	+$30,000,000
MAI (non add)	$10,145,000	$10,145,000	$10,145,000	---
ADAP (non add)	$900,313,000	$900,313,000	$900,313,000	---
Total Funding	$1,315,005,000	$1,315,005,000	$1,345,005,000	+$30,000,000
FTE	61	66	66	---

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

FY 2021 Authorization……Expired

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part B is the largest RWHAP Part and provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and five Associated Pacific Jurisdictions to provide services for people with HIV. RWHAP Part B grants support outpatient ambulatory medical care, HIV-related prescription medications, case management, oral health care, health insurance premium and cost-sharing assistance, mental health and substance abuse services, and support services.

RWHAP Part B funds are distributed through base and supplemental grants, AIDS Drug Assistance Program (ADAP) base and ADAP supplemental grants, Emerging Communities (ECs) grants, and Minority AIDS Initiative (MAI) grants. The base awards are distributed by a formula based on a state or territory's prevalent HIV cases weighted for cases outside of the jurisdictions that receive RWHAP Part A funding. The ECs are metropolitan areas that do not qualify as RWHAP Part A EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years. States apply on behalf of the ECs for funding through the RWHAP Part B base grant application. RWHAP Part B supplemental grants are available through a competitive process to eligible states with demonstrated need.

A portion of the RWHAP Part B appropriation supports ADAP, which supports the provision of HIV medications and related services, including health insurance premium and cost-sharing assistance. These funds are distributed by a formula based on prevalent HIV cases. In addition, ADAP supplemental funds are a five percent set aside for states with severe need. ADAP provides FDA-approved prescription medications for people with HIV who cannot afford HIV medications. ADAP is instrumental in efforts to end the HIV epidemic across the nation. ADAP provides the access to medications and insurance necessary for people with HIV to achieve optimal health outcomes and viral suppression. Individual ADAPs operate in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands.

The MAI funds are a statutory set-aside funding component for RWHAP Parts A – D and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. The RWHAP Part B MAI funding is statutorily required to specifically support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to the RWHAP ADAP.

Of all the clients served by the RWHAP Part B program in 2019, 73 percent were racial and/ethnic minorities, and 26 percent were women. Per statute, 75 percent of RWHAP Part B funds must be used to support core medical services and in 2019, RWHAP Part B funded sites provided 2.7 million core medical service visits for health-related care utilizing RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of RWHAP Part B in delivering primary care and related services for people with HIV by increasing the availability and accessibility of care.

Ending the HIV Epidemic in the U.S. - States

Seven RWHAP Part B recipients and the state of Ohio (on behalf of Hamilton County, which is currently not part of an EMA/TGA), received a cooperative agreement to implement EHE initiative activities related to Pillar Two (Treat) and Pillar Four (Respond) in FY 2021. This initiative is now in its second year and jurisdictions will continue to utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. See the final pages of the RWHAP section for more information on the EHE initiative.

AIDS Drug Assistance Program

The RWHAP Part B has been successful in helping to ensure that people with HIV have access to the care and treatment services they need to live longer, healthier lives. According to the RWHAP ADAP Report, ADAPs, which are run by states and territories, continue to provide robust formularies of antiretroviral medications to treat HIV infection, prevent and treat opportunistic infections, manage side effects, and treat co-morbidities. Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral suppression are not at risk to transmit HIV to others. The RWHAP provides the care and

treatment services that support the achievement of viral suppression and therefore, has a significant public health impact on HIV incidence as well. These efforts demonstrate the central role of the RWHAP in ending the HIV epidemic by ensuring that people with HIV have access to regular care, are started on, and adhere to, their antiretroviral medications.

According to the RWHAP ADAP data, the number of people with HIV receiving ADAP services has grown 42 percent over the last nine years from 208,809 clients in 2010, to 296,930 clients in 2019, exceeding the FY 2019 target by 37,399. In FY 2019, the RWHAP ADAP provided medication and health care coverage assistance for 28 percent of people diagnosed with HIV in the United States and 70 percent of all clients served by ADAPs were racial and ethnic minorities. Of all the ADAP clients served nationwide, nearly 72 percent had incomes at or below 200 percent of the federal poverty level.

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

Across the RWHAP, grant recipients are encouraged to maximize resources and leverage efficiencies. One example of this is within RWHAP Part B, where ADAPs use a variety of the above-mentioned strategies to maximize resources, which result in effective funds management, enabling ADAPs to serve more people. In 2019, ADAPs participating in cost-savings strategies on medications saved $2.6 billion, exceeding the FY 2019 performance target of $2.1 billion. Over the last 5 years, ADAPs participating in medication cost-savings strategies saved $8.9 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 2022, HRSA will continue the use of RWHAP ADAP Emergency Relief Funds (ERF) through "311 authority" in order to maintain infrastructure in the states and territories that had previously imposed waiting lists and to mitigate the risk of the establishment new wait lists. This is particularly important as EHE initiative efforts diagnose more people with HIV and engage people who are out of HIV care and treatment. This funding also addresses the gaps in access created by ongoing cost-containment measures in many ADAPs such as HIV medication formulary reductions, lower client financial eligibility levels, and capped enrollment. However, with no individuals on the ADAP waiting lists, states requested and HRSA distributed $75 million in ERF funding in FY 2021. 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 also have the ability to request RWHAP Part B supplemental funds to assist in meeting shortfalls. HRSA continues to closely monitor the impact of COVID-19 on the ADAPs as they anecdotally report an increase in client applications due to the loss of employment and/or health care coverage.

The RWHAP ADAP plays a crucial role that ensures access to HIV medications for pregnant women. 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 2019, 99 percent of HIV-positive pregnant women served by the RWHAP were prescribed antiretroviral therapy to prevent maternal-to-child transmission of HIV, exceeding the FY 2019 performance target by 3 percentage points.

Funding History

FY	Amount	ADAP (Non-Add)
FY 2012	$1,360,827,000	($933,299,000)
FY 2013	$1,287,535,000	($886,313,000)
FY 2014	$1,314,446,000	($900,313,000)
FY 2015	$1,315,005,000	($900,313,000)
FY 2016	$1,315,005,000	($900,313,000)
FY 2017	$1,311,837,000	($900,313,000)
FY 2018	$1,309,251,000	($894,559,000)
FY 2019	$1,315,005,000	($900,313,000)
FY 2020	$1,315,005,000	($900,313,000)
FY 2021 Enacted	$1,315,005,000	($900,313,000)
FY 2022 President's Budget	$1,345,005,000	($900,313,000)

Budget Request

The FY 2022 President's Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part B of $1.3 billion is $30.0 million above the FY 2021 Enacted Level. This request includes $900.3 million for RWHAP ADAPs to provide access to life saving HIV related medications and direct health care services to people with HIV in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Associated Pacific Jurisdictions. HRSA will continue to utilize the 311 authority to implement the Emergency Relief Fund to prevent, reduce, or eliminate ADAP waiting lists through cost containment and/or cost savings measures.

The RWHAP Part B ADAP program has seen a significant increase in utilization during the COVID-19 pandemic, due to people with HIV losing other sources of health coverage (such as employer insurance) and state government revenue dropping, resulting in state funding cuts. The Budget requests an additional $30.0 million for the RWHAP Part B program base to meet this greater need. By increasing the RWHAP Part B program base, states will have the greatest flexibility in utilizing the funds, whether for ADAP or for other critical services. Additionally, a portion of the additional funding will be directed by statute to the RWHAP Part B supplemental, which will be available to states with the highest unmet needs.

As part of the program's efforts to continue to provide access to life-saving medications and related services for low-income people with HIV, the RWHAP has established a target for FY 2022 of serving at least 280,000 RWHAP ADAP clients. This target is based on anticipated steady funding - not demand. While the number of ADAP clients is projected to remain constant in future years with anticipated steady funding, health care coverage and costs related to co-pays, co-insurance, premiums, etc., are difficult to anticipate. The increased demand for ADAP services in recent years has required many states to recover costs when possible by coordinating benefits with Medicare Part D or exhausting all coverage options, participating in rebate programs, and improving drug-purchasing models.

An important contributing factor to the demand for services for RWHAP ADAP continues to be access to HIV medications and high cost-sharing requirements for these medications. In order to meet this demand, the number of ADAPs participating in cost-savings strategies on medications will need to remain steady (the FY 2022 target is to maintain the previous year's output measure).

The FY 2022 funding request will support the RWHAP Part B in achieving its target of providing 2.7 million core medical service visits for health-related care. RWHAP Part B grant recipients will continue to work directly with uninsured people with HIV to ensure access to health care coverage and will continue to support HIV medications not on health plan formularies and the cost sharing required by health coverage plans. ADAP resources will also support the continued:

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

- need for medication and/or health care coverage assistance for clients who remain uninsured.

HRSA and the CDC continue to collaborate to accelerate the elimination of perinatal HIV transmission in the United States. The FY 2022 funding request will support RWHAP ADAP to ensure that at least 96% of HIV-positive pregnant women served by the RWHAP will receive antiretroviral medications. RWHAP Part B funding will also contribute to achieving the FY 2022 targets for performance goals that related to cross-cutting activities, such as the percentage of racial and 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 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
18.I.A.2: Number of RWHAP Part B visits for health-related care. *(Output)*	2019: 2.7M Target: 3.4M (Target Not Met)	3M	2.7M	Maintain
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. *(Output)*	2019: 296,930 Target: 259,531 (Target Exceeded)	285,000	280,000	Maintain
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. *(Efficiency's)*	2019: $2.6B Target: Sustain Prior Year Results or $2.1B (Target Met)	Sustain Prior Year Results	Sustain Prior Year Results	Maintain
16.II.A.3: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive antiretroviral medications.[234] *(Output)*	2019: 99% Target: 96% (Target Exceeded)	96%	96%	Maintain

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	59	59	59
Average Award	$19,763,315	$19,763,315	$19,763,315
Range of Awards	$42,532 - $146,344,356	$42,532 - $146,344,356	$43,638 - $150,149,309

[234] This RWHAP overarching performance measure applies to RWHAP Parts A, B, C, and D and is not Part B specific.

RWHAP Part B – FY 2020 State Table[235]

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Total
Alabama	$8,095,260	$767,689	$10,268,851	$317,466	$151,643	$19,600,909
Alaska	$500,000	$0	$560,119	$0	$0	$1,060,119
American Samoa	$41,773	$0	$759	$0	$0	$42,532
Arizona	$4,233,467	$2,723,197	$11,856,615	$0	$0	$18,813,279
Arkansas	$3,398,523	$0	$4,419,477	$0	$51,211	$7,869,211
California	$33,510,917	$2,628,306	$108,753,746	$171,809	$1,279,578	$146,344,356
Colorado	$3,425,452	$711,412	$9,513,677	$0	$79,436	$13,729,977
Connecticut	$2,618,061	$0	$8,171,820	$0	$0	$10,789,881
Delaware	$1,940,948	$0	$2,462,096	$186,786	$36,418	$4,626,248
Dist. of Columbia	$3,456,187	$2,180,234	$11,499,140	$0	$195,519	$17,331,080
F States Micronesia	$50,000	$0	$0	$0	$0	$50,000
Florida	$30,305,612	$2,638,412	$92,248,697	$469,875	$1,266,484	$126,929,080
Georgia	$14,793,780	$2,741,725	$54,833,146	$177,164	$623,479	$73,169,294
Guam	$200,000	$0	$81,210	$0	$0	$281,210
Hawaii	$1,561,613	$513,098	$1,980,909	$0	$0	$4,055,620
Idaho	$577,976	$1,314,037	$2,049,857	$0	$0	$3,941,870
Illinois	$9,534,864	$0	$36,728,514	$0	$427,133	$46,690,511
Indiana	$3,669,463	$2,405,909	$17,000,874	$0	$0	$23,076,246
Iowa	$1,480,242	$2,561,208	$8,017,985	$0	$0	$12,059,435
Kansas	$1,111,063	$1,805,270	$2,480,311	$0	$0	$5,396,644
Kentucky	$4,261,828	$2,410,169	$5,406,137	$286,038	$47,643	$12,411,815
Louisiana	$6,543,625	$0	$16,766,386	$0	$257,052	$23,567,063
Maine	$768,242	$187,339	$974,516	$0	$0	$1,930,097
Marshall Islands	$49,999	$0	$0	$0	$0	$49,999
Maryland	$7,762,853	$3,656,178	$24,941,241	$0	$436,445	$36,796,717
Massachusetts	$5,143,469	$2,338,089	$18,034,198	$0	$183,482	$25,699,238
Michigan	$5,039,574	$0	$12,970,022	$0	$176,927	$18,186,523
Minnesota	$2,075,344	$1,310,503	$6,265,290	$0	$66,281	$9,717,418
Mississippi	$5,819,121	$0	$7,619,290	$278,355	$125,440	$13,842,206
Missouri	$3,503,041	$0	$9,918,208	$0	$0	$13,421,249
Montana	$500,000	$0	$360,510	$0	$0	$860,510
N. Marianas	$50,000	$4,969	$9,867	$0	$184	$65,020
Nebraska	$1,254,676	$0	$1,591,558	$0	$0	$2,846,234
Nevada	$2,263,676	$0	$6,832,239	$0	$0	$9,095,915

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Total
New Hampshire	$500,000	$0	$934,291	$0	$0	$1,434,291
New Jersey	$9,955,480	$1,621,342	$28,883,327	$0	$470,626	$40,930,775
New Mexico	$1,904,450	$229,151	$2,415,799	$0	$0	$4,549,400
New York	$32,272,472	$6,275,061	$97,256,570	$569,515	$1,587,106	$137,960,724
North Carolina	$11,472,688	$2,697,088	$24,837,731	$301,946	$352,690	$39,662,143
North Dakota	$500,000	$0	$282,336	$0	$0	$782,336
Ohio	$7,207,059	$0	$16,925,010	$342,842	$0	$24,474,911
Oklahoma	$3,680,860	$0	$4,669,178	$234,821	$0	$8,584,859
Oregon	$1,768,127	$0	$4,767,085	$0	$0	$6,535,212
Pennsylvania	$10,648,813	$0	$26,832,592	$274,475	$381,297	$38,137,177
Puerto Rico	$5,473,871	$0	$17,624,246	$0	$281,371	$23,379,488
Republic of Palau	$50,000	$0	$6,831	$0	$0	$56,831
Rhode Island	$1,491,610	$585,727	$3,274,811	$188,260	$21,164	$5,561,572
South Carolina	$10,168,539	$2,318,928	$19,254,012	$560,594	$205,090	$32,507,163
South Dakota	$500,000	$0	$428,818	$0	$0	$928,818
Tennessee	$5,167,971	$1,128,246	$20,055,424	$0	$181,935	$26,533,576
Texas	$24,514,430	$1,291,654	$92,634,440	$0	$1,023,292	$119,463,816
Utah	$1,804,531	$462,211	$3,186,215	$0	$0	$5,452,957
Vermont	$500,000	$131,429	$388,592	$0	$0	$1,020,021
Virgin Islands	$500,000	$0	$468,284	$0	$8,683	$976,967
Virginia	$7,034,434	$0	$17,794,030	$377,064	$257,634	$25,463,162
Washington	$3,661,768	$0	$16,493,287	$0	$83,065	$20,238,120
West Virginia	$1,005,088	$1,581,275	$1,376,770	$0	$0	$3,963,133
Wisconsin	$3,627,267	$1,024,973	$4,624,398	$262,990	$53,738	$9,593,366
Wyoming	$500,000	$0	$242,111	$0	$0	$742,111
Total	**$315,450,107**	**$52,244,829**	**$900,273,453**	**$5,000,000**	**$10,312,046**	**$1,283,280,435**

RWHAP Part C - Early Intervention Services

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$201,079,000	$201,079,000	$207,079,000	+$6,000,000
MAI (non-add)	$71,012,000	$71,012,000	$71,012,000	---
Total Funding	$201,079,000	$201,079,000	$207,079,000	+$6,000,000
FTE	53	59	63	+4

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

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

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

HRSA's Ryan White HIV/AIDS Program (RWHAP) Part C provides grants directly to community and faith-based organizations, health centers, health departments, and university or hospital-based clinics in 49 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. RWHAP Part C supports comprehensive primary health care and support services in an outpatient setting for low-income, uninsured, and underserved people with HIV.

Minority AIDS Initiative (MAI) funds are a statutory set-aside funding component for RWHAP Parts A – D, and Part F AIDS Education and Training Center programs to evaluate and address the disproportionate impact of HIV on, racial and ethnic minorities. RWHAP Part C MAI funding supports HIV care, treatment, and support services to racial and ethnic minorities. RWHAP Part C is also authorized to fund capacity development grants that strengthen organizational development and infrastructure, resulting in a more effective delivery of HIV care and services.

The RWHAP Part C provides services for people with HIV disproportionately affected by the HIV epidemic and who have poor health outcomes, including ethnic and minority populations and youth. In 2019, RWHAP Part C funded sites served over 330,000 clients utilizing a combination of RWHAP Parts A, B, C, and D funding. Of the total clients served, 73 percent were racial and ethnic minorities and 26 percent were female.

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

expertise and cultural competency to provide quality care and treatment to low-income, diverse people with HIV. In 2019, RWHAP Part C funded sites provided nearly 2.3 million medical service visits for health-related care utilizing a combination of RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of RWHAP Part C in delivering primary care and related services for people with HIV by increasing the availability and accessibility of care.

Expansion of Services

In 2019, HRSA funded 10 RWHAP Part C clinics to provide comprehensive medical care and support services. Six of the ten recipients are located in the southern United States, where there is the greatest burden of new HIV diagnoses, HIV cases, and deaths from HIV. Expanding patient access to direct HIV care services is a priority for HRSA.

Funding History

FY	Amount
FY 2012[236]	$215,086,000
FY 2013	$194,444,000
FY 2014	$205,544,000
FY 2015	$204,179,000
FY 2016	$205,079,000
FY 2017	$200,585,000
FY 2018	$201,079,000
FY 2019	$201,079,000
FY 2020	$201,079,000
FY 2021 Enacted	$201,079,000
FY 2022 President's Budget	$207,079,000

Budget Request

The FY 2022 President's Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part C of $207.1 million is $6.0 million above the FY 2021 Enacted Level. This funding will support comprehensive medical, treatment and support services necessary to achieve improved health outcomes, such as improved viral suppression rates, essential to ending the HIV epidemic.

The RWHAP has seen a significant increase in utilization during the COVID-19 pandemic as people with HIV have lost other sources of health coverage (such as employer insurance) and state governments' revenue has dropped, resulting in state funding cuts. The Budget requests an additional $6.0 million to fund new RWHAP Part C community based clinics in areas of the country with the greatest need.

[236] 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).

RWHAP Part C supports direct health care services for low-income people with HIV who are uninsured or underserved. These services are considered essential to improving health outcomes and are a crucial part of the care network that links and retains people with HIV into health care. Such critical health care services include intensive case management and care coordination services, linking and retaining people with HIV into care, and getting them on antiretroviral medications as early as possible.

The funding request will support the RWHAP Part C in achieving its target of providing 2.2 million visits for health-related care in FY 2022. RWHAP Part C funding will also contribute to achieving the FY 2022 targets for performance goals that relate to cross-cutting activities, such as percentage of racial and ethnic minorities and women served, percentage of clients who achieved viral suppression, and percentage of HIV-positive pregnant women served by the RWHAP who receive antiretroviral medications.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
19.II.A.3: Number of RWHAP Part C visits for health-related care. *(Output)*	2019: 2.2M Target: 2.3M (Target Not Met)	2.2M	2.2M	Maintain

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	347	347	347
Average Award	$518,183	$518,183	$518,183
Range of Awards	$92,999-$1,507,775	$92,999-$1,507,775	$92,999-$1,507,775

RWHAP Part D - Women, Infants, Children and Youth

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$75,088,000	$75,088,000	$75,088,000	---
MAI (non-add)	$23,671,000	$23,671,000	$23,671,000	---
Total Funding	$75,088,000	$75,088,000	$75,088,000	---
FTE	11	12	12	---

Authorizing Legislation: Public Health Service Act, Section 2671, as amended by Public Law 111-87

FY 2021 Authorization…….……Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements

Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part D provides grants directly to public or private community-based organizations, hospitals, and State and local governments. Currently, there are 115 RWHAP Part D grant recipients located in 40 states, the District of Columbia and Puerto Rico. The RWHAP Part D focuses on providing access to coordinated, comprehensive, culturally and linguistically competent, family-centered HIV primary medical care and support services. RWHAP services focus on low-income, uninsured, and underserved women, infants, children, and youth with HIV and their affected[237] 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 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 and ethnic minorities. In 2019, RWHAP Part D funded sites provided nearly 1.6 million visits for health-related care and support services utilizing a combination of RWHAP Parts A, B, C, and D funding.

[237] Support services are available for family members who do not have HIV. Some examples are family-centered case management, childcare services during medical appointment attendance, and psychosocial support services that focus on equipping affected family members, and caregivers, to manage the stress associated with HIV.

The RWHAP Part D serves women, infant, children, and youth – populations disproportionately affected by HIV epidemic that have poor health outcomes. In 2019, RWHAP Part D funded sites served 219,813 clients utilizing a combination of RWHAP Parts A, B, C, and D funding. Of the total clients served, 75 percent were racial and ethnic minorities and 28 percent were female.

RWHAP Part D providers have the clinical expertise and cultural competency to provide quality care and treatment to low-income, diverse women, infant, children, and youth with HIV.

Funding History

FY	Amount
FY 2012	$77,167,000
FY 2013	$72,361,000
FY 2014	$72,395,000
FY 2015	$73,008,000
FY 2016	$75,088,000
FY 2017	$74,907,000
FY 2018	$75,088,000
FY 2019	$75,088,000
FY 2020	$75,088,000
FY 2021 Enacted	$75,088,000
FY 2022 President's Budget	$75,088,000

Budget Request

The FY 2022 President's Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part D of $75.1 million is equal to the FY 2021 Enacted Level. This funding will support the comprehensive array of medical and supports services necessary to achieve improved health outcomes, such as improved viral suppression rates, essential to ending the HIV epidemic.

RWHAP Part D supports health care services for low-income people with HIV who are uninsured or underserved. These services are considered essential to improving health outcomes and are a crucial part of the care network that links and retains people with HIV into health care, especially for women, infants and children and youth. Such critical health care services include intensive case management and care coordination services, linking and retaining people with HIV into care, and getting them on antiretroviral medications as early as possible.

The funding request will support the RWHAP Part D in achieving its target of providing at least 1.5 million health-related care and support service visits in FY 2022. RWHAP Part D funding will also contribute to achieving the FY 2022 targets for performance goals that relate to cross-cutting activities, such as the percentage of racial and ethnic minorities and women served, percentage of clients who achieved viral suppression, and percentage of pregnant women with HIV served by the RWHAP who receive antiretroviral medications.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
20.II.A.2 Number of RWHAP Part D visits for health-related care and support services *(Output)*	2019: 1.5M Target: 1.7M (Target Not Met)	1.5M	1.5M	Maintain

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 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

RWHAP Part F - AIDS Education and Training Programs

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
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	6	6	---

Authorizing Legislation: Public Health Service Act, Sec. 2692(a), as amended by Public Law 111-87.

FY 2020 Authorization……...….Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part F AIDS Education and Training Center (AETC) program supports a network of eight regional centers and two national centers that conduct targeted, multidisciplinary education and training programs for health care providers serving people with HIV in all states, DC, Puerto Rico, the U.S. Virgin Islands, and the Associated Jurisdictions. The RWHAP AETC improves the quality of life of people with or at-risk of HIV through the provision of specialized professional education and training. The program uses a strategy of implementation of multidisciplinary education and training programs for health care providers in the prevention and treatment of HIV.

The RWHAP AETCs target training to health care providers who serve minority populations, the homeless, rural communities, incarcerated persons, federally qualified community and migrant health centers, and RWHAP sites. In addition, nearly half the providers themselves are racial and ethnic minorities. In 2018-2019, the proportion of racial and ethnic minority health care providers participating in RWHAP AETC training intervention programs was 51 percent, exceeding the most recent performance target by 8 percentage points.[238]

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

[238] Due to changes in the reporting instrument, an estimated proportion of racial and ethnic minority providers was calculated using data from the past three reporting years.

workshops, hands-on preceptorships and mini-residencies, on-site training, tele-education, and technical assistance. For example, the RWHAP AETC implemented an online interactive platform that hosts an HIV care and treatment curriculum targeted to health care professionals. Clinical faculty also provides timely clinical consultation in person or via the telephone or internet.

Funding History

FY	Amount
FY 2012	$34,542,000
FY 2013	$32,390,000
FY 2014	$33,275,000
FY 2015	$33,349,000
FY 2016	$33,611,000
FY 2017	$33,530,000
FY 2018	$33,611,000
FY 2019	$33,611,000
FY 2020	$33,611,000
FY 2021 Enacted	$33,611,000
FY 2022 President's Budget	$33,611,000

Budget Request

The FY 2022 President's Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F AETC of $33.6 million are equal to the FY 2021 Enacted Level. This funding will support targeted, multidisciplinary education and training programs for novice and experienced health care providers treating people with HIV in order to assure access to high quality HIV care delivered by competent providers. The RWHAP AETC program also provides expert advice to providers across the country on HIV treatment, pre-exposure prophylaxis to reduce HIV transmission, substance use disorders, viral hepatitis co-infection, post-exposure prophylaxis, and the treatment of pregnant women with HIV and their newborns to prevent mother-to-child transmission.

The RWHAP AETC program funds a national curriculum for medical providers on HIV care and treatment to assure continued training of providers from medical/nursing school through in-service training. The central focus of RWHAP AETC training is to ensure high quality care and good patient outcomes through HIV care and treatment that is consistent with established treatment guidelines and reflects current research. This is increasingly important as people with HIV are living longer. In addition, the number of experienced HIV care professionals is projected to decrease as many of those who have worked in the epidemic since its inception reach retirement age. Training an expanded cadre of culturally competent, high quality providers is vital to increasing access to quality HIV care and treatment and improving health outcomes for people with HIV.

HRSA will continue to prioritize interactive training and technical assistance that result in health system strengthening and transformation. Focus will be on training health care providers,

particularly racial and ethnic minority providers, to deliver high quality HIV care and treatment services in primary care settings – settings that have typically not provided services to people with HIV.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
21.V.B.1: Proportion of RWHAP AETC training intervention participants that are racial and ethnic minorities. *(Output)*	FY 2018: 51% Target: 43% (Target Exceeded)	46%	46%	Maintain

Grant Awards Table

	FY 2020 Final	FY 2021 President's Budget	FY 2022 Target Level
Number of Awards	14	14	14
Average Award	$2,179,249	$2,187,500	$2,187,500
Range of Awards	$300,000 - $4,205,789	$300,000 - $4,205,789	$300,000 - $4,205,789

RWHAP Part F - Dental Programs

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$13,122,000	$13,122,000	$13,122,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 2692(b) as amended by Public Law 111-87

FY 2021 Authorization……..……..Expired

Allocation Method:

- Competitive Grants
- Formula Grants
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part F funding supports two dental programs: 1) HIV/AIDS Dental Reimbursement Program (DRP); and 2) Community-Based Dental Partnership Program (CBDPP).

The RWHAP DRP ensures access to oral health care for low-income people with HIV by reimbursing dental education programs for the non-reimbursed costs they incur providing such care. By offsetting the costs of non-reimbursed HIV care in accredited dental education institutions, the RWHAP DRP improves access to oral health care for low-income, people with HIV and ensures quality services by dental students, dental hygiene students, and dental residents for providing oral health care services to people with HIV. The care provided through the program includes a full range of diagnostic, preventive, and treatment services, including oral surgery, as well as oral health education and health promotion. Dental schools, post-doctoral dental education programs, and dental hygiene education programs accredited by the Commission on Dental Accreditation that have documented non-reimbursed costs for providing oral health care to people with HIV are eligible to apply for reimbursement. Funds are then distributed to eligible organizations taking into account the number of people served and the cost of providing care.

In FY 2019, the RWHAP DRP awards were able to provide over 39 percent of the total non-reimbursed costs requested by 50 participating institutions in support of oral health care. These institutions reported providing care to 26, 929 people with HIV (13,008 for whom no other funded source was available). In FY 2019, the demographic characteristics of patients who were

cared for by institutions participating in the RWHAP DRP were 63 percent minority and 28 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 2019, 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.

Part F-Dental Subprograms	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
RWHAP Dental Reimbursement Program	$9,133,546	$9,133,546	$9,133,546
RWHAP Community-Based Dental Partnership Program	$3,475,672	$3,475,672	$3,475,672

Funding History

FY	Amount
FY 2012	$13,485,000
FY 2013	$12,646,000
FY 2014	$12,991,000
FY 2015	$13,020,000
FY 2016	$13,122,000
FY 2017	$13,090,000
FY 2018	$13,122,000
FY 2019	$13,122,000
FY 2020	$13,122,000
FY 2021 Enacted	$13,122,000
FY 2022 President's Budget	$13,122,000

Budget Request

The FY 2022 President's Budget for the Ryan White HIV/AIDS Program (RWHAP) Part F-Dental of $13.1 million is equal to the FY 2021 Enacted Level. This funding will support oral health care for people with HIV and the reimbursement of applicant institutions through the RWHAP DRP and funding of the RWHAP CBDPP.

The FY 2022 funding request will support RWHAP target for reimbursing at least 26,000 people with HIV for a portion of their unreimbursed oral health costs through the RWHAP Dental Reimbursement Program.

The FY 2022 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 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
22. I.D.1: Number of persons for whom a portion/percentage of their unreimbursed oral health costs were reimbursed. *(Output)*	2019: 26,929 Target: 36,232 (Target Not Met)	26,000	26,000	Maintain

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	61	61	61
Average Award	$206,708	$206,708	$206,708
Range of Awards	$2,483 - $1,259,850	$2,483 - $1,259,850	$2,483 - $1,259,850

RWHAP Part F - Special Projects of National Significance

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$25,000,000	$25,000,000	$25,000,000	---
FTE	3	2	2	---

Authorizing Legislation: Public Health Service Act, Section 2691, as amended by Public Law 111-87

FY 2021 Authorization…….……..Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) Part F Special Projects of National Significance (SPNS) supports the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of RWHAP clients. Through its demonstration projects, SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models while promoting the dissemination and replication of successful interventions. This unique program advances knowledge and skills in the delivery of health care and support services to underserved populations.

As healthcare systems work under increasingly dynamic conditions, evidence-based, evidence-informed, and emerging 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 document and capture how well interventions and strategies improve the quality and effectiveness of health services, maximize resources, and improve health outcomes for people with HIV.

The RWHAP SPNS evaluates the effectiveness of various models, interventions, strategies, implementation, utilization, cost, and health-related outcomes. Systematic strategies are used to identify emerging strategies among RWHAP recipients and to coordinate, develop tools kits and other modalities that allow for rapid dissemination and uptake. Through these special projects, RWHAP SPNS grant recipients implement a variety of interventions, which contribute to the advancement of public health knowledge and the ultimate goal of ending the HIV epidemic in the United States.

Of the 55 FY 2020 RWHAP SPNS grant recipients currently funded, 19 percent are community-based/AIDS services organizations; 9 percent are state/county/local departments of health; 26 percent are community health centers; 13 percent are academic-based clinics; and 33 percent are universities/evaluation and technical assistance providers.

Current SPNS initiatives focus on: Leveraging a data to care approach to cure hepatitis C within RWHAP; building capacity to implement rapid start of antiretroviral treatment (ART) for improved care engagement in RWHAP; improving care and treatment coordination focusing on black women with HIV; building capacity to support innovative program model replication among RWHAP jurisdictions; enhancing linkages of sexually transmitted infections and HIV surveillance data in the RWHAP; strengthening systems of care for people with HIV and opioid use disorder; improving sexually transmitted infection screening and treatment among people living with or at risk of HIV; and gathering evidence-informed approaches to improve health outcomes for people with HIV.

Funding History

FY	Amount	COVID-19 Supplemental Funding
FY 2012	$25,000,000	---
FY 2013	$25,000,000	---
FY 2014	$25,000,000	---
FY 2015	$25,000,000	---
FY 2016	$25,000,000	---
FY 2017	$24,940,000	---
FY 2018	$25,000,000	---
FY 2019	$25,000,000	---
FY 2020	$25,000,000	---
FY 2021 Enacted	$25,000,000	---
FY 2022 President's Budget	$25,000,000	---

Budget Request

The FY 2022 President's Budget Request for the Ryan White HIV/AIDS Program (RWHAP) SPNS of $25.0 million is equal to the FY 2021 Enacted Level. The FY 2022 funding will support the continued development of innovative models of HIV care and treatment for populations that are significantly difficult to engage in continuous care and achieve viral suppression.

Through its funded demonstration projects, RWHAP SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models, interventions, and strategies, while promoting the dissemination and replication of successful ones. RWHAP SPNS funding also supports projects to build capacity in the health information technology (HIT) systems of RWHAP grant recipients and provider organizations to report client-level data and to improve health outcomes.

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

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	48	39	50
Average Award	$443,337	$506,304	$434,809
Range of Awards	$296,596 - $4,343,596	$205,000 - $4,825,000	$205,000 - $4,825,000

RWHAP – Ending the HIV Epidemic Initiative (EHE)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$70,000,000	$105,000,000	$190,000,000	+$85,000,000
FTE	3	29	29	---

Authorizing Legislation: Section 311 of the Public Health Service Act and Title XXVI of the Public Health Service Act

FY 2022 Authorization……..……..…….Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ending the HIV Epidemic in the U.S. (EHE) initiative is an HHS-wide effort to reduce new infections by 75 percent in the first five years of the initiative and by 90 percent over a 10-year period, with the goal of decreasing the number of new HIV infections to fewer than 3,000 per year. HRSA's focus is on linking people with HIV who are either newly diagnosed, diagnosed but currently not in care, or are diagnosed in care but not yet virally suppressed to the essential HIV care and treatment and support services needed to help them achieve viral suppression.

In 2020, the first year of the EHE initiative, HRSA RWAP anticipated serving 18,000 new or re-engaged people with HIV. Achieving this goal is supported by preliminary data which show that nearly 10,000 clients were either new or had been re-engaged in RWHAP services during the first six months of the initiative. RWHAP EHE grant recipients made significant progress toward implementing the EHE work plans in spite of the COVID-19 pandemic. This progress included developing administrative infrastructure and service delivery infrastructure, engaging with community members and new partners, and delivering services to clients.

In 2021, HRSA RWHAP expects to serve 27,000 people with HIV through the EHE initiative (includes continued care for 18,000 people from year 1 and 9,000 new and re-engaged people in year 2). In 2022, HRSA RWHAP expects to serve 50,000 people with HIV through the EHE initiative (includes 27,000 people from year 2 and 23,000 new and re-engaged people in year 3). HRSA continues to monitor the impact of COVID-19 on the RWHAP and is working to more fully understand the impact the pandemic is having on the EHE initiative.

In FY 2022, RWHAP Part A and Part B jurisdictions that encompass the 48 counties, Washington, D.C., San Juan (PR), and seven states that have a substantial rural HIV burden will continue their focus on engaging people newly diagnosed with HIV, or are diagnosed but currently not in care, or diagnosed in care but not yet virally suppressed. These jurisdictions will

continue to build off of their locally developed five-year work plans submitted through the Notice of Funding Opportunity in FY 2020 and reviewed annually. The jurisdictions will continue using evidence-based strategies to engage these populations into HIV medical care, treatment, and support services that will ensure retention and viral suppression. As patients are linked and retained in care, the jurisdictions will support the HIV care and treatment needs of the newly identified and re-engaged people with HIV.

The EHE funded technical assistance (TA) and systems coordination cooperative agreements will support strategies such as data to care efforts; using acuity tools to identify and provide care for the most challenging patients; developing models such as low-barrier clinics to meet patients where they are; rapid engagement and medication initiation protocols; and others that have been successful in the field. As lessons are learned from the first year, HRSA and the TA entity will work to utilize and disseminate those lessons nationally.

The HRSA funded jurisdictions will work with their respective AIDS Drug Assistance Programs (ADAPs) to ensure necessary resources are available to provide assistance for medications and health care coverage premiums and cost sharing for people newly diagnosed with HIV or re-engaged in care through the EHE initiative.

As part of the EHE initiative, the RWHAP AIDS Education and Training Centers (AETCs) will work to expand workforce capacity by providing training and technical assistance to health care providers and paraprofessionals. This will include activities such as training health care providers on HIV medical care and treatment and Pre-Exposure Prophylaxis (PrEP) service delivery; working with clinics and health care providers to develop culturally competent settings and approaches to the populations reached through the EHE initiative; and providing technical assistance on practice transformation in clinics to increase HIV testing, linkage to care, rapid antiretroviral therapy delivery, and improved viral suppression.

Funding History

FY	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	---
FY 2018	---
FY 2019	---
FY 2020	$70,000,000
FY 2021 Enacted	$105,000,000
FY 2022 President's Budget	$190,000,000

Budget Request

The FY 2022 President's Budget Request for the Ryan White HIV/AIDS Program (RWHAP) EHE initiative of $190.0 million is $85.0 million above the FY 2021 Enacted Level. The additional resources will support HIV care and treatment services in the identified jurisdictions. Funding will also support evidence informed practices to link, engage, and retain people with HIV in care. The request provides funding for capacity building, technical assistance, and resources for program implementation and oversight.

Under the FY 2022 President's Budget Request, HRSA estimates that 50,000 clients will be served by this initiative through FY 2022.

In FY 2022, HRSA will continue to direct RWHAP funding to the 48 counties, DC, San Juan (PR), and seven states that contain more than 50% of new HIV infections. Funding will continue to be awarded to the current 39 RWHAP Part As that contain one or more of the counties and the current eight RWHAP Part B states (including funding to the state of Ohio for Hamilton County, which is not a RWHAP Part A). HRSA requires coordination with the respective AIDS Drug Assistance Program (ADAPs) to ensure necessary resources are available to provide assistance for medications and health care coverage premiums and cost sharing for people newly diagnosed with HIV or re-engaged in care through the initiative. The RWHAP's comprehensive system of HIV care and support services and effective system for medication delivery creates a very efficient and effective service delivery mechanism for this initiative.

Starting in FY 2020 and continuing into FY 2022, HRSA will fund the AETCs to provide training and technical assistance to health care providers, clinics, and paraprofessionals as well as health departments to increase HIV testing, care and treatment, the provision of PrEP services, and retention in care.

HRSA will continue to direct funding to support technical assistance and systems coordination to enhance the current RWHAP data collection systems to provide timely monitoring of the initiative; to support dissemination of effective interventions to increase the number of people with HIV served by the initiative; to provide additional technical assistance to jurisdictions to implement models of care that work to identify and link and retain the key populations for the EHE initiative.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
60.1 Number of new clients served through the EHE initiative *(Output)*[239]	N/A	43,000	50,000	---
60.2 Viral suppression among new clients served by the EHE initiative *(Outcome)*[1]	N/A	TBD	TBD	TBD

Grants Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Jurisdiction Awards	47	47	47
Average Award	$1,200,000	$2,900,000	$6,700,000
Range of Awards	$750,000 – $6,553,979	$1,000,000 – $10,925,485	N/A

[239] The first target is 18,200 new clients in FY 2020, for FY 2021, the estimated number of clients served is now 27,000 people with HIV, based on amount of funds appropriated.

[1] This is a long-term measure without annual targets. The first target will be set for FY 2024 to align with the first 5-year phase of the initiative.

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Technical Assistance Awards	2	2	2
Average Award	$2,500,000	$4,000,000	$4,000,000
Range of Awards	N/A	N/A	N/A

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of AETC Awards	10	10	10
Average Award	$300,000	$900,000	$900,000
Range of Awards	$86,897 - $700,020	$86,897 - $700,020	N/A

Healthcare Systems

TAB

HEALTHCARE SYSTEMS

Organ Transplantation

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$27,549,000	$29,049,000	$29,049,000	---
FTE	3	5	5	---

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 2022 Authorization……..……..……..……...……..……..…..... Expired

Allocation Method:

- Contracts
- Competitive Grants/Co-operative Agreements
- Other (Interagency Support)

Program Description

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 organ transplants. Organ allocation is guided by OPTN policies informed by analytic support from the Scientific Registry of Transplant Recipients (SRTR). HRSA funds the Living Organ Donation Reimbursement Program (LODRP) (formerly Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation Program) to provide financial assistance to eligible living organ donors. HRSA also invests in public education and outreach to increase the number of registered organ donors, increase the supply of deceased donor organs for transplantation, 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 high 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 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 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 www.srtr.org. It publishes online transplant program risk-adjusted patient and graft outcomes data and organ procurement organization risk-adjusted data on organs procured per donor. SRTR also publishes 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 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 the number of donors from these groups.
- Organ donation and transplantation related articles for newspapers and journals
- Downloadable print materials on a variety of organ donation and transplantation topics for multiple audiences
- HRSA's organ donation sites: www.organdonor.gov and https://donaciondeorganos.gov
- Grant projects to test approaches to promote public awareness of the need for organ donation and increase registration in donor registries

In September 2020, HRSA increased the income eligibility threshold for the LODRP from 300 percent to 350 percent of the HHS Poverty Guidelines. The program also expanded the qualified reimbursable expenses to include reimbursement of lost wages and dependent care expenses (child-care and elder-care). The changes are aimed at increasing the number of kidney transplants from living donors and decreasing recipient waiting times.

Program Accomplishments

The COVID-19 pandemic significantly affected organ donation and transplantation in the United States. Deceased donor organ procurement and transplantation fell by approximately 50 percent in early April 2020 before returning to an upward trajectory in late May 2020. Most transplant programs temporarily deferred living donor transplantation in areas particularly affected by

outbreaks of the virus due to concerns of unnecessarily exposing potential living organ donors and recipients to possible COVID-19 infection. Beginning in June 2020, living donor transplants also returned to rates more similar to pre-pandemic levels. Post-transplant data collection for recipients and living donors was temporarily modified in March 2020 to reduce patient exposure to COVID-19 infection at transplant hospitals. As of April 2021, post-transplant data collection has returned to normal.

One of HRSA's primary goals for the Organ Transplantation Program is to increase the annual number of transplants using deceased donor organs. The organ procurement and transplantation community has achieved record-breaking annual numbers of deceased donor organs procured and organ transplants performed, year after year since 2015. In CY 2020, in spite of the downturn at the beginning of the COVID-19 pandemic, another CY record was set for procurement and transplantation of deceased donor organs. The number of deceased donor organs transplanted in CY 2020 was 36,544, a 2.2 percent increase over the CY 2019 total of 35,746.

Another important program goal is to increase the deceased 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 has averaged at approximately 71 percent for the last five years, as shown in Table 1. HRSA will continue to monitor conversion rates and determine potential next steps.

The organ donor conversion rate is based on "eligible deaths," including 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 age or other risk factors that may have excluded them from being counted as "eligible deaths."

Table 1. Conversion Rates and Eligible Deaths 2016-2020

Year	Number of Donors	Number of Eligible Deaths	Conversion Rate (%)	Change in Eligible Deaths (%)
2016	7,753	10,706	72.4	9.5
2017	8,104	11,653	69.5	8.8
2018	8,272	11,661	70.9	0.1
2019	8,703	12,116	71.8	3.9
2020	8,973	12,653	70.9	4.4

Funding History

FY	Amount
FY 2018	$25,486,000
FY 2019	$25,437,000
FY 2020	$27,549,000
FY 2021 Enacted	$29,049,000
FY 2022 President's Budget	$29,049,000

Budget Request

The FY 2022 Budget Request for the Organ Transplantation program of $29.0 million is equal to the FY 2021 Enacted level. With this additional funding, HRSA will target up to $13.8 million towards increasing access to transplants by removing financial barriers to living organ donation.

HRSA will accomplish this work through the Living Organ Donation Reimbursement Program, which provides reimbursement to living organ donors who lack other forms of financial support. HRSA will use funds to scale up the program to serve more living donors to provide life-saving organs to patients on the waiting list.

This request also includes $13.7 million for the OPTN, SRTR, and public and professional education to increase public awareness about organ donation. Additionally, this request includes approximately $1.5 million for activities related to the Advisory Committee, interagency agreements, and other internal support and Program-related activities. The funding request includes costs associated with the grant review and award process, follow-up performance reviews, and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
23.II.A.1: Annual number of deceased donor organs transplanted.[240] *(Outcome)*	FY 2020: 36,544 Target: 32,010 (Target Exceeded)	32,652	32,652	Maintain
23.II.A.8: Annual conversion rate of eligible donors. *(Efficiency)*	FY 2020: 70.9% Target: 74.0% (Target Not Met)	74.50%	74.50%	Maintain

[240] Performance Measure 23.II.A.1 2019 data using OPTN data as of January 14, 2020.

Grants Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	4	1	1
Average Award	$9,338,689	$9,711,636	13,790,500
Range of Awards	$389,562-$8,150,000	$9,711,636	13,790,500

The Blood Stem Cell Transplantation Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$47,275,000	$49,275,000	$49,275,000	---
FTE	11	11	11	---

Authorizing Legislation: Public Health Service Act, Section 379-379B, as amended by Public Law 114-104

FY 2022 Authorization…….....Expired

Allocation Method…….…….....……Contract

Program Description

The Blood Stem Cell Transplantation Program (BSCTP) is charged with increasing the number of transplants for recipients suitably matched to biologically unrelated bone marrow[241] 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 marrow donors; 3) building a genetically and ethnically diverse inventory of at least 150,000 new units of high-quality umbilical cord blood units (CBU) for transplantation; 4) coordinating the procurement of bone marrow and umbilical cord blood units for transplantation; 5) offering patient and donor advocacy services; 6) providing public and professional education; and, 7) collecting, analyzing, and reporting data on transplant outcomes. These activities, which were previously implemented and reported through two separate programs, the National Cord Blood Inventory (NCBI) Program and the C.W. Bill Young Cell Transplantation Program (CWBYCTP), have been combined in FY 2022.

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 BSCTP operates through four major contractual functions that require close coordination and oversight and supports an Advisory Council that provides recommendations to the HHS Secretary and HRSA on activities related to the BSCTP. The major functions of the BSCTP are:

[241] Public Health Service Act, Sections 379-379B, as amended by P.L. 114-104 states that the term 'bone marrow' means the cells found in the adult bone marrow and peripheral blood.

- The combined Single Point of Access – Coordinating Center (SPA-CC) maintains a system for health care professionals and physicians, searching on behalf of patients, to search electronically for cells derived from adult marrow donors and cord blood units through a single point of access and supports coordination activities for bone marrow and cord blood.

- The Office of Patient Advocacy (OPA) maintains a system for patient advocacy, which provides individualized patient services for ongoing searches for bone marrow donors or cord blood units. The OPA also assists patients with information regarding treatment options and payment matters.

- The Stem Cell Therapeutic Outcomes Database (SCTOD) provides an electronic blood stem cell transplant outcomes database for researchers and health care professionals. The SCTOD provides a repository that stores donor and recipient samples for research and the collection and analysis of data on clinical outcomes of blood stem cell transplants.

- The Blood Stem Cell Transplantation Program (BSCTP) provides funds through competitive contracts for the collection and storage of qualified cord blood units (CBUs) by a network of cord blood banks in the U.S. HRSA prioritizes cord blood banks that have biological license agreement (BLA) with the U.S. Food and Drug Administration and the demonstrated capability to collect and bank significant numbers of CBUs from genetically and ethnically 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 assessments of technical merit, overall quality, geographic dispersion of collection and storage sites, evaluation of past performance, and evaluation of proposed costs. Additionally, HRSA prioritizes the demonstrated ability of cord blood banks to collect and bank significant numbers of CBUs from genetically and ethnically diverse populations.

Program Accomplishments

The BSCTP continues to serve a diverse patient population, with volunteer adult donors and umbilical cord blood units playing a vital role in expanding transplant access to patients from underrepresented racial and ethnic populations. Increasing the number of blood stem cell transplants facilitated for patients from genetically and ethnically diverse backgrounds addresses the statutory aim of ensuring comparable access to transplantation for patients from all populations. As of the end of FY 2020, more than 23 million potential adult volunteer donors and 111,500 HRSA-funded CBU (see Table 1) were listed on the BSCTP's registry.

Table 1. Cord Blood Collections

Fiscal Year	Number of Units Contracted	Cord Blood Units Collected and Made Available[242] for Patient Searches	Cumulative Units Made Available[2]
2016	5,840	6,660	90,261
2017	6,369	7,719	97,980
2018	7,785	4,889	102,869
2019	4,585	4,594	107,463
2020	4,567	4,049	111,512

The FY 2020 goal of 4.08 million adult donors who self-identify as belonging to an underrepresented racial or ethnic population was not met. One of the primary reasons for the unmet goal was the limited in-person recruitment activity during the COVID-19 pandemic. Due to the anticipated ongoing impact of COVID-19, HRSA expects the registry will add 4 million adult donors who self-identify as belonging to an underrepresented racial or ethnic population and 2,400 cord blood units in FY 2022. The number of cord blood units collected varies from year to year, based on funding levels and the contractors' abilities to collect and store units from diverse populations.

As shown in Table 2, the number of cord blood units released for transplants decreased in FY 2020 from FY 2019, at 344 and 459 cord blood units, respectively. The total number of cord blood units released for transplantation have been decreasing since FY 2016 due to the increasing use of alternative therapies. In particular, haploidentical transplants, which use blood stem cells from a donor who is biologically related to the recipient-patient, are still on the rise. Despite this recent trend, cord blood remains key in servicing a diverse population.

Table 2. Cord Blood Units Released for Transplantation

Fiscal Year	Units Released for Transplantation	Total Cord Blood Units (HRSA-funded and Non- HRSA funded) released for Transplantation through the BSCTP
2016	529	1,154
2017	494	1,050
2018	493	949
2019	459	848
2020	344	702

[242] 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.

Funding History

FY	Amount
FY 2018	$39,375,000
FY 2019	$40,696,000
FY 2020	$47,275,000
FY 2021 Enacted	$49,275,000
FY 2022 President's Budget	$49,275,000

Budget Request

The FY 2022 Budget Request for the Blood Stem Cell Transplantation Program of $49.3 million is equal to the FY 2021 Enacted level. This Budget request supports continued progress toward the statutory goal of building a genetically and ethnically diverse inventory of at least 150,000 new units of high-quality cord blood for transplantation. HRSA estimates that approximately 2,400 additional cord blood units and 4.0 million adult volunteer donors from underrepresented racial and ethnic populations will be added and made available for patient searches in FY 2022. The budget request also continues the following activities: 1) collecting comprehensive outcomes data on both related and unrelated-donor blood stem cell transplants; 2) assessing the quality of life for transplant recipients; 3) working with foreign transplant centers to obtain data on U.S. stem cell products provided for transplant; and, 4) continuing critical planning in collaboration with HHS on a response to a potential national radiation or chemical emergency. In such an event, casualties could involve temporary or permanent marrow failure and could 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 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
40.II.A.1: The cumulative number of cord blood units from underrepresented racial and ethnic populations available through the BSCTP[243](Outcome)	FY 2020: 153,351 Target: 145,721 (Target Exceeded)	148,721	148,721	Maintain

[243] 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. The 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 BSCTP.

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
40.II.A.2: The size of the # of cord blood units banked and available through the BSCTP) (Outcome)	FY 202 111,512 Target: 99,000 (Target Exceeded)	113,000	115,000	+2,000
40.II.A.3: The annual number of cord blood units released for transplant[244] (Outcome)	FY 2020: 344 Target: 500 (Target Not Met)	500	400	-100
24.1: The number of blood stem cell transplants facilitated by the Program [245] (Outcome)	FY 2017: 5,994 Target: 6,960 (Target Not Met)	Not Defined	6,000	N/A
24.2: The number of blood stem cell transplants facilitated for minority patients by the Program [246] (Outcome)	FY 2017: 875 Target: 1,150 (Target Not Met)	Not Defined	875	N/A
24.3: The rate of patient survival at one year post-transplant [247] (Outcome)	FY 2017: 71% Target: 69% (Target Exceeded)	Not Defined	69%	N/A
24.4: The number of blood stem cell transplants facilitated for domestic patients by the Program [248] (Outcome)	FY 2017: 4,835 Target: 5,135 (Target Not Met)	Not Defined	4,800	N/A
24.E: The unit cost of human leukocyte antigen (HLA) typing of potential donors (Efficiency)	FY 2020: $58.00 Target: $58.00 (Target Met)	$58.00	$62.00	+$4.00
24.II.A.2: The number of adult volunteer potential donors of blood stem cells from minority race and ethnic groups (Outcome)	FY 2020: 3.90M Target: 4.08M (Target Not Met but Improved)	4.08M	4.00M	-0.08M

[244] 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.
[245] This is a long-term measure. The next target will be set for FY 2025.
[246] This is a long-term measure. The next target will be set for FY 2025.
[247] This is a long-term measure. The next target will be set for FY 2025.
[248] This is a long-term measure. The next target will be set for FY 2025.

Contracts Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	9	9	9
Average Award	$5,475,000	$5,475,000	$5,475,000
Range of Awards	$60,000-$21,600,000	$60,000-$21,600,000	$60,000 - $21,600,000

Poison Control Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$22,846,000	$24,846,000	$24,846,000	---
FTE	1	2	2	---

Authorizing Legislation: Public Health Service Act, Sections 1271-1274, as amended by Public Law 116-94

FY 2022 Authorization $24,846,000

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; and implement a nationwide media campaign to educate the public and health care providers about poison prevention, poison center services, and the toll-free number.

The PCP grant program supports Poison Control Centers' efforts to: 1) prevent and provide treatment recommendations for poisonings; 2) comply with operational requirements to sustain accreditation and/or achieve accreditation; and 3) improve and enhance communications and response capability and capacity. Funds may also be used to improve the quality of data uploaded from poison centers to the National Poison Data System in support of national toxic surveillance activities conducted by the Centers for Disease Control and Prevention (CDC).

The national toll-free Poison Help line was established in 2001. Individuals can call from anywhere in the U.S. and its territories and connect to the poison centers that serve their respective areas. The PCP maintains the number, provides interpretation services in over 150 languages, and offers services for the hearing impaired.

Today, a network of 55 Poison Control Centers, supported by 52 grant awards, provide cost-effective, quality health care advice regarding poisoning 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 consulted, not only when children get into household products, but also when seniors and people of all ages mismanage medicine or when workers are exposed to harmful substances on the job. Emergency 911 operators refer poison-related calls to Poison Control Centers, and health care professionals regularly consult Poison Control Centers for expert advice on complex cases. Poison Control Centers are a critical resource for emergency preparedness and response as well as for other public health emergencies. The PCP ensures that the Poison Help line is operational, calls are routed seamlessly to the appropriate poison center, and multilingual interpreter services are available.

According to the American Association of Poison Control Centers, poison centers managed 2.5 million cases in 2019, a 1.7 percent increase from 2018. Of the approximate 2.1 million human exposure poisonings reported in 2019, Poison Control Centers managed about 66 percent at the site of exposure, avoiding unnecessary visits to emergency departments and reducing health care costs. Health care facilities represented less than one percent of exposures, but made approximately 24 percent of poison control calls. Consistent with the previous year, the top 5 substance classes most frequently involved in all human exposures were analgesics (11.0%), household cleaning substances (7.13%), cosmetics/personal care products (6.16%), sedatives/hypnotics/antipsychotics (5.21%), and antidepressants (5.32%). [249] Multiple studies have demonstrated that poison centers' accurate assessments and triage of poison exposures save dollars by reducing the severity of illness and death, and by eliminating or reducing the expense of unnecessary trips to emergency departments.

Poison center consultations also decrease patients' length of stays in hospitals and decrease hospital costs. Health care facilities' use of poison centers continues to increase, indicating an increase in the severity of poisonings and the need for toxicological expertise in clinical settings.

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 2020, the Poison Help media campaign included an investment of $393,392. Based on over 892 million media impressions through television, radio, and social media, the PCP was able to leverage an advertising return on investment of over $21.8 million.

Another critical function of the Poison Control Centers is to collect 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. Many state health departments collaborate directly with poison centers within their jurisdictions, using data from poison control centers to monitor exposures to e-cigarette devices and liquid nicotine, synthetic cathinones and cannabinoids, opioids, hand sanitizer, and laundry detergent packets.

[249] David D. Gummin, James B. Mowry, Daniel A. Spyker, Daniel E. Brooks, Krista O. Osterthaler & William Banner: 2019 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 37th Annual Report, Clinical Toxicology.

According to the CDC, in 2018, the most recent year for which data are available, unintentional poisoning continues to be the leading cause of unintentional injury deaths and the sixth leading cause of nonfatal emergency department visits. Opioid-involved overdose deaths rose from 21,088 in 2010 to 46,802 in 2018 and increased in 2019, to 49,860[250]. Poison Control Centers play a critical role in combatting opioid drug-related abuse and misuse, from helping to define and trace the problem within a local and national context to responding to calls from health care providers seeking treatment advice for patients.

In addition, Poison Control Centers 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. They 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.

Finally, it should be noted that the above does not include the Coronavirus Aid, Relief, and Economic Security (CARES) Act funding of roughly $5 million, awarded to all 55 Poison Centers last Fiscal Year to improve their capacity to respond to increased calls to the Help and Language lines during the COVID-19 pandemic.

Funding History

FY	Amount
FY 2018	$20,810,000
FY 2019	$22,746,000
FY 2020	$22,846,000
FY 2021 Enacted	$24,846,000
FY 2022 President's Budget	$24,846,000

Budget Request

The FY 2022 Budget Request of $24.8 million is equal to the FY 2021 Enacted level. This request will support the Poison Control Centers' infrastructure and core triage and treatment services. They predominantly rely on state and local funding, as Federal funding accounts for approximately 13 percent of total funding. While Poison Control Centers have innovatively secured funding from a variety of local sources, including philanthropic organizations, their financial stability is tenuous. Federal funding helps reinforce the nationwide Poison Control Center infrastructure, enabling the sustainability of public health and toxic surveillance efforts.

[250] Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019 – Morbidity and Mortality Weekly Report (MMWR), February 12, 2021

In FY 2022, the PCP plans to issue grant continuation awards to 52 recipients and maintain the funding of the national toll-free Poison Help line and 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 efforts to highlight the role of Poison Control Centers in the public health system The campaign's goal includes increasing public awareness of the national Poison Help toll-free number; providing education on poisoning risk and prevention; and showcasing the role of the national network of Poison Control Centers and the services they provide.

The 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 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
25.III.D.3: Percent of inbound volume on the toll-free number. (Output)	FY 2020: 78% Target: 85% (Target Not Met)	78%	73%	-5%
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) [251]	FY 2017: 37% Target: 25% (Target Exceeded)	N/A	25%	N/A
25.III.D.6: Percent of human exposure calls made to Poison Control Centers that came from health care facilities. (Output)	FY 2021: 24% Baseline (Target: 24%)	24%	24%	Maintain

[251] This is a long-term measure based on periodic survey data, reported about every 5 years. The next survey findings are expected in FY 2022, with results in 2023 once a final report is approved by HRSA.

Grants Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards [252]	52	52	52
Average Awards	$392,307	$392,307	$392,307
Range of Award	$12,466-$2,411,210	$12,466-$2,411,210	$12,466-$2,411,210

Contracts Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Contracts	2	2	2
Average Contract	$452,110	$452,110	$452,110
Range of Contracts	$393.392-$511,000	$393,392-$511,000	$393,392-$511,000

[252] There are 55 Poison Control Centers across the Nation. Fifty-two awards were made in FY 2020 and are anticipated in FY 2021 under the Poison Control Stabilization and Enhancement Program, representing all of the poison centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, while it encompasses four California poison centers.

Office of Pharmacy Affairs/340B Drug Pricing Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$10,238,000	$10,238,000	$17,238,000	+$7,000,000
FTE	21	23	25	+2

Authorizing Legislation: Public Health Service Act, Section 340B, as amended by Public Law 111-309, Section 204

FY 2022 Authorization…….…….…….…….....SSAN

Allocation Method……...…….……..….Contract

Program Description and Accomplishments

The 340B Program requires drug manufacturers to provide discounts on outpatient prescription drugs to certain safety net health care providers specified in statute, known as covered entities. These include Federally Qualified Health Centers, AIDS Drug Assistance Programs, and certain disproportionate share hospitals. The 340B Program helps these designated hospitals and clinics provide more care to additional patients.

The 340B ceiling price – the maximum amount a drug manufacturer can charge a covered entity for a given drug – is equal to the Average Manufacturer Price (AMP) minus the Unit Rebate Amount, both set by the Centers for Medicare & Medicaid Services (CMS). Covered entities purchase 340B drugs that are at least 23 percent below AMP for brand name drugs; 13 percent below AMP for generic drugs; and 17 percent below AMP for clotting factor and pediatric drugs. In 2019, total sales in the 340B Program were approximately $29 billion. Covered entities saved between 25 to 50 percent on what they would have otherwise paid for covered outpatient drugs. HRSA estimates 340B sales are approximately 6 percent of the total U.S. drug market.

HRSA places a high priority on the integrity of the 340B Program and continually works to improve Program oversight. HRSA conducts the following activities to ensure both covered entities and manufacturers are in compliance with program requirements:

- Performs initial eligibility checks of all entities seeking to register with the Program.
- Recertifies covered entities annually including an attestation to compliance with all Program requirements.
- Performs audits of covered entities to assure compliance within the Program. Since FY 2012, HRSA completed 1,588 covered entity audits, which included review of 21,406 offsite outpatient facilities and 36,274 contract pharmacies. Final audit results, including statuses of corrective actions, are available on HRSA's website. As of April 1, 2021,

HRSA closed out and finalized 1,473 of the 1,588 audits conducted, with 35 percent of findings related to diversion and 31 percent related to duplicate discount.
- Reviews every non-compliance allegation received through targeted communication and, if necessary, performs on-site audits.
- Performs 5 audits of manufacturers.
- Provides assistance to covered entities that self-disclose compliance issues, including developing corrective action plans and working with affected manufacturers.
- Supports an integrated system of compliance tracking for covered entities and manufacturers, enabling enhanced communication to ensure that all covered entities and manufacturers are in compliance with 340B program requirements.
- Publishes verified ceiling prices of covered outpatient drugs available for purchase under the 340B Program on a quarterly basis in the 340B Office of Pharmacy Affairs Information System (OPAIS), Pricing Component.

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 2020, the PVP had nearly 4,400 products available to participating entities below the 340B ceiling price, including 2,600 covered outpatient drugs with an estimated average savings of 29 percent below the 340B ceiling price. From 2009 to 2019, the PVP contracts provided over $4.1 billion in additional sub-ceiling savings for covered entities.

Funding History

FY	Amount
FY 2018	$10,210,000
FY 2019	$10,193,000
FY 2020	$10,238,000
FY 2021 Enacted	$10,238,000
FY 2022 President's Budget	$17,238,000

Budget Request

The FY 2022 Budget Request for the Office of Pharmacy Affairs/340B Drug Pricing Program of $17.2 million is $7.0 million above the FY 2021 Enacted level. Appropriated resources will support implementation of 340B Program statutory obligations, oversight of participating manufacturers and covered entities, operational improvements, and increased efficiencies using information technology.

The $7.0 million increase will allow the 340B Program to continue to build on its program integrity efforts. First, the Affordable Care Act (Pub. L. 111-148) added a provision to the 340B statute that requires the Secretary to issue regulations concerning an Administrative Dispute Resolution process designed to resolve (1) claims by covered entities that they have been overcharged for covered outpatient drugs by manufacturers and (2) claims by manufacturers, after the manufacturer has conducted an audit of a covered entity, that a covered entity has violated the prohibition on diversion or duplicate discounts. The Office of Pharmacy Affairs requires additional resources to establish this formal dispute resolution process. Implementation

includes establishment of a system to intake and handle the workflow of documents between internal and external parties, and creating a secure environment for exchanging information, much of which is expected to be proprietary across multiple agencies. Further, additional funding is required to increase the number of full-time equivalents by two personnel and to increase audit and oversight of the program including regulation support, systems support and up to 25 additional audits of covered entities and up to an additional five audits of manufacturers.

HRSA is also proposing general rulemaking authority to reform the 340B Program. HRSA's enforcement ability is limited, as guidance does not provide HRSA appropriate enforcement capability. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program. These reforms would strengthen program integrity and oversight activities. HRSA would also address issues raised by various stakeholders to assist covered entities and manufacturers in their ability to satisfy 340B Program expectations and where oversight needs to be enhanced.

The FY 2022 Budget Request also 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 Component of the 340B OPAIS 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 have been available to covered entities, after review and validation, on April 1, 2019.

Performance Measures

HRSA measures 340B Program performance by two key metrics: numbers of covered entities and manufacturers audits. As of April 1, 2021, participation levels included 13,214 covered entities and 37,738 associated sites participating in the 340B Program, for a total of 51,952 registered sites.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
39.I.A.1: Covered Entity Audits Conducted (Output)	FY 2020: 200 Target: 200 (Target Met)	200	225	+25
39.I.A.2: Manufacturer Audits Conducted (Output)	FY 2020: 5 Target: 5 (Target Met)	5	10	+5

Contracts Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Contracts	3	3	3
Average Contract	$3,000,000	$3,000,000	$4,800,000
Range of Contracts	$1,000,000 - $4,000,000	$1,000,000 - $4,000,000	$4,000,000 - $5,000,000

National Hansen's Disease Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$13,706,000	$13,706,000	$13,706,000	---
FTE	43	45	45	---

Authorizing Legislation: Public Health Service Act, Section 320, as amended by Public Law 105-78, Section 211

FY 2022 Authorization .....Indefinite

Allocation Methods:
- Direct Federal/Intramural
- Contract

Program Description and Accomplishments

The National Hansen's Disease Program (NHDP) provides medical care, education, and research for Hansen's disease (HD, leprosy) and related conditions as authorized since 1917. Medical care includes providing direct patient care (diagnosis, treatment, and rehabilitation), HD drug regimens at no cost to patients, consultations, laboratory services, and outpatient referral services to any patient living in the United States (U.S.) or its territories. The Program strengthens the safety net infrastructure for patients with this rare disease by focusing on case management, patient compliance, and clinical training on the diagnosis and management of Hansen's disease. The Program makes specific outreach efforts to health care providers who are likely to encounter and treat patients in geographic areas most impacted by the disease. More complicated HD cases are treated as short-term referrals in the NHDP clinic in Baton Rouge, Louisiana.

Ninety-five percent of the human population is not susceptible to infection with *Mycobacterium leprae* or *Mycobacterium lepromatosis,* the bacterium that causes leprosy. Hansen's disease is not highly transmissible, is very treatable, and, early diagnosis and treatment prevent nerve involvement and the disability it causes. 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. People with leprosy can generally continue their normal work and other activities while under treatment, which may last several years.

Increasing Quality of Care: Increasing health care provider knowledge about Hansen's disease will lead to earlier diagnosis and treatment, which are key to blocking or arresting the trajectory

of Hansen's disease-related disability and deformity. The Program facilitates outpatient management of leprosy by providing additional laboratory, diagnostic, consultative, and referral services to private-sector physicians. NHDP increases U.S. health care providers' knowledge by serving as an education and referral center.

The NHDP outpatient care is comprehensive and includes treatment protocols for multi-drug therapy, diagnostic studies, provider consultations, ancillary medical services, clinical laboratory analysis, hand and foot rehabilitation, leprosy surveillance, and indigent patient transportation.

Improving Health Outcomes: The Program is improving health outcomes through scientific research. Early diagnosis and treatment are essential for decreasing HD-related disability. With advanced scientific knowledge and breakthroughs in genomics and molecular biology, the Program has been advancing the standard-of-care for leprosy diagnosis and treatment. Currently, lab research uses rapid techniques for diagnosis, assessment of drug resistance, and strain typing of leprosy bacilli to support effective treatment selection and to determine the origin and transmission of infection.

Fostering Collaboration: NHDP is the sole worldwide provider of reagent grade viable leprosy bacilli and collaborates with researchers across the globe to further scientific investigations and advances related to the disease. NHDP coordinates and collaborates with Federal, state, local, and private programs to further leverage and promote efforts to improve the quality of care and health outcomes related to Hansen's disease.

Funding History

FY	Amount
FY 2018	$13,650,000
FY 2019	$13,646,000
FY 2020	$13,706,000
FY 2021 Enacted	$13,706,000
FY 2022 President's Budget	$13,706,000

Budget Request

The FY 2022 Budget Request of $13.7 million is equal to the FY 2021 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 funding level reflects improvements in health outcomes through research and health care provider education. Two new performance measures related to laboratory research output are implemented for FY 2022; the shipment of reagent grade viable leprosy bacilli for worldwide research activities and the number of human pathology samples on which NHDP staff performs diagnostic polymerase chain reactions.

The FY 2022 request will allow the NHDP to expand and enhance outreach and training activities to providers to improve early diagnosis and treatment to reduce permanent disability in patients. Due to COVID-19 related travel restrictions, NHDP's training target was not met for

FY 2020 and reduced for FY 2021. The lifting of travel restrictions should allow the resumption of NHDP's training target for FY 2022 and beyond.

NHDP will fund eleven ambulatory care contracts in FY 2022 with continuing efforts to align resources with levels of care. Hansen's disease patients with severe complications who are advanced on the HD spectrum or who have HD related disabilities may be referred to the primary clinic in Baton Rouge free of charge. The National Hansen's Disease Program also provides free HD medication to all providers upon request for the care and treatment of HD patients in the U.S. and its territories. 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.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
3.II.A.4.: Number of health care providers who have received training from NHDP (Output)	FY 2020: 610 Target 650 (Target Not Met)	350	750	+400
3.II.B.1: Number of reagent-grade leprosy bacilli packages provided to research scientists outside of NHDP (Output)	Measure is new for FY 2022	Set Baseline	12	N/A
3.II.B.2: Number of human tissue samples on which clinically diagnostic Polymerase Chain Reactions were performed (Output)	Measure is new for FY 2022	Set Baseline	200	N/A

Program Indicators

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Resident Population: Inpatients	1	1	1
Baton Rouge Clinic: Outpatients	70	70	399
Baton Rouge Clinic: Outpatient Visits	1,348	1,348	2,261
Ambulatory Care Program (ACP) Contracts	11	11	11
ACP Clinic: Outpatients	882	882	882
ACP Clinic: Outpatient Visits	1,418	1,500	1,500

National Hansen's Disease Program – Buildings and Facilities

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$122,000	$122,000	$122,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 320 and 321(a)

FY 2022 Authorization .....Indefinite

Allocation Method ..... Direct Federal

Program Description and Accomplishments

This activity provides for facility related expenses for the buildings of the Gillis W. Long Hansen's Disease Center in the vicinity of Baton Rouge, Louisiana, to eliminate deficiencies according to applicable laws, and in keeping with accepted standards of safety, comfort, human dignity, efficiency, and effectiveness. Projects ensure safe facilities and functional environments for patients, research animals, the general public and staff.

Funding History

FY	Amount
FY 2018	$122,000
FY 2019	$122,000
FY 2020	$122,000
FY 2021 Enacted	$122,000
FY 2022 President's Budget	$122,000

Budget Request

The FY 2022 Budget Request of $122,000 is equal to the FY 2021 Enacted level. This request seeks flexibility to broaden the appropriations language to better support facility-related expenses at the National Hansen's Disease Program. In FY 2022, HRSA operations that remain at Carville are solely related to the Museum.

Payment to Hawaii

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$1,857,000	$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 2022 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 2018	$1,852,000
FY 2019	$1,849,000
FY 2020	$1,857,000
FY 2021 Enacted	$1,857,000
FY 2022 President's Budget	$1,857,000

Budget Request

The FY 2022 Budget Request of $1.9 million is equal to the FY 2021 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 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$10,351,000	$11,076,000	$11,076,000	---
FTE	3	3	3	---

Authorizing Legislation: Social Security Act, Section 711

FY 2022 Authorization ..... Indefinite

Allocation Method ..... Competitive Cooperative Agreements

Program Description and Accomplishments

The Federal Office of Rural Health Policy (FORHP) is charged with advising the HHS Secretary on how rural health care is affected by current policies as well as proposed statutory, regulatory, administrative, and budgetary changes in the Medicare, Medicaid and other key HHS programs. The authorizing legislation requires FORHP to advise on: (1) the financial viability of small rural hospitals; (2) the ability of rural areas (particularly rural hospitals) to attract and retain physicians and other health professionals; and (3) access to and quality of health care in rural areas. FORHP is also charged with overseeing compliance, per the requirements of section 1102(b) of the Social Security Act, related to assessing the impact of key regulations affecting a substantial number of small rural hospitals. Rural Health Policy Development funds a number of programs to carry out these advisory and compliance roles, including supporting clearinghouses for collecting and disseminating information on rural health care issues, promising approaches to improving and enhancing health care delivery in rural communities, and policy-relevant research findings addressing rural health care delivery.

FORHP provides funding for the only Federal research programs specifically designed to provide publicly available, policy relevant studies on rural health issues. The Rural Health Research Center (RHRC) Program funds eight core 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 the Federal and state levels. The RHRC publications also align with Administration priorities, such as addressing opioid use and issues related to health and geographic inequities.

The Rapid Response Rural Data Analysis and Issue Specific Rural Research Studies Program supports one award to conduct rapid data analyses and short-term rural research studies. The

Rural Health Research Dissemination Cooperative Agreement, currently awarded to the Rural Health Research Gateway, disseminates and promotes FORHP funded rural health services research to stakeholders at the national, state, and community levels with the goal of informing and raising awareness of key policy issues important to rural communities.

In FY 2020, these Federally-funded research programs conducted and disseminated 107 research reports, including policy briefs posted on the Rural Health Research Gateway website and manuscripts published in peer-reviewed journals. The National Rural Health Information Clearinghouse Program, currently awarded to the Rural Health Information Hub, serves as a clearinghouse for information on rural health, including HRSA's rural health programs, for residents of rural areas in the United States and other rural health stakeholders.

In FY 2020, FORHP established a Rural Telementoring Training Center Program to provide training for academic medical centers and other centers of excellence to create technology-enabled telementoring learning programs that focus on reaching regionally diverse populations and addressing unique cultural aspects across rural areas. This three-year grant will continue in FY 2022.

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, in alignment with its authorizing legislation, FORHP continues to monitor and track the number of rural hospitals across the country that have closed completely or converted to another type of facility that provides only non-inpatient care. From January 1, 2010 to March 31, 2021, 136 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 2018	$9,325,000
FY 2019	$9,284,000
FY 2020	$10,351,000
FY 2021 Enacted	$11,076,000
FY 2022 President's Budget	$11,076,000

Budget Request

The FY 2022 Budget Request of $11.1 million is the same as the FY 2021 Enacted level. This request would allow FORHP to fully fund the following: Rural Health Research Center Cooperative Agreement; Rapid Response Rural Data Analysis and Issue Specific Rural Research

Studies Program; Rural Health Research Gateway; Rural Health Information Hub; National Rural Health Policy, Community, and Collaboration Program; Rural Telementoring Training Center Program; Rural Health Clinic Technical Assistance Program; Rural Health System Analysis & TA Program; and the National Advisory Committee on Rural Health and Human Services. The Rural Health Research Center program will produce 43 rural policy briefs or journal manuscripts in FY 2022.

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 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Output)	FY 2020 : 107 Target: 39 (Target Exceeded)	43	43	Maintain

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	15	16	16
Average Award	$822,333	$835,625	$835,625
Range of Awards	$100,000 - $3,000,000	$100,000 - $3,000,000	$100,000 - $3,000,000

Rural Health Care Services Outreach, Network and Quality Improvement Grants

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$79,500,000	$82,500,000	$90,000,000	+$7,500,000
FTE	7	8	9	+1

Authorizing Legislation: Public Health Service Act, Section 330A (42 U.S.C. 254c) and Social Security Act, Section 711

FY 2022 Authorization (330A).....$90,000,000

FY 2022 Authorization (711)…… Indefinite

Allocation Method ..... Competitive Grants and Cooperative Agreements

Program Description and Accomplishments

The Rural Health Care Services Outreach, Network and Quality Improvement Grants (Outreach programs) improve rural community health by focusing on quality improvement, increasing health care access, coordination of care, and integration of services.

Outreach grant programs support collaborative models to deliver basic health care services to rural areas and are uniquely designed to meet rural needs. Under the Coronavirus Aid, Relief, and Economic Security Act, the Outreach grants were reauthorized to expand eligibility to include both rural and urban applicants with the demonstrated experience or capacity to serve rural underserved populations, and allowed for increased flexibility of project period length for programs.[253] The Outreach programs are among the only non-categorical grants within HHS, allowing grantees to determine the best ways to meet local needs. This flexibility responds to the unique health care challenges in rural communities and enables communities to determine the best approaches for addressing needs.

- Outreach Service Grants focus on improving access to health care in rural communities through community coalitions and evidence based and promising practice models. These grants focus on disease prevention, health promotion, and can support the expansion of services around primary care, opioid use disorder treatment and prevention, behavioral health, and oral health care. HRSA will support 61 continuing awards.

[253] 42 USC 254c: Rural health care services outreach, rural health network development, and small health care provider quality improvement grant programs

- Rural Network Development Grants support formalized partnerships among health care providers and social and community service organizations collaborating to improve access and enhance the quality of healthcare in rural areas. The program focuses on demonstrating improved health outcomes resulting from network collaboration, as well as positioning healthcare networks and their products and services to be sustainable as the health care landscape continues to evolve. Grantees under this program are likely to focus on improving health outcomes, enhancing health care quality, and increasing services provided by the network. HRSA will support 44 continuing awards.

- Network Planning Grants assist in the development of integrated healthcare networks to address local health care challenges. The Network Planning program provides an opportunity for grantees to work on priority and emerging local public health issues, such as care coordination, patient engagement, rural hospital closure/conversion, telehealth, mental health, and substance use (particularly opioid use disorder). HRSA will make new awards in FY 2022.

- Small Healthcare Provider Quality Improvement Grants help improve patient care and chronic disease outcomes by assisting rural primary care providers with the implementation of quality improvement activities. Specifically, program objectives include increased care coordination, enhanced chronic disease management, and improved health outcomes for patients. An additional program goal is to prepare rural health care providers for quality reporting and pay-for-performance programs. HRSA will make new awards in FY 2022.

- The Delta States Rural Development Network Grant Program provides network development grants to the eight states in the Mississippi Delta for network and rural health infrastructure development. This program is geographically targeted, given the health care disparities across this eight-state region. The program supports chronic disease management, oral health services, and recruitment and retention efforts for health professionals. The program requires grantees to focus on diabetes, cardiovascular disease, and obesity and to develop programs based on promising practices or evidence-based models. HRSA will support 12 continuing awards in FY 2022.

- 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 also provides resources to help rural communities develop partnerships and jointly address health problems that affect the Delta region. HRSA will support 20 continuing communities and several new communities in FY 2022 in coordination with the Delta Regional Authority.

- Rural Health Care Coordination Program supports rural health consortiums/networks aiming to achieving the overall goals of improving access, delivery, and quality of care through the application of care coordination1 strategies in rural communities. The goals of the program is to 1) enhance integrated systems to collaborate and share data among member organizations; 2) develop effective care coordination workforce to meet needs

within the rural communities; 3) improve access, delivery, and quality of services and overall patients' health outcomes; and 4) increase program financial sustainability. HRSA will support 10 continuing awards in FY 2022.

- Rural Northern Border Region Planning Program supports planning activities to identify key rural health issues, assess rural health challenges, and engage in strategic planning activities to inform rural health plans across the Northern Border Regional Commission service area. The goal of the program is to help underserved rural communities identify and better address their health care needs. Projects may include planning activities that address challenges related to access to care and health care workforce or assist small rural hospitals improve their financial and operational. HRSA plans to make new awards in FY 2022.

- Rural Maternity and Obstetrics Management Strategies (RMOMS) grants improve access and continuity of maternal and obstetrics care in rural communities. In FY 2019, HRSA created RMOMS in response to research by the University of Minnesota that revealed a decreasing availability of obstetric units in rural areas.[254] RMOMS goals include:

  (1) Developing a sustainable network approach to coordinate maternal and obstetrics care within a rural region;
  (2) Increase the delivery and access of preconception, pregnancy, labor and delivery, and postpartum services;
  (3) Developing sustainable financing models for the provision of maternal and obstetrics care; and
  (4) Improving maternal and neonatal outcomes.

  The HHS Rural Health Taskforce further validated these study results.

  In FY 2021, HRSA launched an HHS-wide initiative to improve maternal health, which focused on a four-pillar strategy to achieve: 1) Healthy Outcomes for All Women of Reproductive Age by improving prevention and treatment, 2) Healthy Pregnancies and Births by prioritizing quality improvement, 3) Healthy Futures by optimizing post-partum health, and 4) Improved Data and Bolster Research to inform future interventions. HRSA will provide continuation funding for six grantees in FY 2022. HRSA plans to make new RMOMS awards in FY 2022 to support this maternal health initiative in rural communities.

- HRSA plans to respond to emerging public health needs including COVID-19 and priorities through strategic initiatives and efforts that would strengthen the health care infrastructure and capacity in rural areas and improve health outcomes.

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

[254] Hung P, Henning-Smith C, Casey M, Kozhimannil, K. Access to Obstetric Services in Rural Counties Still Declining, with 9 Percent Losing Services, 2004-14. Health Affairs. 2017; 36 (9): 1663-1671. doi:10.1377/hlthaff.2017.0338

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[255] 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, at least 75 percent, 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[256] so that rural communities from across the country can benefit from Outreach program investments and results.

Funding History

FY	Amount
FY 2018	$71,300,000
FY 2019	$76,942,000
FY 2020	$79,500,000
FY 2021 Enacted	$82,500,000
FY 2022 President's Budget	$90,000,000

Budget Request

The FY 2022 Budget Request of $90.0 million is $7.5 million above the FY 2021 Enacted level. This request will support the continuation of existing grantees, and new competitive grants, including $5.0 million to support a new cohort for the RMOMS program in FY 2022, that will positively affect health care service delivery for over 430,000 people. Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Table

[255] https://www.ruralhealthinfo.org/econtool
[256] https://www.ruralhealthinfo.org/community-health

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
29.IV.A.3. Track number of unique individuals who received direct services through FORHP Outreach grants, subject to availability of resources. (Output)	FY 2019: 1,771,930 Target: 430,000 (Target Exceeded)	430,000	430,000	Maintain
29.IV.A.4: Percent of Outreach Authority grantees that will continue to offer services after the Federal grant funding ends.[257] (Outcome)	FY 2019: 100% Target: 75% (Target Exceeded)	75%	75%	Maintain

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	215	193	207
Average Award[258]	$255,469	$296,690	$307,747
Range of Awards	$100,000 - $10,000,000[259]	$100,000 - $10,000,000[260]	$100,000 - $10,000,000[261]

Rural Hospital Flexibility Grants

[257] 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.

[258] Average award amount does not include the Delta Region Community Health Systems Development Cooperative Agreement, which is $8.0 million in FY 2019 and $10.0 million in FY 2020 and FY 2021.

[259] This represents one cooperative agreement worth up to $10.0 million for the Delta Region Community Health Systems Development Cooperative Agreement.

[260] This represents one cooperative agreement worth up to $10.0 million for the Delta Region Community Health Systems Development Cooperative Agreement.

[261] This represents one cooperative agreement worth up to $10.0 million for the Delta Region Community Health Systems Development Cooperative Agreement.

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$53,609,000	$55,609,000	$57,509,000	+$1,900,000
FTE	2	2	3	+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 2022 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. With FY 2021 funds, HRSA continues to support year three of a three-year initiative supporting emergency medical services (EMS) across eight states and focusing on quality and operational improvement initiatives.

The Flex Program plays a key role in ensuring that CAHs are aligned with certain Medicare Program quality initiatives. All prospective payment system hospitals (PPS) are required to submit quality data to the Centers for Medicare & Medicaid Services (CMS) to receive a full Medicare payment update. While not subject to this CMS requirement, CAHs, through this program, can elect to submit quality data to CMS to demonstrate areas of high quality while also identifying areas for improvement. This provides an avenue for ensuring that CAH quality efforts are aligned with broader Medicare quality initiatives. HRSA has initiated a project to gather input for rural stakeholders to inform the future direction of the Medicare Beneficiary Quality Improvement Project to ensure it aligns with hospital priorities in providing high quality care, and in FY 2021, to encourage focus on quality improvement in key priorities even during a pandemic, established a program to encourage peer learning.

State Flex grantees adjusted their activities, moved trainings online, and adjusted topics based on the emerging needs of hospitals given the impacts on the pandemic. Given the focus of hospitals during the pandemic, the results below show a decrease in the percent of hospitals showing

improvement as hospitals focused on pandemic related care and not on planned grant improvement initiatives. The participation in CAHs in HCAHPS patient experience reporting continued to improve, with the most recent result for a reporting period that ended just before the COVID-19 pandemic. Given the focus of hospitals on pandemic response, the target for FY 2022 has been adjusted to reflect this change.

- 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. HRSA will make continuation awards in FY 2022.

  In FY 2020, SHIP received $150 million through the Coronavirus Aid, Relief, and Economic Security (CARES) Act to support COVID-19 detection, treatment and prevention activities for over 1,770 rural hospitals. Hospitals received approximately $80,000 each, and state grantees quickly got money to the hospitals and the hospitals had flexibility to spend funds based on their needs.

- 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 educating community providers on how to best serve veterans. HRSA continues to partner with the Veteran's Health Administration Office of Rural Health to connect the state level grantees with VHA knowledge and expertise. HRSA plans to make new awards in FY 2022.

Funding History

FY	Amount
FY 2018	$49,470,000
FY 2019	$53,233,000
FY 2020	$53,609,000
FY 2021 Enacted	$55,609,000
FY 2022 President's Budget	$57,509,000

Budget Request

The FY 2022 Budget Request of $57.6 million is $1.9 million above the FY 2021 Enacted level. This request will support the continued efforts to states to the Medicare Rural Hospital Flexibility Grant, and the increased funding will expand activities for the state support of hospitals.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
30.V.B.6: Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (Output)	FY 2019: 91.7% Target: 82% (Target Exceeded)	86%	83%	-3%
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)[262] (Outcome)	FY 2019: 64.4% (Target Not in Place)	70%	70%	Maintain
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) [263] (Outcome)	FY 2019: 45.9% (Target Not in Place)	50%	50%	Maintain

[262] FY 2015 was the first year of data for this measure. Targets were set beginning for FY 2019 Results.
[263] FY 2015 was the first year of data for this measure. Targets were set beginning for FY 2019 Results.

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	94	94	94
Average Award	$565,000	$570,000	$575,000
Range of Awards	$23,732-$945,000	$38,508 - $1,545,992	$38,508 - $1,565,992

State Offices of Rural Health

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$12,500,000	$12,500,000	$12,500,000	---
FTE	1	1	1	---

Authorizing Legislation: State Offices of Rural Health Reauthorization Act of 2018, Section 338J of the Public Health Service Act (42 U.S.C. 254r)

FY 2022 Authorization .....Expires after FY 2022

Allocation Method .....Competitive Grants

Program Description and Accomplishments

This grant program provides funding to establish and maintain a State Office of Rural Health (SORH) within states to strengthen rural health care delivery systems. Every dollar of Federal support is matched by three state dollars. SORHs serve as focal points and clearinghouses for the collection and dissemination of information on rural health issues, research findings, innovative approaches, and best practices pertaining to the delivery of health care in rural areas.

As the state's rural institutional framework, SORHs help link rural communities with state and Federal resources to develop long-term solutions to rural health problems. SORHs form collaborative partnerships to better coordinate rural health activities, maximize limited resources, and avoid duplication of effort and activities. SORHs facilitate clinical placements through recruitment initiatives and help rural constituents meet recruitment challenges by sharing information. SORHs identify Federal, state, and nongovernmental programs and funding opportunities and provide technical assistance to public and nonprofit private entities regarding participation in rural health programs.

All SORHs played a role in supporting COVID-19 information sharing on public health information during the pandemic, and many SORHs were actively involved in state response efforts. The number of TA encounters increased this year as a result to the amount of information going out to rural communities during the pandemic.

Funding History

FY	Amount
FY 2018	$10,000,000
FY 2019	$9,928,000
FY 2020	$12,500,000
FY 2021 Enacted	$12,500,000
FY 2022 President's Budget	$12,500,000

Budget Request

The FY 2022 Budget Request of $12.5 million is the same as the FY 2021 Enacted level. This request will continue to invest in the State Offices of Rural Health. With this level of funding, states will continue to support rural communities by connecting them with resources about funding opportunities, information on health care policy changes.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Output)	FY 2019: 83,276 Target: 69,996 (Target Exceeded)	67,695	68,371	+676
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. (Output)	FY 2019: 24,873 Target: 22,691 (Target Exceeded)	23,261	23,611	+350
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Output)	FY 2018: 1,676 Target: 1,260 (Target Exceeded)	1,260	1,500	+240

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	50	50	50
Average Award	$229,270	$229,270	$229,270
Range of Awards	$229,270 – $229,270	$229,270 – $229,270	$229,270 – $229,270

Radiation Exposure Screening and Education Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$1,834,000	$1,834,000	$2,734,000	+$900,000
FTE	1	1	1	--

Authorizing Legislation: Public Health Service Act, Section 417C, as amended by Public Law 109-482, Sections 103 and 104

FY 2022 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 2019, the number of individuals screened under RESEP was 605.

Screening numbers for RESEP clinics were impacted by the escalation of the COVID-19 pandemic during FY 2019. Due to strict travel restrictions put in place in states across the U.S in order to detain the spread of the virus, many RESEP clinics were unable to perform in person screenings. The utilization of Lung Spirometry, a common breathing test, at RESEP clinics also created an obstacle to continuing work during an outbreak of a virus such as COVID-19 with airborne transmissibility. Due to these factors, the collective number of individuals screened at RESEP clinics was lower than in prior years.

Funding History

FY	Amount
FY 2018	$1,834,000
FY 2019	$1,821,000
FY 2020	$1,834,000
FY 2021 Enacted	$1,834,000
FY 2022 President's Budget	$2,734,000

Budget Request

The FY 2022 Budget Request of $2.7 million is $900,000 above the FY 2021 Enacted level. This request will increase 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

RESEP is authorized under the Radiation Exposure Compensation Act (RECA), the compensation portion of the Act is under the authority of the Department of Justice while the RESEP portion is under the authority of the Department of Health and Human Services. Per RECA, compensation claims cannot be processed after July 9, 2022. However, RESEP will continue providing referrals for medical treatment and increased screening services past July 2022. HRSA has updated its performance measure targets in alignment with the statute and the upcoming end of compensation claim processing.

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
32.1: Percent of RECA successful claimants screened at RESEP centers. (Outcome)	FY 2019: 21 % Target: 13% (Target Exceeded)	13%	7%	-6%
32.2: Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits. (Outcome)	FY 2019: 92% Target: 77% (Target Exceeded)	77%	38%	-39%
32.I.A.1: Total number of individuals screened per year. (Output)	FY 2019: 605 Target: 1,300 (Target Not Met)	1,300	300	-1,000

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	8	8	8
Average Award	$205,913	$205,913	$312,594
Range of Awards	$107,016 - 223,956	$107,016 - 223,956	$162,500 – 340,000

Black Lung

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$11,500,000	$11,500,000	$12,190,000	+$690,000
FTE	1	1	1	---

Authorizing Legislation: Federal Mine, Health, and Safety Act of 1977, Public Law 91-173, Section 427(a), as amended by Public Law 95-239, Section 9

FY 2022 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants and Cooperative Agreement

Program Description and Accomplishments

The Black Lung Clinics Program (BLCP) funds eligible public, private, and state entities that provide medical, outreach, educational, and benefits counseling services to active, inactive, retired, and disabled coal miners throughout the United States with the goal of reducing the morbidity and mortality associated with occupationally related coal-mine dust lung disease. To support the longer-term need faced by miners with severe disability due to black lung disease, grantees may also assist coal miners and their families in preparing the detailed application for Federal Black Lung benefits from the Department of Labor (DOL). In the recent years, most grantees have been able to use funds to upgrade equipment, enhance their workforce capacity and increase behavioral health screenings and care integration.

HRSA funds the Black Lung Data and Resource Center (BLDRC), formerly known as the Black Lung Center of Excellence, to improve patient-level data collection and analysis, clinic operations, and the quality and breadth of services provided by the BLCP recipients.

In FY 2019, HRSA deployed a new patient-level data reporting system across all 15 recipients to better capture the number of coal miners served, and the number and types of medical and benefits counseling services received. HRSA can track a unique coal miner patient's disease and case progression to better assess the quality and breadth of services provided. The data collected also better aligns with other publicly available data such as the National Institute for Occupational Safety and Health's (NIOSH) Coal Workers' Health Surveillance Program (CWHSP) and Department of Labor's (DOL) Division of Coal Mine Workers' Compensation (DCMWC) program.

Published data highlights the continued need for black lung services. The National Institute of Occupational Safety and Health (NIOSH) identified a cluster of 60 progressive massive fibrosis (PMF) cases among current and former Appalachian coal miners at a single eastern Kentucky radiology practice from January 2015 to August 2016. This figure exceeded the 19 PMF cases in

Kentucky detected by NIOSH's National Coal Workers' Health Surveillance Program between August 2011 and July 2016.[264] The most recently published prevalence data for CWP among underground coal miners with 25 years or more of underground mining tenure in central Appalachia (Kentucky, Virginia, and West Virginia) is 20.6 percent and the national prevalence is over 10 percent.[265]

Services provided to Black Lung Clinic recipients were impacted by the escalation of the COVID-19 pandemic. Coal miners suffering from the suite of coal dust respiratory diseases were especially susceptible to severe illness or death.[266] The clinics had to initially suspend then greatly reduce the services provided in order to keep their coal miner patients safe. The primary method of diagnosing Black Lung diseases involves the Pulmonary Function Test which requires the rapid inhalation and expiration of breath. As an aerosol generating procedure, this puts both the coal miner and clinic staff at risk for COVID-19 exposure. With BLCP funds, clinics were able to obtain PPE, cleaning and sanitizing supplies; install filters, fans, and negative pressure rooms; and administer rapid tests in order to resume critical services to coal miners. After a decrease in coal miner patient volume in the late FY19 and early FY20 project years, most clinics have been able to welcome coal miners back to their clinics. In FY 2021, clinics are still limited in their outreach and education services due to continued travel and group size restrictions. HRSA anticipates the services to increase in FY 2022.

Funding History

FY	Amount
FY 2018	$10,000,000
FY 2019	$10,921,000
FY 2020	$11,500,000
FY 2021 Enacted	$11,500,000
FY 2022 President's Budget	$12,190,000

Budget Request

The FY 2022 Budget Request of $12.2 million is $690,000 above the FY 2021 Enacted level. HRSA will increase funding to 15 Black Lung Clinic Program awards that provide primary care and other services to coal miners and a cooperative agreement with one Black Lung Data and Resource (BLDRC) to enhance the quality of services provided by BLCP grantees. The BLDRC cooperative agreement recipient will work closely with HRSA to strengthen the quality of data collection and analysis. The primary medical services provided to coal miners at Black Lung clinics include aerosol generating procedures to screen for, diagnose, and treat Black Lung diseases. Due to the COVID-19 pandemic, the clinics have been burdened with additional disinfecting and sanitizing protocols, staffing shortages, facility renovations, and travel

[264] Blackley DJ, Crum JB, Halldin CN, Storey E, Laney AS. "Resurgence of Progressive Massive Fibrosis in Coal Miners — Eastern Kentucky, 2016." MMWR 2016;65:1385–1389.
[265] Blackley DJ, Halldin CN, Laney AS. "Continued Increase in Prevalence of Coal Workers' Pneumoconiosis in the United States, 1970–2017", *American Journal of Public Health* 108, no. 9 (September 1, 2018): pp. 1220-1222.
[266] Centers for Disease Control and Prevention. "People with Certain Medical Conditions" Updated Mar. 29, 2021

restrictions. An increase in funds will support the clinics to implement safety procedures and resume work at a level which may return to near pre-pandemic targets.

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

HRSA has lowered the Program's FY 2022 performance measure targets in anticipation of the long-term impact of the coronavirus pandemic on Black Lung Clinics.

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
33.I.A.1: Number of miners served each year (Output)	FY 2019: 7,075 Target: 13,800 (Target Not Met)	13,800	12,000	-1,800
33.I.A.2: Number of medical encounters from Black Lung each year. (Output)	FY 2019: 12,346 Target: 19,880 (Target Not Met)	19,000	18,000	-1,000

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	16	16	16
Average Award	$711,168	$711,168	$754,293
Range of Awards	$125,000 - $2,065,696	$125,000 - $2,064,465	$125,000 - $2,188,524

Telehealth

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$29,000,000	$34,000,000	$36,500,000	+$2,500,000
FTE	3	5	6	+1

Authorizing Legislation: Public Health Service Act, Section 330I and Section 330L, and Social Security Act, Section 711.

FY 2022 Authorization (Section 330I and 330L) $36,500,000

FY 2022 Authorization (Section 711).....Indefinite

Allocation Method .....Competitive Grants/Cooperative Agreements

Program Description and Accomplishments

The Office for the Advancement of Telehealth (OAT) promotes the use of telehealth technologies for health care delivery, education, and health information services. OAT plays two distinct roles with the Department of Health and Human Services (HHS). The first is to serve as the central focal point for the Department's broad efforts in leveraging telehealth programs and policies to improve access, enhance outcomes, and support clinicians and patients. The second is to administer grant programs focused on telehealth for direct services, research, and technical assistance. OAT's investments advance the provision of telehealth services to rural and underserved communities while simultaneously building the evidence-base for telehealth. OAT administers the following grant programs:

- Telehealth Network Grant Program (TNGP) funds programs that demonstrate how telehealth networks improve healthcare services in rural communities. More specifically, the networks are used to: expand access to, coordinate, and improve the quality of health care services, improve and expand the training of health care providers; and/or expand and improve the quality of health information available to health care providers, patients, and their families. The current cohort is aimed towards promoting rural tele-emergency services by enhancing telehealth networks to deliver 24-hour emergency department (ED) consultation services via telehealth to rural providers without emergency care specialists. HRSA will support continuation awards in FY 2022.

- Evidence-Based Telehealth Network Program (EB THNP) demonstrates how healthcare systems can increase access to healthcare services and improve health outcomes by using direct-to-consumer technologies. The EB THNP grantees will conduct evaluations of these efforts to establish an evidence base for direct-to-consumer telehealth services. The emphasis on data collection and research to further the telehealth evidence base separates this program from the other Telehealth Network Grant Program. HRSA will support continuation awards in FY 2022. In addition, HRSA plans to support new EB THNP

awards to increase access to healthcare services and improve health outcomes by using direct-to-consumer technologies.

- 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. The National Telehealth Resource Center Program (NTRC) and the Regional Telehealth Resource Center Program (RTRC) are designed to expand the availability of technical assistance in the development of telehealth services, leveraging the experience of mature programs with expertise in providing and implementing telehealth services. HRSA will support regional and national TRC continuation awards in FY 2022.

- Telehealth Center of Excellence (COE) Program examines the efficacy of telehealth services in rural and urban areas and serves as a national clearinghouse for telehealth research and resources. The purpose of this program is to assess specific telehealth uses, operate as incubators to pilot, track and refine telehealth, examine the efficacy of telehealth services in rural and underserved areas and explore new telehealth applications, for telehealth research and resources. The program focuses on the delivery and impact of telehealth across diagnosis-based projects, numerous care settings and telehealth education and incorporate wide-ranging technology and modalities to advance telehealth. HRSA will support continuation awards in FY 2022.

- Telehealth-Focused Rural Health Research Center (TF-RHRCs) Program conducts telehealth research to expand the evidence base of telehealth services in rural and underserved areas. The TF-RHRCs focus on policy-relevant, clinically informed telehealth research and comprehensive evaluation of nationwide telehealth investments in rural areas and populations. As part of the research and evaluation, the Telehealth Research Centers will also work with Telehealth Network Grant Program (TNGP) awardees, helping them quantify and analyze their results and preparing summaries and publications of TNGP's clinical impact. HRSA will support continuation awards in FY 2022.

- Licensure Portability Grant Program (LPGP) 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. This assistance benefits practitioners who would like to provide telehealth services across state lines. HRSA will support continuation awards in FY 2022.

- Telehealth Technology-Enabled Learning Program (TTELP) connects specialists at academic medical centers with primary care providers in rural and underserved areas, providing evidence-based training and support to help treat patients with complex conditions in their communities. TTELP recipients develop telehealth technology-enabled collaborative learning and capacity building models (such as Project ECHO, ECHO-like models, distance learning, tele-mentoring, clinical decision support, and other

emerging models in the field), and share freely accessible tools and resources that are adaptable to culturally and regionally diverse populations to provide training nationwide to facilitate the dissemination of best practice specialty care to primary care providers and care teams in rural and underserved areas. HRSA will support continuation awards in FY 2022.

Funding History

FY	Amount
FY 2018	$23,434,000
FY 2019	$24,324,000
FY 2020	$29,000,000
FY 2021 Enacted	$34,000,000
FY 2022 President's Budget	$36,500,000

Budget Request

The FY 2022 Budget Request of $36.5 million is $2.5 million above the FY 2021 Enacted level. HRSA will continue to utilize telehealth to provide access to healthcare in rural and underserved areas. This request will allow HRSA to expand the EB THNP with new awards in support of increasing access to healthcare services and improving health outcomes by using direct-to-consumer technologies. In FY 2022, HRSA will continue to support grant awards to strengthen the networks and the technical assistance providers that support effective implementation of telehealth services. Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
34.E.1: Increase the number of communities that have access to tele-behavioral health services where access did not exist in the community prior to the TNGP grant (NEW)	FY 2019: 176 Target: Set Baseline[267]	TBD	TBD	N/A

[267] Baseline data includes school-based TNGP and SAT TNGP which were discontinued after FY 19. This data and outyear data from the ED TNGP and EB THNP programs will be used to identify trending over a three-year period,

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
34.E.2: Increase the number of telehealth encounters provided through the TNGP (NEW)	FY 2019: 48,391 Target: Set Baseline	TBD	TBD	N/A
34.E.3: Increase the number of unduplicated patients receiving care via telehealth through the TNGP (NEW)	FY 2019: 13,206 Target: Set Baseline[1]	TBD	TBD	N/A
34.E.4: Increase the number of clients receiving technical assistance from the Telehealth Resource Centers program (NEW)	FY 2019: 14,455 Target: Set Baseline[268]	TBD	TBD	N/A

Grant Awards Table

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	64	70	77
Average Award	$416,453	$435,504	$426,250
Range of Awards	$250,000 - $3,000,000	$245,250 - $3,250,000	$76,250-$3,250,000

as the measure is developmental. Once a trend is analyzed, appropriate targets will be identified. It is expected that with turnover in cohorts and focus areas, the target will need to be evaluated on an ongoing basis.

[268] Data reflects FY 2019 data collection of TA encounters and will be used to identify trending over a three year period as the measure is developmental. Once a trend is analyzed, appropriate targets will be identified.

Rural Residency Planning and Development

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$10,000,000	$10,500,000	$12,700,000	+$2,200,000
FTE	2	2	2	---

Authorizing Legislation: Social Security Act, Section 711

FY 2022 Authorization ..... Indefinite

Allocation Method .....Competitive Grants/Cooperative Agreement

Program Description and Accomplishments

The purpose of the Rural Residency Planning and Development Program is to expand the number of rural residency training programs and subsequently increase the number of physicians choosing to practice in rural areas. For the purpose of this program, rural residencies are allopathic and osteopathic physician residency training programs that primarily train in rural communities. This includes Rural Training Tracks (RTTs), a specific model of rural residency training in which residents receive more than 50 percent of their training in a rural location after spending their initial year in a larger, often urban, residency setting. Research has shown that residents often practice near where they complete their residency training. RTT graduates are twice as likely to practice family medicine in a rural setting as compared to family medicine residents trained in an urban program. The Federal Office of Rural Health Policy collaborates with HRSA's Bureau of Health Workforce (BHW) to fund two rural residency programs:

- Rural Residency Planning and Development (RRPD) creates new physician residency training programs that support physician workforce expansion in rural areas and that are sustainable beyond the grant performance period through public (i.e., Medicare or Medicaid), other state or private funding. Grantees may use funds to cover planning and development costs incurred while achieving program accreditation through the Accreditation Council for Graduate Medical Education (ACGME).

- Rural Residency Planning and Development Technical Assistance (RRPD-TA) funds a cooperative agreement that serves as a technical assistance center to support RRPD awardees.

In FY 2019, HRSA funded the first cohort of 27 three-year RRPD awards across 21 states and in FY 2020, HRSA funded a new cohort of 11 three-year RRPD awards across 10 states. In FY 2021 HRSA anticipates awarding approximately eight additional RRPD awards as well as making one new award for the RRPD-TA cooperative agreement. The awardees from all three RRPD cohorts and the RRPD-TA program were fully funded at the start of the project period and will be active in FY 2022. These awards support new rural residency programs in family

medicine, internal medicine and psychiatry; applicants also had the opportunity in FY 2020 to develop rural residency programs in general surgery, OB/GYN, and preventive medicine. To date, 13 RRPD grantees have already received ACGME accreditation. The RRPD competitions have generated significant interest from rural stakeholders.

Funding History

FY	Amount
FY 2018	$14,958,000
FY 2019	$9,956,000
FY 2020	$10,000,000
FY 2021 Enacted	$10,500,000
FY 2022 President's Budget	$12,700,000

Budget Request

The FY 2022 Budget Request of $12.7 million is $2.2 million above the FY 2021 Enacted level. This request will support new RRPD awards and provide funding for the RRPD TA 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	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
Percent of RRPD grantees who achieve ACGME accreditation by the end of the period of performance	N/A	N/A	N/A - Baseline	N/A

Grant Awards Table

	FY 2020 Final[269]	FY 2021 Enacted[270]	FY 2022[271] President's Budget
Number of Awards	11	9	14
Average Award	$747,720	$1,144,444	$750,000
Range of Awards	$732,350 - $750,000	$750,000 - $4,300,000	$750,000 - $750,000

[269] Data represents 11 RRPD awards that were fully funded at the beginning of the project period using FY 2020 multi-year funds.
[270] Data represents 8 RRPD awards and 1 RRPD-TA award that were fully funded at the beginning of the project period using FY 2021 multi-year funds.
[271] Data represents 14 RRPD awards fully funded at the beginning of the project period using FY 2022 multi-year funds.

Rural Communities Opioid Response

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$110,000,000	$110,000,000	$165,000,000	+$55,000,000
FTE	14	19	21	+2

Authorizing Legislation: Social Security Act, Section 711

FY 2022 Authorization .....Indefinite

Allocation Method .....Competitive Grants/Cooperative Agreement

Program Description and Accomplishments

The Rural Communities Opioid Response Program (RCORP) initiative aims to reduce the morbidity and mortality associated with substance use disorder (SUD), including opioid use disorder (OUD), in high risk rural communities by providing funding and technical assistance to multi-sector consortia to enable them to identify and address OUD prevention, treatment, and recovery needs at the community, county, state, and/or regional levels.

HRSA supports three grant programs through RCORP:

- **RCORP-Implementation** provides multi-year support to rural communities to strengthen and expand SUD/OUD prevention, treatment, and recovery services with an emphasis on implementing evidence-based, promising, and innovative approaches and improving organizational and infrastructural capacity at the regional and state levels. HRSA awarded 90 Implementation awards in FY 2020. HRSA plans to award new Implementation awards in FY 2022.

- **RCORP-Neonatal Abstinence Syndrome** provides multi-year support to rural communities to reduce the prevalence of neonatal abstinence syndrome by improving systems of care, family supports, and social determinants of health. HRSA will support continuation awards in FY 2022.

- **RCORP-Psychostimulant Support** provides multi-year funding to rural communities to address psychostimulant misuse, including methamphetamine misuse, through prevention, treatment, and recovery interventions. HRSA plans to award new Psychostimulant Support awards in FY 2022.

In FY 2022, HRSA will continue funding the Rural Centers of Excellence on Substance Use Disorders program that supports the dissemination of best practices related to the treatment for and prevention of substance use disorders within rural communities. HRSA will also continue supporting a cooperative agreement to conduct program-wide evaluation activities for the

RCORP Initiative and will re-compete funding for one cooperative agreement award to provide technical assistance to RCORP grantees. HRSA will continue to support the four Rural Behavioral Health Workforce Centers cooperative agreements, which aim to improve access to behavioral health care services and gainful employment opportunities for rural residents in the Northern Border Regional Commission service area.

Funding History

FY	Amount
FY 2018	$100,000,000
FY 2019	$120,000,000
FY 2020	$110,000,000
FY 2021 Enacted	$110,000,000
FY 2022 President's Budget	$165,000,000

Budget Request

The FY 2022 Budget Request of $165.0 million is $55.0 million above the FY 2021 Enacted level. This request will enable HRSA to fund new RCORP-Implementation grants that provide needed SUD/OUD prevention, treatment, and recovery services to rural residents.

This request will provide HRSA with flexibility to respond to the evolving needs of the epidemic. Drug overdose deaths in rural counties have increased from 4.0 per 100,000 in 1999 to 19.6 in 2019. In 2019, the rate of drug overdose deaths involving psychostimulants with abuse potential was 1.4 times higher in rural counties than in urban counties.[272] Drug overdose deaths have accelerated during the COVID-19 pandemic.[273] In FY 2021, HRSA expanded RCORP's focus to include psychostimulants such as methamphetamines and for FY 2022, HRSA plans to fund additional awards to address psychostimulants as well as continue to allow rural communities to broaden their focus on other SUDs in addition to opioids.

HRSA recognizes that about half of those who experience a substance use disorder during their lives will also experience a mental illness, and vice versa.[274] RCORP award recipients have noted continuing problematic or worsening COVID-19 impacts on behavioral health**.** Approximately 58 percent of Mental Health Professional Shortage Areas are in rural areas, representing nearly 26 million people who do not have adequate access to mental healthcare providers.[275] In FY 2022, HRSA will fund new awards for the existing Psychostimulant Support program allowing rural communities to respond to new and ongoing behavioral health needs of rural residents impacted by SUD/OUD. HRSA will also continue to solicit feedback from rural stakeholders and engage and partner with other Federal agencies to promote a coordinated approach to combatting this devastating epidemic and identifying additional priority areas.

[272] Urban–Rural Differences in Drug Overdose Death Rates, 1999–2019
[273] Overdose Deaths Accelerating During COVID-19 see also Provisional Drug Overdose Death Counts
[274] Common Comorbidities with Substance Use Disorders Research Report
[275] Designated HPSA Quarterly Summary, 2020

HRSA will include health and racial equity as a key component of any FY 2022 funded RCORP programs.

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 Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
35.1 Number of individuals screened for Substance Use Disorder (Output and Developmental)	FY 2020: Result Expected Sep 30, 2020 Target: Set Baseline (Pending)	Not Defined[276]	Not Defined	N/A
35.2 Percent of Rural Communities Opioid Response Program (RCORP) grantees with other sources of funding for sustainability (aside from RCORP grant) (Output and Developmental)	FY 2020: Result Expected Sep 30, 2020 Target: Set Baseline (Pending)	Not Defined[277]	Not Defined	N/A
35.3 Number of providers who have provided Medication-Assisted Treatment (Output and Developmental)	FY 2020: Result Expected Sep 30, 2020 Target: Set Baseline (Pending)	Not Defined[278]	Not Defined	N/A

[276]Baseline data is being collected and will be available by September 30, 2020. Once the data is analyzed, appropriate targets will be identified.
[277]Baseline data is being collected and will be available by September 30, 2020. Once the data is analyzed, appropriate targets will be identified.
[278]Baseline data is being collected and will be available by September 30, 2020. Once the data is analyzed, appropriate targets will be identified.

Grant Awards Table

	FY 2020 Final [279]	FY 2021 Enacted [280]	FY 2022 President's Budget[281]
Number of Awards	132	101	166
Average Award	$803,030	$1,039,604	$963,855
Range of Awards	$200,0000 - $6,000,000	$375,000 - $6,000,000	$500,000 - $10,000,000

[279] Data represents awards funded using one-year funds appropriated in FY 2020. Awards made during the FY 2020 project period using multi-year funds are not included.
[280] Data represents awards funded using one-year funds appropriated in FY 2021. Awards made during the FY 2021 project period using multi-year funds are not included.
[281] Data represents awards funded using one-year funds appropriated in FY 2022. Awards made during the FY 2022 project period using multi-year funds are not included.

Program Management TAB

Program Management

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$155,300,000	$155,300,000	$167,971,000	+$12,671,000
FTE	762	871	886	+15

Authorizing Legislation: Public Health Service Act, Section 301

FY 2022 Authorization……...……Indefinite

Allocation Method……....Other

To achieve its mission, HRSA requires qualified staff to operate at maximum efficiency. One of HRSA's goals is to strengthen program management and operations by improving program customer satisfaction, increasing employee engagement, and implementing organizational improvements and innovative projects. Program Management is the primary means of support for staff, business operations and processes, information technology and overhead expenses such as rent, utilities, and miscellaneous charges for HRSA.

Improving Processes and Business Operations

HRSA continues to improve operational planning processes to foster cross-agency collaboration. HRSA has automated its contracting process to operate in a totally paperless environment, including the receipt of committed funds, the obligation of funds, and the generation and storage of contract documents. Over the past several years, HRSA has supported telework participation by increasing the agency-wide utilization of real-time web collaboration tools. Real-time collaboration is accomplished using automated tools that support a full range of requirements from one-on-one for teleworkers to web-based meetings supporting as many as 500 participants.

Developing a 21st Century Workforce

Numerous efforts are underway to enhance efficiency and effectiveness of the agency and to ensure the workforce is positioned to succeed in the 21st century. The hiring process has been improved, reducing the time it takes to complete the hiring cycle from recruitment to onboarding.

HRSA is focused on intense employee engagement improvement efforts. The agency had over an 85% participant rate in the 2019 Federal Employee Viewpoint Survey (FEVS). HRSA performs custom analysis and consultations with organizations at all levels to inform improvement strategies.

Maintaining a skilled workforce is a top priority. In 2018, The HRSA Learning Institute (HLI) delivered 246 classes, including both in person and virtual. More than 1,330 HRSA employees participated in at least one class, an increase of 10 percent compared to 2017. HLI received and

assisted agency staff on requests for organizational development facilitation services, and collaborated with the Bureaus/Offices to create custom training curriculum.

Sharing Quality Services

HRSA relies on HHS-provided shared services for many of the services represented in this CAP goal, such as human resources, financial management, grants, and procurement. HRSA actively seeks out and deploys shared services to improve and simplify processes, and to maximize the efficiency of shared services with other components of HHS.

Creating a Culture of Program Integrity

Program Management also supports Enterprise Risk Management (ERM) activities that align with core principles and performance and strategic planning activities to reduce programmatic risk and improve performance. HRSA has established a HRSA-wide governance structure for enterprise-wide business operations and risk management activities to ensure a proactive and customer-focused suite of business operation services and risk management functions.

HRSA is currently engaged in ERM implementation strategies aligned with the revised OMB Circular A-123. Recent revisions to the circular's Appendices A and C, respectively, include prioritizing risk based assessments and a focus on fraud identification and prevention activities. HRSA's ERM efforts include Governance and Process support for the promotion of a risk-aware organizational culture, the creation of a comprehensive view of risks to drive strategic decision making and the establishment and communication of risk appetite.

Operations during the COVID-19 Pandemic

During the COVID-19 pandemic, HRSA used its secure and mobile infrastructure to immediately transition to 100 percent telework for all staff. HRSA averages approximately 3,000 Virtual Private Network sessions per day. HRSA also implemented new technologies to quickly disperse Provider Relief funds to hospitals and healthcare providers on the front lines of the coronavirus response. Using enhanced technologies HRSA was able to reduce its grant award cycle from 90-120 days to 12-18 days for COVID-19 grants. These key IT enhancements expedited the time to award for over 5,000 grants between March and May, 2020**.**

Funding History

FY	Amount
FY 2018	$154,615,000
FY 2019	$154,568,000
FY 2020	$155,300,000
FY 2021 Enacted	$155,300,000
FY 2022 President's Budget	$167,971,000

Budget Request

The FY 2022 Budget Request of $168.0 million is $12.7 million above the FY 2021 Enacted level. This funding level supports program management activities to effectively and efficiently

support HRSA's operations. An additional $12.7 million is requested to further support HRSA operations at an overall increased funding level of $2.1 billion over FY 2021 Enacted.

HRSA is committed to improving quality at a lower cost and improving the effectiveness and efficiency of government operations. HRSA supports telework by increasing the agency-wide utilization of web collaboration tools, which have led to greater business productivity.

HRSA also continues to enhance its program integrity activities by supporting analytical tools using HRSA's electronic grants system, program data, Office of Federal Assistance Management data sources, HHS sources, and government-wide sources. The goal is for HRSA to identify potential issues in the pre- and post-award processes and to address issues before they become audit findings. HRSA plans to focus on a risk-based approach to grantee monitoring using the information and corresponding analysis to help staff spend their time on grantees at risk of noncompliance. HRSA will also continue to provide training for grants management and program staff to support the alignment of program integrity initiatives with planning and performance activities. These efforts will enhance HRSA grantees awareness and ability to avoid potential financial integrity issues.

IT Investments
Significant progress has been made in a range of program management activities. Some highlights include:

- Improve cybersecurity efforts by enhancing HRSA's public-facing websites in compliance with OMB and DHS requirements, by implementing enterprise-wide Security Event Management using Splunk, and by initiating a successful "PhishMe" campaign to train HRSA staff to recognize and properly report suspicious emails.

- Continue implementation of the Enterprise Architecture, Capital Planning and Investment Control (CPIC) and Enterprise Performance Life Cycle (EPLC) processes.

- Enhance Electronic Handbooks (EHBs) by adding a team based approach to all modules, adding auto-save, and implementing a Modern Business analytics Platform (MDAP) using Tableau. Launched a new EHBs user interface for grantees with simpler navigation, widgets, fly-out menus, and other shortcuts.

- Continue modernizing the Data Warehouse. Developed a series of colorful and interactive Tableau dashboards to replace 130 legacy reports, giving HRSA staff and the public deeper analytical insight into HRSA funding, location, and program performance. Upgraded geocoding technology, resulting in 20 percent faster map generation and improved accuracy of Health Center site locations. Collapsed 250 web pages into 75, resulting in a simpler, more organized site that is easier to search and navigate.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
35.VII.A.4 Implement Enterprise Risk Management (ERM) (Output)	FY 2019: Assessed HRSA's ERM implementation efforts, including alignment with revised OMB Circular A-123 (Target Met) Target: Assess HRSA's ERM implementation efforts, including alignment with HHS and OMB Circular A-123 ERM guidance. (Target Met)	Discontinued	Discontinued	N/A
35.VII.B.1. Ensure Critical Infrastructure Protection: Security Awareness Training (Output)	FY 2018: Full participation in Security and Privacy Awareness training by 100% of HRSA staff. specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff (Target Met) Target: Full participation in Security and Privacy Awareness training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff. (Target Met)	Full participation in Security and Privacy Awareness training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	Full participation in Security and Privacy Awareness training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	N/A

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
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 went through continuous monitoring to ensure that critical patches were applied, security controls were implemented and working as intended, and risks were managed and mitigated in a timely manner. (Target Met) Target: 100% of HRSA information systems will be assessed and Authorized to Operate (ATO). In addition, all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner. (Target Met)	100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner	100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner	N/A
35.VII.B.2a Ensure Critical Infrastructure Protection: Security HSPD-12 Privilege and Non-Privilege (Output)	FY 2018: Privacy - 100% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts used PIV cards or other 2-factor authentication (Target Met) Target: Privacy - 100% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts must use PIV cards or other 2-factor authentication (Target Met)	Discontinued	Discontinued	N/A

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
35.VII.B.2b Ensure Critical Infrastructure Protection: Security Cyber Sprint (Output)	FY 2018: Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 days (Target Met) Target: Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 days (Target Met)	Cyber Sprint - Remediation of critical findings from cyber hygiene scanning: Critical findings within 15 days High findings within 30 days	Cyber Sprint - Remediation of critical findings from cyber hygiene scanning: Critical findings within 15 days High findings within 30 days	N/A
35.VII.B.2c Ensure Critical Infrastructure Protection: Security Privacy Impact Assessment (PIA) or Privacy Threshold Assessment (PTA) (Output)	FY 2018: 90% of systems that required a PIA or a Privacy Threshold Assessment (PTA) were identified (Target Met) Target: Identify 90% of systems that require a PIA or a Privacy Threshold Assessment (PTA) (Target Met)	Identify 95% of systems that require a PIA or a Privacy Threshold Assessment (PTA)	Identify 95% of systems that require a PIA or a Privacy Threshold Assessment (PTA)	N/A
35.VII.B.2d Ensure Critical Infrastructure Protection: Security Phishing (Output)	FY 2018: 17 Phishing Campaigns completed (Target Exceeded) Target: 6 Phishing Campaigns completed (Target Exceeded)	24 Phishing Campaigns completed	24 Phishing Campaigns completed	N/A

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
35.VII.B.3 Capital Planning and Investment Control (Output)	FY 2018: 1) Received FITARA score of "A" for IT Portfolio; 2) 75% of major Investment Managers were in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM). (Target Met) Target: 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). (Target Met)	Discontinued	Discontinued	N/A
35.VII.B.4 Enterprise Architecture (Output)	FY 2018: Enterprise Architecture: 90% of IT investments were reported to OMB with mapping to at least one HHS segment and domain (Target Met) Target: Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain. (Target Met)	Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain	Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain	N/A

Family Planning
TAB

Title X Family Planning Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	$286,479,000	$286,479,000	$340,000,000	+$53,521,000
FTE	12*	17*	35	+18

*Due to coding error, Family Planning is reporting lower than the actual 35 FTE

Authorizing Legislation - Title X of the Public Health Service Act, 42 U.S.C. 300 et seq
FY 2021 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 is administered by the Office of Population Affairs (OPA) in the Office of the Assistant Secretary for Health (OASH).

The Title X Program fulfills its mission through awarding competitive grants to public and private nonprofit organizations. According to the 2019 Family Planning Annual Report (FPAR) data (the most recent data available), in 2019 Title X services were provided through 100 family planning service grants that supported a nationwide network of 3,825 community-based sites that provided clinical and educational services to more than 3,095,666 persons. As a result of the provision of a broad range of effective and acceptable family planning methods, counseling and education, and other clinical services, the Title X Program was responsible for the prevention of an estimated 672,638 unintended pregnancies. As of August 2020, there was at least one Title X services grantee in 44 of the 50 states, the District of Columbia, and in each of the U.S. territories, including the six Pacific jurisdictions. Current Title X grants are entering their third and final year of their project period in FY 2021. OPA will conduct a national competition for all Title X services for a new project period starting in FY 2022.

Through screening and testing, Title X service providers help to prevent and treat STDs. STD services are integral to family planning services because they improve health and can affect a

person's ability to conceive and have a healthy birth outcome. In 2019, Title X service sites tested 1,577,243 female and male clients for chlamydia. Screening for chlamydia is important not only in reducing the impact of STDs, which continue to rise in the United States, but also reducing infertility. Untreated chlamydia infection may lead to the development of pelvic inflammatory disease, which if left untreated may cause infertility. In addition to screening for chlamydia, Title X service sites tested 1.8 million clients for gonorrhea; tested 674,764 clients for syphilis; and conducted 961,859 confidential tests for HIV. Of the confidential HIV tests performed, 3,685 were positive for HIV.

In addition to providing grants to clinical service providers, the Title X Program supports HHS and OASH's initiative to identify and provide solutions to reduce substance use disorders (SUD) and the impact that they have on future health outcomes. In 2019, the Title X Program built off of a previously held expert work group focused on the identification of interventions to better incorporate and link SUD screening, referral, and treatment with Title X family planning centers. As a result of this, OPA is funding research programs that focus on innovative ideas to improve the delivery of Title X family planning services, including funding programs that integrate SUD screening, referral, and/or treatment with family planning and related reproductive health services. The awards were made in fall 2019. OPA also continues to collaborate with SAMHSA's Addiction Technology Transfer Centers (ATTCs) and other Federal and community-based programs in order to improve counseling, screening and referral for treatment services at Title X service sites.

In FY 2019, the program completed a 3-year initiative to improve the ability of Title X family planning projects to provide Pre Exposure Prophylaxis (PrEP) 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 STI clinics and other service sites which provide family planning and related preventive health services. The Title X Program also played a key role in helping to develop the STI Federal Action Plan. Emphasis is placed on underserved populations or communities where high rates of STIs impact the ability of individuals to achieve healthy pregnancies.

OPA and the Title X grantees are committed to continuously improving and enhancing the services provided to clients by providing training and technical assistance for all levels of family planning personnel, collecting and using data to assess and improve program performance, and researching improved delivery mechanisms for family planning services. OPA continues to focus on providing quality family planning services, including emphasizing the importance of making the broad range of family planning methods and services available at Title X family planning centers. Supporting the overall health of clients will continue to be an important focus of the program. Therefore, each Title X project is strongly encouraged to ensure access to primary health care services, either onsite or through robust referral linkages. OPA will continue its 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.

The Title X program continues to provide targeted technical assistance on financial and program management topics, including effective billing practices, billing all appropriate third-party payers, and other cost recovery methods. These and other technical assistance and trainings are provided through the Title X National Training Center. Grantees are urged to implement more efficient administrative systems such as health information technologies, electronic health records, and payment management systems. Focusing on these areas will also assist in better data collection and increase the ability to report on the outputs and outcomes of Title X projects and the overall program.

On March 4, 2019, the Final Rule, Compliance with Statutory Program Integrity Requirements – 84 FR 7714, pp. 7714-7791, to revise 42 CFR 59, was published in the Federal Register. On January 28, 2021, President Biden issued a "Memorandum on Protecting Women's Health at Home and Abroad," directing the Department of Health and Human Services (HHS) to review the 2019 Title X Final Rule and "consider, as soon as practicable, whether to suspend, revise, or rescind, or publish for notice and comment proposed rules suspending, revising, or rescinding, those regulations, consistent with applicable law, including the Administrative Procedure Act." HHS conducted an extensive review and consideration of the 2019 Title X Final Rule (84 Fed. Reg. 7714) pursuant to this Presidential memorandum. After reviewing the 2019 rule, HHS published a new Notice of Proposed Rulemaking (NPRM) in the *Federal Register* on April 15, 2021 that is substantively similar to those issued in 2000 (65 Fed. Reg. 41270), under which the program operated successfully for years, with a few definitional updates that account for minor operational changes over the past 20 years. HHS will review and carefully consider all comments submitted in response to this NPRM and plans to have any Title X Final Rule in place by early fall and effective in time for the Fiscal Year 2022 funding announcement.

Funding History

Fiscal Year	Amount
FY 2018	$286,479,000
FY 2019	$286,479,000
FY 2020	$286,479,000
FY 2021 Enacted	$286,479,000
FY 2022 President's Budget	$340,000,000

Budget Request

The FY 2022 President's Budget request for Title X Family Planning Program is $340.0 million, which is $53.5 million above the FY 2021 Enacted Level.

In FY 2022, OPA will conduct a national competition for all Title X services funding. The additional funds requested will enable the Title X program to expand access to family planning services to address unmet needs across communities and populations throughout all 50 States and Territories. The FY 2022 Budget is expected to support family planning services for approximately 3.5 million persons, with approximately 90 percent having family incomes at or below 250 percent of the federal poverty level. The FY 2022 request provides funding for

family planning methods and related preventive health services, as well as, related training, information, education and research to improve family planning service delivery.

The FY 2022 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 in order to increase access and the quality of services for all individuals seeking Title X family planning services.

The targets for FY 2022 assume other sources of revenue that contribute to the family planning program at the grantee level will remain at current levels, including Medicaid, state and local government programs, other federal, state, and private grants, and private insurance.

OPA is increasing its focus on improving chlamydia screening rates within the Title X projects. While OPA has always stressed the importance of screening for chlamydia infection, following CDC's clinical recommendations, the continued increase in STIs over the past decade stresses the added importance of identifying and treating this preventable infection as early as possible. In addition, OPA is continuing to stress the importance of vaccination against HPV, screening for undiagnosed cervical tissue abnormalities, providing preconception care and counseling and basic infertility services, providing pregnancy testing and counseling, increasing access to fertility awareness-based methods (FABM) —which includes natural family planning methods— hormonal and non-hormonal contraceptives methods, adolescent services and related education and counseling. These services, along with community-based education and outreach, assist individuals and families with effective family planning services, whether it be to prevent or achieve pregnancy to the extent practicable, Title X clinics also encourage family participation when delivering such services.

OPA will also coordinate with other federal agencies, and with other data collection efforts reflecting performance and impact. The program is anticipating that additional investment in training on 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. Based on the FPAR, billing revenue has continued to increase over the past decade. In addition, the program is assessing traditional and innovative ways to increase access to family planning and related preventive health services, specifically in rural and hard to reach areas.

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 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
36.II.A.1: Total number of unduplicated clients served in Title X service sites. *(Outcome)*	FY 2019: 3,095,666 Target: 4,018,000 (Target Not Met)	3,300,000	3,500,000	+200,000
36.II.A.2: Maintain the proportion of clients served who are at or below 250% of the Federal poverty level at 90% of total unduplicated family planning users. *(Outcome)*	FY 2019: 88% Target: 90% (Target Not Met)	90%	90%	Maintain
36.II.A.3: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals. *(Outcome)*	FY 2019: 672,638 Target: 905,000 (Target Not Met)	810,000	830,000	+20,000
36.II.B.1: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24. *(Outcome)*	FY 2019: 644,080 Target: 1,195,000 (Target Not Met)	850,000	900,000	+50,000
36.II.C.3: Increase the proportion of females' ages 15 – 24 attending Title X family planning clinics screened for Chlamydia infection. *(Outcome)*	FY 2019: 58% Target: 64.4% (Target Not Met)	85%	85%	Maintain

Efficiency Measure

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)*	FY 2019: $335.36 Target: $336.69 (Target Exceeded)	$371.00	$371.00	Maintain

Note: Following implementation of the Title X Final Rule in FY 2019, 19 grantees discontinued participating in the Title X Program. This resulted in Title X serving fewer clients and therefore not meeting the performance targets for 2019.

Grant Awards Tables

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	76	75	90
Average Award	$2,650,150	$2,650,150	$2,650,150
Range of Awards	$150,000 - $21,000,000	$150,000 - $21,000,000	$150,000 - $21,000,000

Note: OPA funded 90 Title X service grantees at the beginning of FY 2019. After implementation of the final rule in FY 2019, 19 grantees discontinued participating in the Title X Program, resulting in 71 Title X service grantees. OPA funded an additional 5 Title X grantees in FY 2020. In FY 2022, OPA will compete all Title X service delivery funds and anticipates funding additional grantees.

Nonrecurring Expense Fund

TAB

Nonrecurring Expenses Fund

Budget Summary
(Dollars in Thousands)

	FY 2020[282]	FY 2021[283,284]	FY 2022[285]
Notification[286]	$2,000	$3,700	$0,000

Authorizing Legislation:
Authorization…….…….Section 223 of Division G of the Consolidated Appropriations Act, 2008

Allocation Method…….……..Direct Federal, Competitive Contract

Overview of NEF

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. Since FY 2016, HRSA has received $28.2 million from the NEF, which has allowed HRSA to meet the requirements of the Digital Accountability and Transparency Act (DATA Act).

Program Descriptions

In FY 2021, HRSA received $3.7 million for three FY 2021 NEF projects. One project will further modernize the HRSA Data Warehouse by reengineering the back-end database architecture to provide a more modern, consolidated, streamlined database design. Another project will enhance HRSA's Injury Compensation System by modernizing its financial management capabilities and measurably improving security, data protection, accuracy, efficiency, and internal controls within program operations. The final project will build enhanced data analytics capabilities that leverage the National Health Service Corps (NHSC) Clinician Tracker, Grantee Performance Management Dashboards, and other internal and external datasets.

[282] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on July 20, 2020.
[283] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on October 22, 2020.
[284] The projects described below are the current list of approved projects through FY 2021. Additional projects may be funded from the FY 2021 notification letter upon approval from OMB.
[285] HHS has not yet notified for FY 2022
[286] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use

Data visualization and GIS mapping tools will provide HRSA more robust business intelligence to enhance program decision-making and reporting.

In FY 2020, HRSA received $1.1 million to continue a lift and shift cloud migration of HRSA's BHW Management Information System Solution (BMISS), which supports facilitating loan repayment, scholarship, shortage designations, and business operations. The migration of BMISS to a cloud environment aligns with the HHS Office of the CIO's adoption of the Federal Cloud First policy, the Office of Management and Budget's M-11-29 mandate, and the HHS 2017-2020 Information Technology Strategic Plan. The migration will result in savings from data center hosting fees and enable business flexibility and scalability for HRSA's computing needs.

HRSA also received $1.95 million in FY 2020 to continue a project that provides critical enhancements and upgrades to HRSA's cybersecurity capabilities and operations. HRSA has initiated efforts to procure a feature-rich, cutting-edge endpoint detection and response solution to effectively defend against adversaries and efficiently respond to cybersecurity incidents. HRSA will also procure a tool focused on monitoring enterprise databases for vulnerabilities, misconfigurations, unauthorized access, and data loss prevention.

Program Accomplishments

NEF resources have allowed HRSA to make critical capital investments in information technology that modernize and secure HRSA's systems and improve the effectiveness of agency operations and the ways HRSA utilizes data.

HRSA continues to make critical upgrades to its cybersecurity infrastructure with NEF funding since FY 2016, including implementing new cybersecurity tools and enhanced authentication practices for HRSA systems users. These cybersecurity investments increase the effectiveness of HRSA's technology infrastructure safeguards that protect valuable data and information systems, while supporting standards and requirements set forth by various federal agencies such as the National Institute of Standards and Technology (NIST), Office of Management and Budget (OMB), and Homeland Security.

With NEF funding, HRSA modernized its enterprise data repository, the HRSA Data Warehouse. HRSA overhauled a legacy mapping system with cutting-edge Geographic Information System (GIS) technology, added a wider range of data and advanced analytics, and improved the user experience. New interactive web-based mapping capabilities allow HRSA to quickly respond to emerging public health threats with data and maps.

In FY 2019, HRSA developed Clinician Dashboards that provide aggregate information on over 28,000 clinicians that have been supported by HRSA's Bureau of Health Workforce (BHW) with NEF funding. Leveraging GIS technology, HRSA rolled out the first series of maps that show detail on all bureau loan repayment, scholarship, and grant training programs.

NEF resources have also provided HRSA the opportunity to initiate the migration of several platforms to a cloud environment. HRSA has completed cloud migration for certain IT systems, including non-production and general system support (GSS) platforms. HRSA's cloud migration efforts align with OMB's Data Center Optimization Initiative (DCOI) to decrease systems

installations at on-premise data centers, utilize cloud virtualization and on demand storage, and to realize cost savings or cost avoidance over the life of HRSA's IT systems.

With a focus on cloud-based solutions, HRSA has also invested in two critical initiatives to modernize the EHBs using FY 2019 NEF resources. HRSA has either completed or is working on a number of cloud adoption proof-of-concepts and platform improvements to enable microservices architecture (MSA), which promotes the more effective and reliable delivery of large, complex applications. MSA are processes that communicate over a network by using technology-agnostic protocols and are independently deployable. HRSA is also engaged in activities to enhance EHBs security features by remediating legacy code vulnerabilities and expanding two-factor authentication to external users.

Supplementary Tables
TAB

Object Class Tables
(dollars in thousands)

DISCRETIONARY

OBJECT CLASS	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$165,999	$191,364	$201,528	+10,164
Other than full-time permanent (11.3)	4,271	4,330	4,373	+43
Other personnel compensation (11.5)	4,192	4,247	4,289	+42
Military personnel (11.7)	20,037	21,543	22,189	+646
Special personnel services payments (11.8)	100	101	102	+1
Subtotal personnel compensation	**$194,599**	**$221,585**	**$232,481**	**+10,896**
Civilian benefits (12.1)	57,915	66,301	70,114	+3,813
Military benefits (12.2)	2,168	2,646	2,725	+79
Benefits to former personnel (13.1)	1,901	1,930	1,949	+19
Total Pay Costs	**$256,583**	**$292,462**	**$307,269**	**+14,807**
Travel and transportation of persons (21.0)	1,210	1,414	1,406	-8
Transportation of things (22.0)	157	157	157	-
Rental payments to GSA (23.1)	16,334	16,075	16,098	+23
Rental payments to Others (23.2)	662	662	662	-
Communication, utilities, and misc. charges (23.3)	2,915	3,505	2,402	-1,103
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	111	111	111	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	16,212	15,911	15,911	-
Other services (25.2)	230,904	232,547	239,010	+6,463
Purchase of goods/services from government accounts (25.3)	187,003	176,718	176,286	-432
Operation and maintenance of facilities (25.4)	914	1,035	835	-200
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	3,419	3,419	3,419	-
Operation and maintenance of equipment (25.7)	13,258	12,451	12,597	+146
Subsistence and support of persons (25.8)	53	53	53	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	704	694	697	+3
Subtotal Other Contractual Services	**$452,467**	**$442,828**	**$448,808**	**+5,980**
Equipment (31.0)	6,822	6,712	6,621	-91
Land and Structures (32)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	6,205,897	6,335,266	6,921,718	+586,452
Insurance Claims and Indemnities (42.0)	94,101	108,042	108,042	-
Total Non-Pay Costs	**$6,780,676**	**$6,914,772**	**$7,506,025**	**+$591,253**
Total Budget Authority by Object Class	**$7,037,259**	**$7,207,234**	**$7,813,294**	**+$606,060**

PRIMARY CARE

Object Class	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$ 29,903	$ 32,271	$ 32,594	+323
Other than full-time permanent (11.3)	577	586	592	+6
Other personnel compensation (11.5)	670	681	687	+6
Military personnel (11.7)	4,372	4,729	4,871	+142
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$ 35,522**	**$ 38,267**	**$ 38,744**	**+477**
Civilian benefits (12.1)	10,501	11,298	11,411	+113
Military benefits (12.2)	357	442	455	+13
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$ 46,380**	**$ 50,007**	**$ 50,610**	**+603**
Travel and transportation of persons (21.0)	419	419	419	-
Transportation of things (22.0)	5	5	5	-
Rental payments to GSA (23.1)	2,924	2,924	2,924	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	15	15	15	-
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)	95,696	95,787	95,787	-
Purchase of good/services from govt. accounts (25.3)	44,895	44,895	44,867	-28
Operation and maintenance of facilities (25.4)	205	205	205	-
Research and Development Contracts (25.5)	-		-	-
Medical care (25.6)	-		-	-
Operation and maintenance of equipment (25.7)	2,186	2,186	2,186	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	120	120	120	-
Subtotal Other Contractual Services	**$ 143,102**	**$ 143,193**	**$ 143,165**	**-28**
Equipment (31.0)	851	852	851	-1
Investments and Loans (33.0)	-		-	-
Grants, subsidies, and contributions (41.0)	1,338,942	1,378,531	1,427,957	+49,426
Insurance Claims and Indemnities (42.0)	93,884	107,826	107,826	-
Total Non-Pay Costs	**$ 1,580,142**	**$ 1,633,765**	**$ 1,683,162**	**+49,397**
Total Budget Authority by Object Class	**$ 1,626,522**	**$ 1,683,772**	**$ 1,733,772**	**+50,000**

HEALTH WORKFORCE

Object Class	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$ 13,327	$ 14,542	$ 16,038	+1,496
Other than full-time permanent (11.3)	380	385	389	+4
Other personnel compensation (11.5)	266	271	273	+2
Military personnel (11.7)	1,889	2,059	2,121	+62
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$ 15,862**	**$ 17,257**	**$ 18,821**	**+1,564**
Civilian benefits (12.1)	4,402	4,694	5,191	+497
Military benefits (12.2)	131	285	293	+8
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$ 20,395**	**$ 22,236**	**$ 24,305**	**+2,069**
Travel and transportation of persons (21.0)	65	65	65	-
Transportation of things (22.0)	29	29	29	-
Rental payments to GSA (23.1)		-	-	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	735	735	735	-
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)	19,801	19,801	19,801	-
Purchase of goods/services from govt. accounts (25.3)	34,552	34,552	34,552	-
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	906	906	906	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**$ 55,259**	**$ 55,259**	**$ 55,259**	**-**
Equipment (31.0)	1,451	1,451	1,451	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	1,116,572	1,144,201	1,298,510	+154,309
Insurance Claims and Indemnities (42.0)	-	30	30	-
Total Non-Pay Costs	**$ 1,174,111**	**$ 1,201,770**	**$1,356,079**	**+154,309**
Total Budget Authority by Object Class	**$ 1,194,506**	**$ 1,224,006**	**$1,380,384**	**+156,378**

MATERNAL & CHILD HEALTH

Object Class	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$ 8,571	$ 10,157	$ 12,509	+2,352
Other than full-time permanent (11.3)	273	271	273	+2
Other personnel compensation (11.5)	191	189	191	+2
Military personnel (11.7)	720	742	765	+23
Special personnel services payments (11.8)	-	-		-
Subtotal personnel compensation	**$ 9,755**	**$ 11,359**	**$ 13,738**	**+2,379**
Civilian benefits (12.1)	3,024	3,555	4,341	+786
Military benefits (12.2)	56	58	59	+1
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$ 12,835**	**$ 14,972**	**$ 18,138**	**+3,166**
Travel and transportation of persons (21.0)	124	124	124	-
Transportation of things (22.0)	26	26	26	-
Rental payments to GSA (23.1)	1,053	1,053	1,053	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	78	78	78	-
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)	11,427	11,125	11,125	-
Other services (25.2)	9,074	9,066	9,066	-
Purchase of goods and services from govt. accounts (25.3)	15,242	15,242	15,242	-
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	2,183	2,183	2,183	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	4	4	4	-
Subtotal Other Contractual Services	**$ 31,638**	**$ 37,620**	**$ 37,620**	**-**
Equipment (31.0)	928	928	928	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	897,102	920,483	1,042,117	+121,634
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$ 930,949**	**$960,312**	**$1,081,946**	**+121,634**
Total Budget Authority by Object Class	**$ 943,784**	**$975,284**	**$1,100,084**	**+124,800**

HIV/AIDS

Object Class	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$ 18,401	$ 22,961	$ 23,341	+380
Other than full-time permanent (11.3)	278	283	285	+2
Other personnel compensation (11.5)	392	394	398	+4
Military personnel (11.7)	3,994	4,452	4,586	+134
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$ 23,065**	**$ 28,090**	**$ 28,610**	**+520**
Civilian benefits (12.1)	6,350	7,877	8,406	+529
Military benefits (12.2)	473	599	617	+18
Benefits to former personnel (13.1)	80	81	82	+1
Total Pay Costs	**$ 29,968**	**$ 36,647**	**$ 37,715**	**+1,068**
Travel and transportation of persons (21.0)	140	362	354	-8
Transportation of things (22.0)	4	4	4	-
Rental payments to GSA (23.1)	1,081	887	910	+23
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	365	983	808	-175
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)	25,382	32,954	33,188	+234
Purchase of goods/services from govt. accounts (25.3)	61,896	63,302	62,973	-329
Operation and maintenance of facilities (25.4)	345	345	345	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	5,566	4,759	4,905	+146
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	46	36	39	+3
Subtotal Other Contractual Services	**$ 93,235**	**$ 101,396**	**$ 101,450**	**+54**
Equipment (31.0)	1,839	1,728	1,638	-90
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	2,262,149	2,281,774	2,411,902	+130,128
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$ 2,358,813**	**$ 2,387,134**	**$ 2,517,066**	+129,932
Total Budget Authority by Object Class	**$ 2,388,781**	**$ 2,423,781**	**$ 2,554,781**	**+131,000**

HEALTHCARE SYSTEMS

Object Class	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$ 6,441	$ 7,214	$ 7,511	+297
Other than full-time permanent (11.3)	220	223	226	+3
Other personnel compensation (11.5)	212	216	218	+2
Military personnel (11.7)	2,066	2,129	2,192	+63
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$ 8,939**	**$ 9,782**	**$ 10,147**	**+365**
Civilian benefits (12.1)	2,351	2,612	2,713	+101
Military benefits (12.2)	219	225	232	+7
Benefits to former personnel (13.1)	229	233	235	+2
Total Pay Costs	**$ 11,738**	**$ 12,852**	**$ 13,327**	**+475**
Travel and transportation of persons (21.0)	159	159	159	-
Transportation of things (22.0)	63	63	63	-
Rental payments to GSA (23.1)	1,437	1,437	1,437	-
Rental payments to Others (23.2)	662	662	662	-
Communication, utilities, and misc. charges (23.3)	287	287	287	-
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)	517	517	517	-
Other services (25.2)	65,154	65,779	72,467	+6,688
Purchase of goods/services from govt. accounts (25.3)	5,052	5,992	5,916	-76
Operation and maintenance of facilities (25.4)	64	185	185	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	3,413	3,413	3,413	-
Operation and maintenance of equipment (25.7)	947	947	947	-
Subsistence and support of persons (25.8)	53	53	53	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	385	385	385	-
Subtotal Other Contractual Services	**$ 75,585**	**$ 77,271**	**$ 83,883**	**+6,612**
Equipment (31.0)	1,082	1,082	1,082	-
Land and Structures (32)	-		-	-
Investments and Loans (33.0)		-		-
Grants, subsidies, and contributions (41.0)	32,573	35,273	35,186	-87
Insurance Claims and Indemnities (42.0)	7	7	7	-
Total Non-Pay Costs	**$ 111,855**	**$ 116,241**	**$ 122,766**	**+6,525**
Total Budget Authority by Object Class	**$ 123,593**	**$ 129,093**	**$ 136,093**	**+7,000**

RURAL HEALTH

Object Class	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$3,193	$4,141	$4,745	+604
Other than full-time permanent (11.3)	168	171	173	+2
Other personnel compensation (11.5)	85	86	87	+1
Military personnel (11.7)	28	29	30	+1
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$3,057**	**$4,427**	**$5,035**	**+608**
Civilian benefits (12.1)	1,136	1,453	1,655	+202
Military benefits (12.2)	7	7	8	+1
Benefits to former personnel (13.1)	-	-		-
Total Pay Costs	**$4,018**	**$5,887**	**$6,698**	**+811**
Travel and transportation of persons (21.0)	120	102	102	-
Transportation of things (22.0)	19	19	19	-
Rental payments to GSA (23.1)	553	489	489	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	86	59	59	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	9,548	7,775	7,775	-
Purchase of goods/ services from govt. accounts (25.3)	3,771	3,650	3,650	-
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	1,274	1,274	1,274	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**$ 12,143**	**$12,699**	**$12,699**	**-**
Equipment (31.0)	320	320	320	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	301,035	309,944	379,823	+69,879
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$ 314,276**	**$ 323,632**	**$393,511**	**+69,879**
Total Budget Authority by Object Class	**$ 318,294**	**$ 329,519**	**$ 400,209**	**+70,690**

PROGRAM MANAGEMENT

Object Class	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$ 82,339	$ 95,632	$ 98,276	+2,644
Other than full-time permanent (11.3)	2,318	2,353	2,377	+24
Other personnel compensation (11.5)	2,318	2,353	2,377	+24
Military personnel (11.7)	6,414	6,833	7,038	+205
Special personnel services payments (11.8)	100	101	-	-101
Subtotal personnel compensation	**$ 93,489**	**$ 107,272**	**$ 110,068**	**+2,796**
Civilian benefits (12.1)	28,791	33,242	34,137	+895
Military benefits (12.2)	878	980	1,009	+29
Benefits to former personnel (13.1)	1,528	1,552	1,567	+15
Total Pay Costs	**$ 124,686**	**$ 143,046**	**$ 146,781**	**+3,735**
Travel and transportation of persons (21.0)	41	41	41	-
Transportation of things (22.0)	11	11	11	-
Rental payments to GSA (23.1)	9,214	9,214	9,214	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	1,289	1,289	361	-928
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	111	111	111	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	5,543	680	221	-459
Purchase of goods/services from govt. accounts (25.3)	13,497	-	-	-
Operation and maintenance of facilities (25.4)	243	243	43	-200
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	53	53	53	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	137	137	137	-
Subtotal Other Contractual Services	**$ 19,473**	**$ 1,113**	**$ 454**	**-659**
Equipment (31.0)	296	296	296	-
Land and Structures (32)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	-	-	10,523	+10,523
Insurance Claims and Indemnities (42.0)	179	179	179	-
Total Non-Pay Costs	**$ 30,614**	**$ 12,254**	**$ 21,190**	**+8,936**
Total Budget Authority by Object Class	**$ 155,300**	**$ 155,300**	**$ 167,971**	**+12,671**

FAMILY PLANNING

Object Class	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$ 3,824	$ 4,445	$ 6,514	+2,069
Other than full-time permanent (11.3)	57	58	58	-
Other personnel compensation (11.5)	57	58	58	-
Military personnel (11.7)	553	569	587	+18
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$ 4,491**	**$ 5,130**	**$ 7,217**	**+2,087**
Civilian benefits (12.1)	1,360	1,569	2,259	+690
Military benefits (12.2)	48	49	50	+1
Benefits to former personnel (13.1)	63	64	65	+1
Total Pay Costs	**$ 5,962**	**$ 6,812**	**$ 9,591**	**+2,779**
Travel and transportation of persons (21.0)	142	142	142	-
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	72	72	72	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	22	58	58	-
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)	4,269	4,269	4,269	-
Other services (25.2)	705	705	705	-
Purchase of goods/services from govt. accounts (25.3)	9,086	9,086	9,086	-
Operation and maintenance of facilities (25.4)	56	56	56	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	7	7	7	-
Operation and maintenance of equipment (25.7)	143	143	143	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	13	13	13	-
Subtotal Other Contractual Services	**$ 14,279**	**$ 14,279**	**$ 14,279**	-
Equipment (31.0)	56	56	56	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	265,946	265,060	315,802	+50,742
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$ 280,517**	**$ 279,667**	**$ 330,409**	**+50,742**
Total Budget Authority by Object Class	**$ 286,479**	**$ 286,479**	**$ 340,000**	**+53,521**

MANDATORY

(dollars in thousands)

OBJECT CLASS	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$ 50,890	$ 56,206	$ 63,308	+7,102
Other than full-time permanent (11.3)	633	644	826	+182
Other personnel compensation (11.5)	1,052	1,069	1,173	+104
Military personnel (11.7)	7,483	8,250	8,727	+477
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$ 60,058**	**$ 66,169**	**$ 74,034**	**+7,865**
Civilian benefits (12.1)	18,017	19,799	22,074	+2,275
Military benefits (12.2)	668	910	1,127	+217
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$ 78,743**	**$ 86,878**	**$ 97,235**	**+10,357**
Travel and transportation of persons (21.0)	62	64	-	-64
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	2,147	2,147	2,147	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	3,513	3,513	3,513	-
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)	11,019	11,019	11,019	-
Other services (25.2)	40,342	40,278	45,073	+4,795
Purchase of goods and services from government accounts (25.3)	109,980	109,966	122,786	+12,820
Operation and maintenance of facilities (25.4)	193	193	-	-193
Research and Development Contracts (25.5)	11,387	11,387	11,387	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	1	1	1	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	1	1	-	-1
Subtotal Other Contractual Services	**$ 172,923**	**$ 172,845**	**$ 190,266**	**+17,421**
Equipment (31.0)	3,713	3,692	3,692	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	4,557,799	4,550,219	4,402,973	-147,246
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**$ 4,740,157**	**$ 4,732,480**	**$4,602,591**	**-129,889**
Total Budget Authority by Object Class	**$ 4,818,900**	**$ 4,819,358**	**$4,699,826**	**-119,532**

Salaries and Expenses
Discretionary
(dollars in thousands)

OBJECT CLASS	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$ 165,999	$ 191,364	$ 201,528	+10,164
Other than full-time permanent (11.3)	4,271	4,330	4,373	+43
Other personnel compensation (11.5)	4,192	4,247	4,289	+42
Military personnel (11.7)	20,037	21,543	22,189	+646
Special personnel services payments (11.8)	100	101	102	+1
Subtotal personnel compensation	**$ 194,599**	**$ 221,585**	**$ 232,481**	**+10,896**
Civilian benefits (12.1)	57,915	66,301	70,114	+3,813
Military benefits (12.2)	2,168	2,646	2,725	+79
Benefits to former personnel (13.1)	1,901	1,930	1,949	+19
Total Pay Costs	**$ 256,583**	**$ 292,462**	**$ 307,269**	**+14,807**
Travel and transportation of persons (21.0)	1,210	1,414	1,406	-8
Transportation of things (22.0)	157	157	157	-
Rental payments to Others (23.2)	662	662	662	-
Communication, utilities, and misc. charges (23.3)	2,915	3,505	2,402	-1,103
Commercial Reimbursement (23.6)	-	-		-
Network use data transmission service (23.8)	-	-		-
Printing and reproduction (24.0)	111	111	111	-
Other Contractual Services: 25.0	-	-		-
Advisory and assistance services (25.1)	16,212	15,911	15,911	-
Other services (25.2)	230,904	232,547	239,010	+6,463
Purchase of goods/services from govt accounts (25.3)	187,003	176,718	176,286	-432
Operation and maintenance of facilities (25.4)	914	1,035	835	-200
Medical care (25.6)	3,419	3,419	3,419	-
Operation and maintenance of equipment (25.7)	13,258	12,451	12,597	+146
Subsistence and support of persons (25.8)	53	53	53	-
Discounts and Interest (25.9)	-	-		-
Supplies and materials (26.0)	704	694	697	+3
Subtotal Other Contractual Services	**$ 452,467**	**$ 442,828**	**$ 448,808**	**+5,980**
Total Non-Pay Costs	**$ 457,522**	**$ 448,677**	**$ 453,546**	**+4,869**
Total Budget Authority by Object Class	**$ 714,105**	**$ 741,139**	**$ 760,815**	**+19,676**

Salaries and Expenses
Mandatory
(dollars in thousands)

OBJECT CLASS	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Full-time permanent (11.1)	$ 50,890	$ 56,206	$ 63,308	+7,102
Other than full-time permanent (11.3)	633	644	826	+182
Other personnel compensation (11.5)	1,052	1,069	1,173	+104
Military personnel (11.7)	7,483	8,250	8,727	+477
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$ 60,058**	**$ 66,169**	**$ 74,034**	**+7,865**
Civilian benefits (12.1)	18,017	19,799	22,074	+2,275
Military benefits (12.2)	668	910	1,127	+217
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$ 78,743**	**$ 86,878**	**$ 97,235**	**+10,357**
Travel and transportation of persons (21.0)	62	64	-	-64
Transportation of things (22.0)	-	-	-	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	3,513	3,513	3,513	-
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)	11,019	11,019	11,019	-
Other services (25.2)	40,342	40,278	45,073	+4,795
Purchase of goods/services from govt accounts (25.3)	109,980	109,966	122,786	+12,820
Operation and maintenance of facilities (25.4)	193	193	-	-193
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	1	1	1	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	1	1	-	-1
Subtotal Other Contractual Services	**$ 161,536**	**$ 161,458**	**$ 178,879**	**+17,421**
Total Non-Pay Costs	**$ 165,111**	**$ 165,035**	**$ 182,392**	**+17,357**
Total Budget Authority by Object Class	**$ 243,854**	**$ 251,913**	**$ 279,627**	**+27,714**

Detail of Full-Time Equivalent Employment

Programs	2020 Actual			2021 Estimate			2022 Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Bureau of Primary Health Care:									
Direct:									
Health Centers/Tort	281	45	326	298	47	345	298	47	345
Free Clinics Medical Malpractice			-			-	-	-	-
Total, Direct:	**281**	**45**	**326**	**298**	**47**	**345**	**298**	**47**	**345**
Mandatory:									
Health Centers	194	9	203	217	11	228	251	11	262
School-based Health Centers- Facilities (ACA)	4	-	4	-	-	-	-	-	-
Total, Mandatory	**198**	**9**	**207**	**217**	**11**	**228**	**251**	**11**	**262**
Total FTE, BPHC	**479**	**54**	**533**	**515**	**58**	**573**	**549**	**58**	**607**
Health Workforce:									
Direct:									
National Health Service Corps	15	-	15	16	-	16	16	-	16
Loan Repayment/Faculty Fellowships	-	-	-	-	-	-	1	-	1
Centers for Excellence	1	-	1	1	-	1	2	-	2
Scholarships for Disadvantaged Students	6	-	6	7	-	7	7	-	7
Health Careers Opportunity Program	-	1	1	1	1	2	2	1	3
Health Care Workforce Assessment	5	-	5	8	-	8	8	-	8
Primary Care Training and Enhancement	5	1	6	5	1	6	5	1	6
Oral Health Training	5	1	6	5	1	6	5	1	6
Area Health Education Centers	3	-	3	3	-	3	3	-	3
Geriatric Programs	4	2	6	5	2	7	6	2	8
Behavioral Health Workforce Development Programs	11	3	14	11	4	15	19	4	23
Public Health/Preventive Medicine	4	-	4	4	-	4	4	-	4
NURSE Corps Loan Repayment & Scholarship	25	3	28	25	3	28	25	3	28
Advanced Education Nursing Program	9	-	9	10	-	10	10	-	10
Nurse Workforce Diversity	2	1	3	2	1	3	2	1	3
Nurse Education, Practice & Retention	4	1	5	4	1	5	4	1	5
Nurse Faculty Loan Program	2	1	3	3	1	4	3	1	4

Programs	2020 Actual			2021 Estimate			2022 Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Children's Hospitals GME Program	15	1	16	15	1	16	15	1	16
Total, Direct	**116**	**15**	**131**	**125**	**16**	**141**	**137**	**16**	**153**
Reimbursable:									
National Practitioner Data Bank	36	1	37	37	1	38	37	1	38
Total, Reimbursable:	**36**	**1**	**37**	**37**	**1**	**38**	**37**	**1**	**38**
Mandatory:									
National Health Service Corps	184	21	205	210	23	233	225	23	248
Teaching Health Center Graduate Medical Education	6	2	8	8	2	10	14	2	16
NURSE Corps	-	-	-	2	-	2	11	-	11
Behavioral Health Workforce Education and Training	-	-	-	-	-	-	6	-	6
Mental and Behavioral Health	-	-	-	1	-	1	6	-	6
Promote Mental and Behavioral Health	-	-	-	-	-	-	4	-	4
Total, Mandatory	**190**	**23**	**213**	**221**	**25**	**246**	**266**	**25**	**291**
Total FTE, Health Workforce	**342**	**39**	**381**	**383**	**42**	**425**	**440**	**42**	**482**
Maternal and Child Health Bureau:									
Direct:									
Maternal & Child Health Block Grant	47	-	47	53	-	53	70	-	70
Autism and Other Developmental Disorders	6	1	7	6	1	7	7	1	8
Sickle Cell Service Demonstrations	2	-	2	1	-	1	1	-	1
Early Hearing Detection and Intervention	4	-	4	4	-	4	4	-	4
Emergency Medical Services for Children	5	-	5	5	-	5	6	-	6
Healthy Start	10	4	14	15	4	19	15	4	19
Heritable Disorders	2	-	2	5	-	5	5	-	5
Pediatric Mental Health Care Access Grants	2	-	2	2	-	2	2	-	2
Screening and Treatment for Maternal Depression	1	-	1	1	-	1	2	-	2
Total, Direct:	**79**	**5**	**84**	**92**	**5**	**97**	**112**	**5**	**117**
Mandatory									
Family to Family Health Info Centers	1	-	1	1	-	1	1	-	1
Home Visiting	36	2	38	42	3	45	50	3	53

Programs	2020 Actual			2021 Estimate			2022 Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Pediatric Mental Health	-	-	-	-	-	-	3	-	3
Total, Mandatory	**37**	**2**	**39**	**43**	**3**	**46**	**54**	**3**	**57**
Total FTE, MCHB	**116**	**7**	**123**	**135**	**8**	**143**	**166**	**8**	**174**
HIV/AIDS Bureau:									
Direct:									
Ryan White Part A	39	6	45	42	6	48	42	6	48
Ryan White Part B	55	6	61	60	6	66	60	6	66
Ryan White Part C	40	13	53	46	13	59	50	13	63
Ryan White Part D	8	3	11	9	3	12	9	3	12
Ryan White Part F	4	1	5	5	1	6	5	1	6
Ryan White Part F Dental	-	-	-	-	-	-	-	-	-
Special Project of National Significance (SPNS)	3		3	2	-	2	2	-	2
Ending HIV/AIDS	3		3	26	3	29	26	3	29
Total, Direct:	**152**	**29**	**181**	**190**	**32**	**222**	**194**	**32**	**226**
Total FTE, HAB	**152**	**29**	**181**	**190**	**32**	**222**	**194**	**32**	**226**
Healthcare Systems Bureau:									
Direct:									
Organ Transplantation	3	-	3	5	-	5	5	-	5
National Cord Blood Inventory	4	1	5	4	1	5	4	1	5
C.W.Bill Young Cell Transplantation Program	6	-	6	6	-	6	6	-	6
Poison Control Centers	1	-	1	2	-	2	2	-	2
340B Drug Pricing Program/Office of Pharmacy Affairs	14	7	21	16	7	23	18	7	25
Hansen's Disease Center	37	6	43	38	6	44	38	6	44
Covered Countermeasures Compensation	2	2	4	3	2	5	11	2	13
Vaccine	13	5	18	15	5	20	15	5	20
Total, Direct:	**80**	**21**	**101**	**89**	**21**	**110**	**99**	**21**	**120**
Reimbursable:									
Hansen's Disease Center	-	-	-	1	-	1	1	-	1
Total, Reimbursable	**-**	**-**	**-**	**1**	**-**	**1**	**1**	**-**	**1**
Total FTE, HSB	**80**	**21**	**101**	**90**	**21**	**111**	**100**	**21**	**121**

Programs	2020 Actual			2021 Estimate			2022 Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Federal Office of Rural Health Policy:									
Direct:									
Rural Health Policy Development	3	-	3	3	-	3	3	-	3
Rural Health Outreach Grants	7	-	7	8	-	8	9	-	9
Rural Hospital Flexibility Grants	2	-	2	2	-	2	3	-	3
State Offices of Rural Health		-	-		-	-	-	-	-
Radiation Exposure Screening & Education Program	1	-	1	1	-	1	1	-	1
Black Lung		-	-		-	-	-	-	-
Telehealth	3	-	3	5	-	5	6	-	6
Rural Communities Opioid Response	14	-	14	19	-	19	21	-	21
Rural Residency	2	-	2	2	-	2	2	-	2
Total FTE, FORHP	**32**	**-**	**32**	**40**	**-**	**40**	**45**	**-**	**45**
Family Planning (Direct)*	11	1	12	16	1	17	34	1	35
Program Management (Direct)	722	40	762	829	42	871	844	42	886
OGAC Global AIDS (Reimbursable)	18	1	19	30	1	31	30	1	31
Office of Provider Support:			-						
Provider Relief Fund Supplemental Funding	13	-	13	69	4	73	69	4	73
Uninsured Supplemental Funding	2	-	2	4	-	4	4	-	4
Telehealth Supplemental Funding	-	-	-	1	-	1	1	-	1
Tribal Programs Supplemental Funding	-	-	-	2	-	2	2	-	2
Rural Health Clinics Supplemental Funding	-	-	-	2	-	2	2	-	2
COVID 19 Reporting Supplemental Funding	-	-	-	1	-	1	1	-	1
Total, Office of Provider Support	**15**	**-**	**15**	**79**	**4**	**83**	**79**	**4**	**83**
Subtotal Direct (non add)	1,473	156	1,629	1,758	168	1,926	1,842	168	2,010
Subtotal Reimbursable (non add)	54	2	56	68	2	70	68	2	70
Subtotal Mandatory (non add)	425	34	459	481	39	520	571	39	610
Subtotal, HRSA FTE	**1,952**	**192**	**2,144**	**2,307**	**209**	**2,516**	**2,481**	**209**	**2,690**

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	
Program	**Section**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**
Community Health Center Fund:													
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(1)	1,000,000	56	1,200,000	47	1,500,000	60	2,144,716	95	3,509,111	122	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	-	-	-	-	3,600,000	240
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
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
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
Family to Family Health Information Centers:													
Non-P.L. 111-148 Mandatory	H.R. 3590, Section 5507	5,000	1	5,000	1	5,000	-	5,000	1	5,000	1	5,000	1
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
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**

		FY 2017		FY 2018		FY 2019		FY 2020		FY 2021		FY 2022	
Program	**Section**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**
Community Health Center Fund:													
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(1)	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		3,510,661	225	3,800,000	174	4,000,000	177	4,000,000	203	4,000,000	228	3,905,348	262
Health Centers - Facilities Construction	H.R. 3590, Section 10503(c)	-	-	-	-	-	-	-	-	-	-	-	-
School-Based Health Centers-Facilities	H.R. 3590, Section 4101	-	9	-	9	-	8	-	4	-	-	-	-
National Health Service Corps:													
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(2)	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		288,610	225	310,000	206	310,000	209	310,000	205	310,000	233	292,330	248
GME Payments Teaching Health Centers:	H.R. 3590, Section 5508												
P.L. 111-148 Mandatory		-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		55,860	8	126,500	10	126,500	7	126,500	8	126,500	10	119,290	16
Family to Family Health Information Centers:													
Non-P.L. 111-148 Mandatory	H.R. 3590, Section 5507	4,655	1	6,000	1	6,000	1	6,000	1	6,000	1	5,658	1
Home Visiting Program:													
P.L. 111-148 Mandatory	H.R. 3590, Section 2951	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		372,400	44	400,000	42	400,000	39	376,40000	38	377,200	45	377,200	53
Total		**4,375,000**	**519**	**4,232,186**	**512**	**4,642,500**	**442**	**4,818,900**	**441**	**4,819,358**	**441**	**4,699,826**	**580**

Programs Proposed for Elimination

The Health Resources and Services Administration has no programs proposed for elimination in the FY 2022 President's Budget.

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.)*

FY20 included (7) Separations of which (3) resigned (2) reassigned and (2) retired. Their average length of service was 9 years.
In FY20, we have (10) vacancies. At this time, (7) vacancies announcement have been posted and (2) vacancies have been filled at this point.
To date there have been (3) Accessions.

3-4) Please complete the table below with details of the PCA agreement for the following years:

	PY 2020 (Actual)	**CY 2021 (Estimates)**	**BY* 2022 (Estimates)**
3a) Number of Physicians Receiving PCAs	26	34	34
3b) Number of Physicians with One-Year PCA Agreements	5	0	0
3c) Number of Physicians with Multi-Year PCA Agreements	21	34	34
4a) Average Annual PCA Physician Pay (without PCA payment)	$171,837	$170,800	$170,800
4b) Average Annual PCA Payment	$22,086	$21,658	$21,658

*FY 2020 data will be approved during the FY 2021 Budget cycle"

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 FY19 there were (4) Separations of which (2) resigned (1) reassigned and (1) retired. Their average length of service was 9.5 years. PCA in addition to their base salary was needed to meet their current salary or salary expectations.

6) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

n/a

Drug Control Budget
Health Resources and Services Administration

Resource Summary

	Budget Authority (in millions)				
	FY 2020		FY 2021		FY 2022
	Enacted	Supplemental	Enacted	Supplemental	President's Budget
Drug Resources by Function					
Prevention	$109.300	--	$93.600	--	$123.500
Bureau of Primary Health Care	$54.300	--	$54.000	--	$54.000
Federal Office of Rural Health Policy	$55.000	--	$39.600	--	$69.500
Treatment	$543.700	--	$556.400	--	$581.500
Bureau of Primary Health Care	$488.700	--	$486.000	--	$486.000
Federal Office of Rural Health Policy	$55.000	--	$70.400	--	$95.500
Total Drug Resources by Function	**$653.000**	**--**	**$650.000**	**--**	**$705.000**
Drug Resources by Decision Unit					
Bureau of Primary Health Care	$543.000	--	$540.000	--	$540.000
Federal Office of Rural Health Policy	$110.000	--	$110.000	--	$165.000
Total Drug Resources by Decision Unit	**$653.000**	**--**	**$650.000**	**--**	**$705.000**
Drug Resources Personnel Summary					
Total FTEs (direct only)	--	--	--	--	--
Drug Resources as a percent of Budget					
Total Agency Budget (in Billions)	$11.9		$12.1		$14.2
Drug Resources percentage	5.5%		5.4%		5.0%

METHODOLOGY

BPHC

For each of fiscal years 2016 – 2019, HRSA provided new annual ongoing grant funding supporting SUD/MH service expansion in health centers totaling $545 million projected to remain in Health Center Program base continuation funding in subsequent fiscal years. Subsequently in FY 2020, HRSA found that 36 health centers were unable to demonstrate sufficient progress to merit continuing their AIMS awards, resulting in a $2 million total reduction in drug control funding. For FY 2021, HRSA found that 63 health centers were unable to demonstrate sufficient progress to merit continuing their SUD-MH awards, resulting in a $3 million total reduction in drug control funding. All of this targeted supplemental funding is scored as drug control funding.

FORHP
The allocation of funds for the Rural Community Opioid Response Program (RCORP) is through competitive grants and cooperative agreements. The entirety of these programs is scored as drug control funding.

BUDGET SUMMARY

The drug control budget for the Health Resources and Services Administration at the FY 2022 President's Budget Request is $705.0 million, which is $55.0 million above the FY 2021 Enacted.

Bureau of Primary Health Care

FY 2022 President's Budget Request: $540 million
(level with FY 2021 Enacted)

In FY 2022, the Health Center program plans to support more than 1,400 grantees and provide primary health care services to over 31 million patients, including access to ongoing SUD services. Health centers will continue to provide SUD services for all age groups.

In FY 2019, the Health Center Program awarded $201 million in new SUD/MH ongoing annual awards. The reported amount of estimated drug resources for FY 2019 and FY 2020, and those projected for FY 2021 through FY 2022, reflect the ongoing annual SUD/MH awards initiated in FY 2016 through FY 2019, health center continuation awards made in FY 2020, and projections for FY 2021 through FY 2022.

Federal Office of Rural Health Policy

FY 2022 President's Budget Request: $165 million
($55 million above FY 2021 Enacted)

In FY 2022, 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 2022 President's Budget Request will fund new and continuing grants and cooperative agreements for RCORP to strengthen the infrastructure and capacity within rural communities at high risk for substance use disorders and provide needed prevention, treatment, and recovery services to rural residents.

The RCORP initiative is currently composed of three active grant programs and four cooperative agreements that provide technical assistance coordination, program evaluation, and dissemination of evidence-based programs and best practices.

- **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.

The Implementation grants that HRSA fully funded in FY 2020 and FY 2021 will remain active in FY 2022. HRSA will also make new Implementation awards in FY 2022.

- **RCORP-Neonatal Abstinence Syndrome** provides multi-year support to rural communities to reduce the prevalence of neonatal abstinence syndrome by improving systems of care, family supports, and social determinants of health. HRSA will support the continuation of 30 awards in FY 2022.

- **RCORP-Psychostimulant Support** provides multi-year funding to rural communities to address psychostimulant misuse, including methamphetamine misuse, through prevention, treatment, and recovery interventions. The three-year grants that HRSA will fully fund in FY 2021 will remain active in FY 2022. HRSA will also make new Psychostimulant Support awards in FY 2022.

In FY 2022, HRSA will continue funding the Rural Centers of Excellence on Substance Use Disorders program that supports the dissemination of best practices related to the treatment for and prevention of substance use disorders within rural communities. HRSA will also continue supporting a cooperative agreement to conduct program-wide evaluation activities for the RCORP Initiative and will re-compete funding for one cooperative agreement award to provide technical assistance to RCORP grantees. Additionally, HRSA will continue to support the Rural Behavioral Health Workforce Centers cooperative agreements, which aim to improve access to behavioral health care services and gainful employment opportunities for rural residents in the Northern Border Regional Commission service area.

The request will also provide HRSA with flexibility to respond to the evolving needs of the opioid epidemic. Drug overdose deaths in rural counties have increased from 4.0 per 100,000 in 1999 to 19.6 in 2019. In 2019, the rate of drug overdose deaths involving psychostimulants with abuse potential was 1.4 times higher in rural counties than in urban counties.[287] Moreover, drug overdose deaths have accelerated during the COVID-19 pandemic.[288] In FY 2021, HRSA expanded RCORP's focus to include psychostimulants such as methamphetamines and for FY 2022, HRSA plans to fund additional awards to address psychostimulants as well as continue to allow rural communities to broaden their focus on other SUDs in addition to opioids.

Additionally, HRSA recognizes that about half of those who experience a substance use disorder during their lives will also experience a mental illness, and vice versa.[289]RCORP award recipients have noted continuing problematic or worsening COVID-19 impacts on behavioral health**.** Approximately 58 percent of Mental Health Professional Shortage Areas are in rural areas, representing nearly 26 million people who do not have adequate access to mental healthcare providers.[290] As a result, in FY 2022, HRSA will fund new awards for a pilot program allowing rural communities to respond to new and ongoing behavioral health needs of rural residents impacted by SUD/OUD. HRSA will also continue to solicit feedback from rural stakeholders and engage and partner with other Federal agencies to promote a coordinated

[287] Urban–Rural Differences in Drug Overdose Death Rates, 1999–2019
[288] Overdose Deaths Accelerating During COVID-19; see also Provisional Drug Overdose Death Counts
[289] Part 1: The Connection Between Substance Use Disorders and Mental Illness
[290] Designated HPSA Quarterly Summary, 2020

approach to combatting this devastating epidemic and identifying additional priority areas. HRSA will include health and racial equity as a key component of any FY 2022 funded RCORP programs.

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 2019 Target	FY 2019 Achieved
» Number of Health Center Program grantees providing SBIRT services	730	802
» Number of Health Center Program grantees providing substance use disorder counseling and treatment services	760	865

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 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 achieved by training health center clinicians to provide high quality and expanded services for those with addiction disorders. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based process used by primary care providers in health centers to detect and treat addiction effectively. Because many communities served by health centers have a high burden of addiction disorders, many health centers have chosen to co-locate and integrate SUD specialty services reflecting efficient and effective approaches in meeting patient needs. The integration of SUD services may include the provision of enhanced services, such as medication-assisted treatment (MAT), by primary care clinicians. In addition, HRSA provides guidance to health centers on collaboration with State agencies to ensure that appropriate standards of care are implemented and that referrals are coordinated.

Screening for substance use disorders has increased 93 percent since 2016 with the number of patients receiving screening, brief intervention, referral and treatment (SBIRT) increasing from 716,677 in 2016 to 1,381,408 in 2019. From 2016–2019, the number of health center providers eligible to prescribe MAT increased over 300 percent (from 1,700 in 2016 to 7,095 in 2019) and the number of patients receiving MAT increased 266 percent (from 39,075 in 2016 to 142,919 in 2019).

In 2019, 865 health centers provided SUD counseling and treatment services, exceeding the program 2019 target. Also in 2019, 802 health centers provided SBIRT services, exceeding the program FY 2019 target.

The Rural Communities Opioid Response Program's goal is to reduce the morbidity and mortality associated with opioid overdoses in rural communities through the strengthening of the organizational and infrastructural capacity of multi-sector consortiums. HRSA has developed OMB-approved performance measures to support this large-scale initiative, and the baseline data is being analyzed in order to identify appropriate targets.

Significant Items

TAB

SIGNIFICANT ITEMS FOR INCLUSION IN L-HHS APPROPRIATIONS COMMITTEE FY 2022 CONGRESSIONAL JUSTIFICATION

CONSOLIDATED APPROPRIATIONS ACT, 2021 P.L. 116-260 (December 27, 2020)

1. **Area Health Education Centers (AHEC).—**The agreement includes a $2,000,000 increase for new competitive grants to expand experiential learning opportunities through simulation labs designed to educate and train healthcare professionals serving rural, medically underserved communities, that shall include as an allowable use the purchase of simulation training equipment. HRSA is directed to consider and prioritize projects from AHEC recipients with a history of successfully graduating and placing graduates in rural, medically underserved communities. **(Page 10)**

   Action to be Taken

   In FY 2021, HRSA plans to award up to 8 new cooperative agreements to support experiential learning opportunities through simulation labs. This training program is designed to develop and enhance education and training networks between communities, academic institutions, and community-based organizations through the expansion of experiential learning opportunities. It includes expanding experiential learning through the use of innovative simulation-based technology and equipment to strengthen the capacity of community-based training. It will augment traditional AHEC program activities, including the AHEC Scholars Program to increase diversity and distribution among health professionals, enhance health care quality, and improve health care delivery to rural and underserved areas and populations. The AHEC-SET Program intends to enhance the capacity of health professions students to address the complex health care needs of those living in rural and medically underserved areas as authorized in Section 751 of the Public Health Service (PHS) Act.

2. **Nurse Education, Practice, Quality and Retention.—**The agreement includes an increase of $3,000,000 for new competitive grants to expand experiential learning opportunities that shall include as an allowable use the purchase of simulation training equipment. HRSA shall give priority to grantees located in a medically-underserved area in a State with an age-adjusted high burden of stroke, heart disease, and obesity, and HRSA is encouraged to prioritize submissions that support high poverty rate communities**. (Page 11)**

   Action to be Taken

   In FY 2021, HRSA plans to award an estimated 11 new grants using the rank order list from the FY 2020 NEPQR-SET competition. HRSA published the NEPQR-SET NOFO with the goal to enhance nurse education and strengthen the nursing workforce through the expansion of experiential learning opportunities. This includes using simulation-based technology, including equipment, to advance the health of patients, families, and

communities in rural and medically underserved areas experiencing diseases and conditions that affect public health such as: high burden of stroke, heart disease, behavioral and mental health, maternal mortality, HIV/AIDS, and/or obesity. This program strengthens the capacity of undergraduate public health nursing students to address the complex health care needs of those living in rural and medically underserved areas.

3. **Regional Pediatric Pandemic Network.—**The agreement provides $10,000,000 within SPRANS to establish a regional pediatric pandemic network comprised of five children's hospitals (centers) as defined by section 340E of the PHS Act (Public Law 106-129) or their affiliated university pediatric partners. The Network shall coordinate among the Nation's pediatric hospitals and their communities in preparing for and responding to global health threats, including the coordination, preparation, response, and real-time dissemination of research-informed pediatric care for future pandemics. Funding shall be equitably distributed among the five centers and the centers shall be located in geographically diverse areas of the country to ensure a regional approach to the network. HRSA is urged to consider eligible pediatric quaternary hospitals or their affiliated university pediatric partners that have participated in a recent pediatric therapeutic or vaccination clinical trial or other pediatric disaster care program. HRSA is directed to establish at least one such center in a State within both the Delta Regional Authority and Appalachian Regional Commission. HRSA is directed to establish at least one such center at a pediatric hospital in each of HRSA's regions V and VII, and at least one such center in region VIII or X. HRSA is also directed to establish at least one such center at a pediatric hospital that is a primary National Institutes of Health Clinical and Translational Science A ward grantee or a partner that contributes to the budget request of an academic medical center's application. **(Page 13)**

Action to be Taken

HRSA plans to issue a cooperative agreement by September 2021 to support the establishment of a Regional Pediatric Pandemic Network, which will be comprised of five children's hospitals located in geographically diverse areas across the United States, as described in the Joint Explanatory Statement to the Consolidated Appropriations Act 2021. The Network will coordinate among the Nation's pediatric hospitals and their communities in preparing for and responding to global health threats, including the coordination, preparation, response, and real-time dissemination of research-informed pediatric care for future pandemics.

4. **Ending the HIV Epidemic.—**The agreement includes $105,000,000 within the Ryan White program for the Ending the HIV Epidemic initiative. The agreement encourages the acceleration of the development of oral, ultralong-acting, sustained-release therapies as part of the Ending the HIV Epidemic initiative. **(Page 15)**

Action to be Taken

Once approved by the Food and Drug Administration, people with HIV would benefit greatly from an oral, ultralong-acting sustained-release therapy to increase adherence to

medication and achieve viral suppression. Research studies demonstrate that people with HIV who take HIV medications 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.

The HRSA Ryan White HIV/AIDS Program (RWHAP) AIDS Drug Assistance Program (ADAP) could include these new therapies on their formulary, once they are approved. RWHAP ADAPs are required to include at least one drug from each approved class of HIV antiretroviral medications on their formulary. However, both the development of such therapies and their approval are outside the purview of HRSA.

5. **Organ Allocation Policy.—**HRSA and the Organ Procurement and Transplantation Network are encouraged to ensure the process for changing organ allocation policies is transparent, thorough, and accommodates the recommendations of transplantation and organ donation professionals. **(Page 16)**

   Action to be Taken
   HRSA and the Organ Procurement and Transplantation Network (OPTN), which is comprised of organ transplantation and donation professionals as well as representatives of donor and recipient families, are committed to an open and deliberative process for OPTN policy development including organ allocation policies. HRSA will continue to ensure that these processes are thorough and transparent with opportunity for the public to comment on all proposed OPTN policy changes.

6. **Rural Health Outreach.—**The agreement provides not less than $24,000,000 for the Delta States Rural Development Network Grant Program, including $12,000,000 to support HRSA's collaboration with the Delta Regional Authority, as described under this heading in Conference Report 115-952. The agreement encourages HRSA to consult with the Northern Border Regional Commission (NBRC) on awarding, implementing, administering, and monitoring grants under rural health outreach and to align awards as closely as possible with the region's strategic vision and economic and community development plans. The agreement provides no less than $1,000,000 to support HRSA's collaboration with the NBRC 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. **(Page 16)**

   Action to be Taken
   HRSA will continue to collaborate with DRA, utilizing $12,000,000 to support technical assistance and rural hospitals in the Delta region.

   In collaboration with the NBRC, HRSA is developing a new network planning program and invest $1,000,000 in NBRC counties. The goal of this program is to help rural communities, in the NBRC service area, identify and better address their health care needs. This includes solutions related to access to care and workforce, or a focus on

helping small rural hospitals improve their financial viability and operational performance.

7. **Telehealth Centers of Excellence (COE).—**The agreement includes $6,500,000 for the Telehealth COE awarded sites. The agreement directs HHS and HRSA to continue to utilize the expertise of the COEs in the Ending the HIV Epidemic initiative to develop best practices for utilizing telehealth in HIV prevention, care, and treatment. **(Page 17)**

   Action to be Taken
   HRSA plans to award $6,500,000 to the Telehealth Centers of Excellence (COE) through a limited competition NOFO, where only the incumbent organizations are eligible to apply. The Telehealth COE will continue to develop best practices for utilizing telehealth in HIV prevention, care, and treatment.

8. **Rural Communities Opioids Response.—**The agreement includes $110,000,000 to continue the program, including $1,500,000 of the funds available for career and workforce training activities in the NBRC region to assist individuals affected by a substance use disorder. Within the funding provided, the agreement includes $10,000,000 to continue the three Rural Centers of Excellence (Centers), as established by Public Law 115-245 and as directed by Conference Report 115-952, and continued in Public Law 116-94 and further directed in the explanatory statement to accompany Public Law 116-94. In addition to the conditions set forth in Conference Report 115-952, the Centers shall work to create a collaborative, multi-partner regional clearinghouse to identify predictors of substance use disorder treatment response. **(Page 17)**

   Action to be Taken
   In collaboration with the NBRC, HRSA will provide $1,500,000 to support cooperative agreements in the NBRC service area. The cooperative agreements will establish Rural Behavioral Health Workforce Centers to improve access to behavioral health care services and gainful employment opportunities for rural residents with behavioral health needs, particularly substance use disorder.

9. **Rural Populations.—**The agreement directs HRSA to provide a briefing to the Committees within 90 days of enactment of this Act on changes to the rural designation methodology and additional factors that affect eligibility for the purposes of rural health grants funded by this Act. **(Page 17)**

   Action to be Taken
   HRSA issued a Federal Register Notice in January 2021 responding to comments and describing a change to the definition of rural for the determination of geographic areas eligible to apply for or receive services by rural health grants.

1. **Health Care for the Homeless.—**Recognizing the complex and serious health challenges homeless individuals face, the Committee urges HRSA to prioritize access to expanded behavioral health services, including mental health services and substance use disorder treatment services. **(Page 41)**

   Action to be Taken
   In each year from FY 2016 to FY 2019, through increased Health Center Program appropriations, HRSA provided targeted ongoing grant awards to existing health centers to expand substance use disorder and mental health services to health center patients, including homeless patients. HRSA estimates that the FY 2021 enacted appropriation level will support approximately $540 million to the provision of mental health and substance use disorder services in ongoing health center continuation awards, including approximately $139 million in Health Care for the Homeless funding for 298 health centers. Additionally, approximately $329 million in supplemental funding under the Coronavirus Aid, Relief, and Economic Security Act and approximately $1.7 billion in supplemental funding under the American Rescue Plan Act was awarded by HRSA to health centers receiving annual Health Care for the Homeless funding which can also be used to supported behavioral health services.

2. **Health Centers and Home Visiting Programs.—**The Committee supports HRSA's continued promotion of expanded partnerships between Health Centers and evidence-based home visiting programs to improve maternal and child health outcomes in high-need communities. Home visiting programs can also provide cost-effective benefits such as care coordination and service referral that help Health Centers achieve community health goals. As such, the Committee directs the Bureau to issue written guidance on how these partnerships fit within Health Centers' scope of practice. **(Page 42)**

   Action to be Taken
   HRSA will continue to promote and encourage partnerships between health centers and home visiting programs, including the provision of written communication to health centers regarding coordination with home visiting programs.

3. **Health Centers as Primary Dental Homes.—**The Committee recognizes the importance of Health Centers in providing integrated care to the nation's underserved communities. Health Centers serve as a primary dental home for many who would otherwise face barriers to dental care. The Committee is aware that some Health Centers have partnered with Community Dental Health Coordinators (CDHCs) to provide patients with greater access to dental care. CDHCs provide community-based prevention, care coordination, and patient navigation to underserved populations in rural, urban, and Native American communities. The Committee encourages HRSA to work with Health Centers to expand their work in this area. **(Page 42)**

Action to be Taken

HRSA will continue to work with health centers to increase and enhance access to integrated oral health services, including the promotion of partnerships with Community Dental Health Coordinators, as appropriate. Oral health continues to be a priority area and health center data is collected through annual Health Center Program uniform data system (UDS) measures for clinical quality reporting and improvement strategies. Health centers continue to experience an increase in the number of dental patients served, approximately 6.7 million dental patients were served in 2019, a 29% increase in the number served since 2015. In 2015, we introduced the Dental Sealants Measure into the UDS to capture the percentage of children age 6 to 9 years, at moderate to high risk, who received a sealant on a first permanent molar during the reporting period. In 2019, health centers achieved a 17.9% increase from 2016 UDS sealant measure data (42.4% vs 56.8%).

BPHC has also supported a training and technical assistance (T/TA) cooperative agreement with the National Network for Oral Health Access (NNOHA) since 2015. Current T/TA priorities and activities include optimizing oral health care as part of integrated, comprehensive primary health care; improving performance on the UDS oral health clinical quality measure; supporting health center oral health workforce recruitment and retention, oral health and primary services HIT integration; and care team capacity building. This T/TA is provided through learning collaboratives, state/regional/national trainings, webinars, newsletters, toolkits, and fact sheets.

Dental workforce is also a priority and is collected annually in our UDS data. The Health Center Program's dental workforce (dentists and dental hygienists) has experienced a 35 percent increase since 2015. Workforce well-being and satisfaction is also a priority. In 2020 and over the next few years, HRSA will be supporting learning collaboratives, listening sessions, well-being assessment through survey administration and data analysis, and targeted technical assistance based upon workforce well-being needs to all of our health center FTEs, including the dental workforce.

Additionally, the role of telehealth in increasing access and quality of care will continue to be a priority area after the response to COVID-19, and will likely include a focus on the role of tele-dentistry.

4. **Rural Health Workforce.—**The Committee encourages HRSA to explore opportunities for collaboration and partnership with schools and programs that offer rural residencies, rural health certificates, or otherwise recognized rural curriculum in order to increase the placement of health care providers and professionals with rural health training in HRSA Health Workforce Programs. The agency shall report to the Committees on these efforts within 60 days of enactment of this Act. **(Page 43)**

Action to be Taken

The information contained in the Rural Health Workforce Report to Congress (RTC) will be provided in the Rural Medical Provider Shortage Appropriation RTC. HRSA anticipates the Rural Medical Provider Shortage RTC will be sent to Congress in 2021.

5. **Health Professionals Staffing Shortages Report.—**The Committee recognizes the current and growing shortage of primary care physicians, psychiatrists, behavioral health specialists, and geriatric medical professionals. The Committee looks forward to receiving the Health Professional Staffing Shortages report requested in House Report 116–62, which was due by June 20, 2020. **(Page 44)**

   Action to be Taken
   The requested report was provided to the Committees July 17, 2020.

6. **National Health Service Corps.—**The Committee directs HRSA to examine the application processes and eligibility requirements for both NHSC recruits and provider locations, including the HPSA qualification and scoring. The Committee looks forward to receiving the report, as directed in House Report 116–62, with recommendations on how the NHSC program, including the HPSA application and scoring process, may be modified to increase recruitment and field strength as well as diversify provider sites on the roles of Department agencies in addressing gaps in maternal mental health, within 60 days of enactment of this Act. **(Page 44)**

   Action to be Taken
   The requested report was provided to the Committees July 22, 2020.

7. **Centers of Excellence.—**The Committee notes that COEs disproportionately educate health professionals from minority and underserved backgrounds and address the need for a diverse and culturally competent American healthcare workforce. The Committee looks forward to receiving the report requested in House Report 116–32 on achievements and challenges faced by COEs and the contribution COEs make to workforce development. **(Page 45)**

   Action to be Taken
   The requested report was provided to the Committees June 15, 2020.

8. **Health Careers Opportunity Program.—**The Committee notes that HCOPs assist students from minority and economically disadvantaged backgrounds navigate careers into the health professions. Given the volume of HCOP scholars that return or remain in medically underserved communities, the Committee encourages HRSA's Bureau of Health Workforce to continue its improvement of the diversity and distribution of needed health care professionals through National Health Career Opportunity Program Academies and urges HRSA to report updates on HCOP pipeline activity back to Congress within 120 days of the enactment of this Act. **(Page 45)**

   Action to be Taken
   Updates were provided to the Committees on July 1, 2020.

9. **Oral Health Training and Dental Faculty Loan Repayment Program.—**Within the total for Oral Health Training, the Committee includes not less than $12,000,000 for General Dentistry Programs and not less than $12,000,000 for Pediatric Dentistry Programs. The Committee directs HRSA to provide continuation funding for section 748 Dental Faculty Loan Program (DFLRP) grants initially awarded in fiscal years 2016, 2017, and 2018. The Committee continues to support DFLRP 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 affiliate sites. **(Page 45)**

   Action to be Taken
   In FY 2021, HRSA plans to provide continuation funding for the 27 Postdoctoral Training in General, Pediatric and Public Health Dentistry grantees initially awarded in FY 2020 and 6 Primary Care Medicine and Dentistry Clinician Educator Career Development awards. In FY 2021, HRSA published the Dental Faculty Loan Repayment NOFO that included a preference for pediatric dentistry faculty, funding an estimated 8 awards. HRSA will provide full continuation funding for 10 DFLRP grantees initially awarded in FY 2017 and 11 DFLRP grantees awarded in FY 2018. HRSA also published the Primary Care Faculty Career Development NOFO and will have 1 awardee. In FY 2022, HRSA anticipates funding 15 awards in the Predoctoral Training in General, Pediatric and Public Health Dentistry and Dental Hygiene, 8 awards in the Dental Faculty Loan Repayment Program, 8 awards in the Primary Care Dental Faculty Development Program and 32 awards in the Grants to States to Support Oral Health Workforce Activities.

10. **AHEC Oral Health Projects.—**The Committee encourages HRSA to support AHEC oral health projects that establish primary points of service and address the need to help patients find treatment outside of hospital emergency rooms. The Committee encourages HRSA to work with programs that have already been initiated by some State dental associations to refer emergency room patients to dental networks. **(Page 45)**

    Action to be Taken
    In FY 2021, HRSA will continue to support 48 Area Health Education Centers (AHEC), originally funded in 2017. A portion of this funding will assist grantees in their efforts to expand oral health projects. AHEC awards will allow grantees to continue to collaborate with community-based organizations to expand access to oral health care, including state dental associations, community health centers, and state offices of rural health. In addition, AHEC grantees will utilize funding to increase their expansion of continuing education opportunities for practicing oral health care professionals and expand rural/underserved interprofessional experiential clinical training opportunities. The funding also allows AHECs to enhance community health worker trainings focused on preventing oral disease, promoting healthy behaviors, developing self-management goals, and improving access to care for diverse and underserved patient populations.

11. **Graduate Psychology Education.—**Within the total for MBHET, the Committee recommendation includes $20,000,000, $2,000,000 above the fiscal year 2020 enacted

level and the fiscal year 2021 budget request, for the interprofessional Graduate Psychology Education (GPE) Program to support health service psychologists trained to provide integrated services to high-need, underserved populations in rural and urban communities. In addressing the opioid epidemic, the Committee recognizes the growing need for highly trained mental and behavioral health professionals to deliver evidence-based behavioral interventions for pain management. The Committee encourages HRSA to help integrate health service psychology trainees at FQHCs. **(Page 46)**

Action to be Taken

HRSA provided supplemental funding to the Graduate Psychology Education (GPE) programs in FY 2021. The supplement helps integrate health service psychology trainees in FQHCs by providing training to existing and potential partnering HRSA-supported Health Center sites on the utilization of evidence-based pain management interventions for the prevention and treatment of OUD and other SUD and its relationship with social determinants of health.

12. **BHWET Support in Rural Settings.—**The Committee is concerned about the utilization of BHWET programs by rural residents and in rural areas. In the 2017–2018 academic year, only 27 percent of BHWET trainees were from rural areas, 25 percent of BHWET clinical sites were located in rural settings, and 20 percent of BHWET trainees were receiving training in rural areas. The Committee encourages HRSA to increase the number of trainees from rural areas, clinical sites located in rural areas, and trainees receiving training in rural areas. The Committee directs HRSA to update the Committee on such efforts within 180 days of enactment of this Act. **(Page 46)**

Action to be Taken

HRSA competed the BHWET Pro and BHWET Para programs in FY 2021. Both programs included a funding priority for applications that supported rural or underserved communities. HRSA will provide an update to Congress once those awards are made.

13. **Peer Support Specialists in the Opioid Use Disorder Workforce.—**Within the total for BHWET, the Committee includes $15,000,000, an increase of $5,000,000 above the fiscal year 2020 enacted level and $15,000,000 above the fiscal year 2021 budget request, to fund training, internships, and national certification for mental health and substance abuse peer support specialists to create an advanced peer workforce prepared to work in clinical settings. The Committee further recommends that consideration should be given to community-based experiential training for students focusing on veterans, first responders, or marginalized populations. **(Page 46)**

Action to be Taken

In FY 2021, HRSA competed the BHWET Paraprofessional program. This program focuses on increasing the number of peer support specialist and other behavioral health related paraprofessionals receiving training in behavioral health including but not limited to OUD and other SUD prevention and treatment.

14. **Mental and Substance Use Disorder Workforce Training Demonstration.—**The Committee remains concerned by the lack of pediatric and adolescent addiction medicine and addiction psychiatry expertise. Currently, there are insufficient opportunities to effectively train a robust mental health and substance use disorder workforce. Only 75 of the nation's 179 accredited medical schools offer addiction medicine fellowships, and only one program focuses on fellowship opportunities for pediatric and adolescent addiction medicine and addiction psychiatry. This gap is even more troubling given that the onset of mental health disorders and substance use disorders are most likely to occur at a young age. Substance use disorders prevent children and adolescents from reaching their full potential and are antecedent to addiction in adulthood, and it is evident that our nation is not equipped to support this population. Therefore, the Committee strongly encourages HRSA to include an adequate number of funding awards to fellowship programs focused on increasing the number of board-certified pediatric and adolescent addiction medicine and addiction psychiatry subspecialists. **(Page 47)**

Action to be Taken

In FY 2022, HRSA anticipates making $24 million in continuing awards for the Addiction Medicine Fellowship (AMF) program, which will increase the number of board certified addiction medicine and addiction psychiatry specialists working in underserved, community-based settings that integrate primary care with mental health disorders and substance use disorder (SUD) prevention and treatment services. In FY 2021 and FY 2022, HRSA will also fund the Integrated Substance Use Disorder Training Program (ISTP) to expand the number of nurse practitioners, physician assistants, health service psychologists, and social workers trained to provide mental health and SUD services in underserved community-based settings that integrate primary care and mental health and SUD services.

15. **Nurse Practitioner Optional Fellowship Program.—**The Committee provides $5,000,000, the same as the fiscal year 2020 enacted level and $5,000,000 above the fiscal year 2021 budget request, to make grants to establish or expand optional community-based nurse practitioner fellowship programs that are accredited for practicing postgraduate nurse practitioners (NPs) in primary care or behavioral health. The Committee directs HRSA to give preference to FQHCs, as defined by section 1861(aa)(4) of the Social Security Act. **(Page 47)**

Action to be Taken

In FY 2021, HRSA plans to provide continuation funding for the 10 Advanced Nursing Education Nurse Practitioner Residency Integration Program (ANE-NPRIP) grantees initially awarded in FY 2020. HRSA published the ANE-NPRIP NOFO with the goal of preparing new primary care or behavioral health nurse practitioners (NPs) to work in integrated, community-based settings. The NOFO included a preference for service to rural and underserved populations, and Federally Qualified Health Centers; and is aimed at the expansion and/or enhancement of existing 12-month NP residency programs in primary care or behavioral health and in an integrated, community-based setting. The NP Residency Programs grant recipients must be accredited or in the accreditation process. For this program, HRSA received 15 Applications, planned for 5 awards, but was able to

make 10 awards. Out of the 10 awards, 5 grantees are FQHCs (50%) and 3 of the grantees partner with FQHCs (30%). One of the 10 grantees is mainly focused on serving rural areas, while 3 of the 10 awardees are partnered with rural health clinics.

16. **Experiential Learning Opportunities.—**Within the total for NEPQR, the Committee includes not less than $2,000,000, the same as the fiscal year 2020 enacted level and $2,000,000 above the fiscal year 2021 budget request, for competitive grants to enhance nurse education and strengthen the nursing workforce through the expansion of experiential learning opportunities. The Committee encourages HRSA to support qualifying nurse education training programs at community colleges throughout the country. The Committee directs HRSA to ensure that these grants include as an allowable use the purchase of simulation training equipment. The Committee also directs HRSA to give priority to grantees located in a health professional shortage area in a State with an age adjusted high burden of stroke, heart disease, and obesity, and to prioritize submissions that support high poverty rate communities. **(Page 48)**

Action to be Taken

In FY 2021, HRSA plans to provide new grant funding to an estimated 11 awards using the rank order list from the FY 2020 NEPQR-SET competition. HRSA published the NEPQR-SET NOFO with the goal to enhance nurse education and strengthen the nursing workforce through the expansion of experiential learning opportunities. This includes using simulation-based technology, including equipment, to advance the health of patients, families, and communities in rural and medically underserved areas experiencing diseases and conditions that affect public health such as: high burden of stroke, heart disease, behavioral and mental health, maternal mortality, HIV/AIDS, and/or obesity. This program strengthens the capacity of undergraduate public health nursing students to address the complex health care needs of those living in rural and medically underserved areas.

17. **Experiential Learning Opportunities.—** The Committee recommends $55,000,000, $5,000,000 above the fiscal year 2020 enacted level and $55,000,000 above the fiscal year 2021 budget request, to support colleges of medicine at public universities located in the top quintile of States projected to have a primary care provider shortage. The Committee directs HRSA to give priority to applications from universities located in States with the greatest number of Federally-recognized Tribes. The Committee also directs HRSA to give priority to applications from public universities with a demonstrated public-private partnership. **(Page 48)**

Action to be Taken

In accordance with the final appropriations, in FY 2021 HRSA plans to provide supplemental funding in the amount of $50,000,000 to the 10 recipients. There are two cohorts of five recipients each from FY 2019 and FY 2020. The amount of supplemental funding for each recipient will result in every recipient being awarded the same total grant amount from FY 2019 through FY 2021 provided the recipients can justify the expenditure of the funds. The supplemental award amount is subject to a matching requirement of non-Federal funds not less than 10 percent of the total amount of Federal

funds provided in the grant to such recipient. The program is designed to prepare and encourage medical students who are training in the most underserved states to choose residencies and careers in primary care that serve tribal communities, rural communities, and/or medically underserved communities after they graduate.

18. **Hereditary Hemorrhagic Telangiectasia (HHT).—**In fiscal years 2017 and 2018, the committee provided $200,000 to CDC to support a collaborative pilot model that enables up to three existing Federally-funded Hemophilia Treatment Centers (HTC) to serve as specialty centers for the evaluation and management of HHT. If proven effective, these joint HTC–HHT Centers have the potential to provide critical diagnostic and treatment services to both hemophilia and HHT populations. The Committee encourages HRSA to work closely with CDC and stakeholder organizations to track the progress of this pilot initiative for potential replication. **(Page 49)**

    Action to be Taken
    HRSA will continue to coordinate with stakeholder organizations on care for patients with hemophilia and related blood or clotting disorders and connect with CDC to learn about the progress and results of the HTC-HHT pilot model.

19. **Maternal, Infant, and Early Childhood Home Visiting Program.—**The Committee recognizes that good oral health is an important component for improving the health and well-being of children and families. The Committee encourages HRSA to explore opportunities to integrate oral health in the agency's Home Visiting Program and provide the home visitors with the training to become a Community Dental Health Coordinator. The Committee also encourages HRSA to work with oral health initiatives such as Community Dental Health Coordinators that have already been initiated by dental organizations to provide dental education, community-based prevention, care coordination, and patient navigation to children and vulnerable families. **(Page 49)**

    Action to be Taken
    In FY 2021, HRSA continues to integrate oral health into the Maternal Infant and Early Childhood Home Visiting (MIECHV) Program by requiring awardees to establish appropriate linkages and referral networks to community resources as specified in statute. HRSA has initiated collection of additional data on whether children enrolled in home visiting programs have a usual source of dental care by 12 months of age. In FY 2020, approximately 67 percent of children enrolled in home visiting had a usual source of dental care. HRSA continues to promote linkages with Community Dental Health Coordinators to MIECHV awardees, where available, and to the extent practical.

20. **State Oral Health Programs.—**The Committee continues to include $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

encourages the Chief Dental Officer to continue to direct the design, monitoring, oversight, and implementation of these projects. **(Page 50)**

Action to be Taken

In FY 2021, with consultation/direction from HRSA's Chief Dental Officer, HRSA will continue support for the National Maternal and Child Center for Oral Health Systems Integration and Improvement program (COHSII) for the Partnership for Integrating Oral Health Care into Primary Care (PIOHCPC) project with $250,000 in funding.

This funding supports the continued provision of technical assistance, training, and other support to continue demonstration projects to increase the implementation of oral health and primary care practice integration, modelled after the 2014 HRSA report, Integration of Oral Health and Primary Care Practice.

21. **Fetal Alcohol Syndrome (FAS) Set-Aside.—**Recognizing that as many as one in 20 school-age children are affected by fetal alcohol spectrum disorders (FASD), yet few have access to essential diagnostic and multidisciplinary services, the Committee includes no less than the fiscal year 2020 level for HRSA to continue activities funded by the FAS set-aside. The Committee also encourages HRSA to consider support for an established FASD-specific national network to improve the well-being of children and families with FASD. **(Page 50)**

Action to be Taken

In FY 2021, HRSA will continue to support the SAFEST Choice Learning Collaborative for the Supporting Fetal Alcohol Spectrum Disorders Screening and Intervention Program at the fiscal year 2020 enacted level. The aim of this three-year program is to reduce the incidence of prenatal alcohol exposure and improve outcomes in children with suspected or diagnosed fetal alcohol spectrum disorders (FASD).

SAFEST Choice expands national access to essential services by providing education, training, and technical assistance to multidisciplinary healthcare teams in community settings located in high-risk areas. Teams receive education and training on screening, diagnosis, and treatment for pregnant women and children with suspected or diagnosed fetal alcohol spectrum disorder.

22. **Infant-Toddler Court Teams.—**The Committee includes $10,000,000, the same as the fiscal year 2020 enacted level, for the fourth year of a cooperative agreement to support research-based infant-toddler court teams to change child welfare practices to improve well-being for infants, toddlers, and their families. The Committee encourages HRSA to use these funds to: (1) build upon the work of sites established or currently supported through the Infant-Toddler Court Program, including by providing training, technical assistance, and additional support for such court teams' efforts across the country; and (2) plan and support additional infant-toddler court teams. **(Page 51)**

Action to be Taken

In FY 2021, HRSA will support the fourth year of the Infant Toddler Court Program (ITCP) to support research-based infant-toddler court teams to change child welfare practices to improve well-being for infants, toddlers, and their families. The program is sustaining the work of sites already established; developing resources and supports for sites interested in starting an infant-toddler court team; and building the evidence regarding effective infant-toddler court team implementation and outcomes for infants, toddlers, and their families.

23. **Severe Combined Immune Deficiency (SCID).—**Within the total amount for Heritable Disorders, the Committee provides $3,000,000, the same as the fiscal year 2020 enacted level, to support wider implementation, education, and awareness of newborn screening and follow-up for SCID and other newborn screening disorders. The Committee applauds HRSA's ongoing work to ensure screening of all newborns for Severe Combined Immune Deficiency (SCID), including through initiatives that help parents of newborns diagnosed with SCID understand the disease and treatment options and to navigate the path forward. The Committee encourages HRSA to support efforts to develop telehealth approaches to link families in rural and underserved communities with support and resources, engage providers in education or training related to SCID, and establish mechanisms to obtain long-term outcomes information on infants with SCID through newborn screening. **(Page 53)**

Action to be Taken

In FY 2021, HRSA will continue to support newborn screening and follow-up for Severe Combined Immunodeficiency (SCID) and other newborn screening disorders. The program works to ensure that newborns and children identified through newborn screening with SCID or other newborn screening disorders achieve the best possible outcomes. The program expands the ability of state public health agencies to provide screening, counseling and services to these newborns and children. The program also supports education, training and collaboration with clinicians, public health agencies and families to create a system of care that can assess and coordinate follow-up and treatment of SCID and other newborn screening disorders. Grantees create follow-up models that provide evidence-based/informed, condition-specific treatments and age-appropriate preventive care for infants and children with SCID or other newborn screening disorders, including using telehealth to link rural and medically underserved populations to knowledgeable clinicians, support, and resources. In addition, grantees collect and analyze long-term follow-up data to evaluate outcomes on infants with SCID and other newborn screening disorders.

24. **Maximizing Deceased Donor Organ Recovery, Acceptance, and Utilization.—**The Committee supports the goal of significantly increasing kidney transplants, established by the President's Executive Order on Advancing American Kidney Health, and supports efforts to establish objective outcome measures for Organ Procurement Organizations (OPO) as well as efforts to decertify underperforming OPOs at the conclusion of the current contract cycles. The Committee encourages HHS and HRSA to monitor transplant center listing and acceptance practices as recorded with the Organ and Procurement and Transplantation Network (OPTN), and to make publicly available its

findings based on one calendar year of data. The listed screening criteria for each patient receiving an organ offer should be compared to center refusals codes for those organs not accepted for transplant by the patient's transplant center. Further, the utilization rates by center should be reported for all organ offers and for both the brain dead and donation after circulatory death subcategories. The Committee supports HHS's Request for Information for the technology system over which these organ offers are facilitated and encourages HHS to promote competition for this contract. **(Page 55)**

Action to be Taken

HRSA fully supports all goals associated with increasing kidney transplants and establishing objective outcome measures for Organ Procurement Organizations (OPOs). HRSA will also take the Committee's recommendations under advisement to maximize organ recovery and increase transplants performed in the U.S.

25. Office of Pharmacy Affairs.— The Committee acknowledges the request for additional regulatory authority and notes that HRSA already has existing oversight authority that allows the agency to conduct audits of stakeholders who participate in the program to ensure compliance. The Committee recognizes that HRSA has used this authority to conduct 1,300 audits of covered entities, but only 20 audits of manufacturers. The Committee is concerned that HRSA is not using their existing oversight authority to pursue balanced oversight of both providers and drug manufacturers. We encourage HRSA to use its existing oversight authority to pursue more balanced oversight of both providers and manufacturers to ensure compliance and integrity of the 340B program. **(Page 56)**

Action to be Taken

HRSA uses its authority, to the fullest extent, to implement a systematic approach to 340B Program integrity for both covered entities and manufacturers. Manufacturer oversight has always been a focus for HRSA; however it is a narrow focus as manufacturers only have one core statutory obligation in the 340B Program - to offer the 340B ceiling price pursuant to section 340B(a)(1) of the Public Health Service Act. HRSA began conducting manufacturer audits in FY 2015. These audits are conducted randomly by selecting manufacturers from a list generated by all signed Pharmaceutical Pricing Agreements (PPAs), and conducts targeted audits in instances where there are potential compliance issues.

The percentage of audits conducted annually for manufacturers is 0.7 percent (5/700) and for covered entities is 1.5 percent (200/12670). As of April 9, 2021, HRSA had finalized 26 manufacturer audits and is on track to finalize five additional manufacturer audits for FY 2021. Each fiscal year, HRSA outlines the number of audits of both covered entities and manufacturers based on budgetary constraints. Finalized manufacturer audits are posted on the HRSA website.

In addition, HRSA has issued final rules on all three of the areas where HRSA has existing regulatory authority (ceiling price calculation, civil monetary penalties for manufacturers, and establishing an alternative dispute resolution process). In January

2017, HRSA issued a final rule in the *Federal Register* (82 FR 1210 (January 5, 2017)) on defined standards on the methodology for the calculation of 340B ceiling prices and the imposition of civil monetary penalties for manufacturers who knowingly and intentionally overcharge covered entities. The final rule became effective on January 1, 2019. On December 14, 2020, HRSA issued a final rule in the *Federal Register* finalizing the ADR process. The rule became effective on January 14, 2021.

While HRSA continues to conduct audits of covered entities and manufacturers, HRSA does not have regulatory authority to enforce all of the compliance elements that it evaluates during its audits unless there is a clear tie to the statute. There is past litigation that has impacted HRSA's authority, in addition to multiple, ongoing lawsuits (by covered entities and manufacturers) that challenge HRSA's authority to establish and enforce program requirements. While HRSA is unable to comment on ongoing litigation, HRSA's limited authority has impacted the ability to enforce compliance to its fullest, and as a result, reported audit findings have decreased.

Without comprehensive regulatory authority, HRSA is unable to develop enforceable policy that ensures clarity in program requirements across all the interdependent aspects of the 340B Program. Therefore, HRSA has requested regulatory authority each year since FY 2017. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program. These reforms would help ensure low income and uninsured patients benefit from the Program, as intended, and strengthen program integrity and oversight activities. HRSA would also address issues raised by various stakeholders to assist covered entities and manufacturers in their ability to satisfy 340B Program expectations and where oversight needs to be enhanced.

26. GAO Study on Obstetrics (OB) Closures.—According to the Rural Health Research Gateway, between 2004 and 2014, 179 rural counties lost hospital-based OB services. The Committee directs the Government Accountability Office (GAO) to submit a report on ways to improve access to obstetrics care in rural areas and prevent OB unit hospital closures in rural areas. **(Page 57)**

Action to be Taken

HRSA will cooperate with GAO as they draft a report on ways to improve access to obstetrics care in rural areas and prevent OB unit hospital closures in rural areas.

27. Community Health Workers.—The Committee recognizes the importance of community health workers, particularly in rural and underserved areas, to help address persistent health issues tied to social determinants of health. The Committee is aware that many States would like to better incorporate community health workers into their systems, but there is currently a lack of a unified training and certification resource available to them. The Committee encourages HRSA to consider supporting a national center, based at an academic medical center with expertise in integrating community health workers into health systems, to assist States and providers through workshops, consultations, certifications and continuing education credits. **(Page 57)**

Action to be Taken
Community health workers (CHWs) are the cornerstone of many HRSA rural community-based programs. HRSA will consider ways to support research with a focus on CHWs working in rural and underserved areas.

28. **Southwest States Rural Development Network Grant Program.—**The Committee encourages HRSA to consider funding a new Southwest States Rural Development Network Grant Program, within the Southwest Border Region as defined by 40 U.S.C. § 15732, to promote the development of integrated health care networks in order to: (1) achieve efficiencies; (2) expand access to, coordinate, and improve the quality of essential health care services; and (3) strengthen the rural health care system as a whole. The Committee also encourages HRSA to consider a pilot program to help underserved rural communities in the region identify and better address their health care needs and to help small rural hospitals improve their financial and operational performance. **(Page 57)**

Action to be Taken
In FY 2021, HRSA will continue to support the needs of rural areas in the Southwest through existing competitive programs funded by the Federal Office of Rural Health Policy.

29. **Rural Residency Planning and Development Program.—**The Committee commends the Office of Rural Health Policy for its efforts to expand the physician workforce in rural areas and supports continuation and expansion of the program to develop new rural residency programs, or Rural Training Tracks (RTTs). The Committee encourages HRSA to expand the current program to include RTTs in obstetrics and gynecology. Women in rural communities are more likely to begin prenatal care late and are more likely to experience maternal mortality and severe maternal morbidity. The expansion of this program would align with the agency's goals of improving maternal health outcomes and eliminating preventable maternal mortality. **(Page 59)**

Action to be Taken
HRSA recognizes the need for Rural Training Tracks in obstetrics and gynecology. Studies show that health care providers who train in rural areas are more likely to practice in rural areas. In FY 2019, HRSA funded the Rural Residency Planning and Development (RRPD) program and made 27 awards to organizations across 21 states to develop newly accredited, sustainable rural residency programs in family medicine, internal medicine, and psychiatry. In FY 2020 HRSA issued a new funding opportunity soliciting applications to start residency programs in family medicine, internal medicine, public health and general preventive medicine, psychiatry, general surgery, and obstetrics and gynecology. From this competition, HRSA made 11 awards to organizations across 10 states to develop new rural residency programs. HRSA plans to make at least another 8 awards in FY 2021.

30. **Chief Dental Officer.—**The Committee is pleased that HRSA has restored the position of Chief Dental Officer (CDO) and looks forward to learning how the agency has ensured

that the CDO is functioning at an executive level authority with resources and staff to oversee and lead all oral health programs and initiatives across HRSA. The Committee requests an update by February 2021 on how the CDO is serving as the agency representative with executive level authority on oral health issues to international, national, State and/or local government agencies, universities, and oral health stakeholder organizations. **(Page 60)**

Action to be Taken

The CDO position at HRSA is responsible for: coordinating oral health activities across HRSA programs and advising HRSA oral health priorities throughout the various programs in the agency. Over the past year, specific activities have included: reviewing and advising on proposed oral health-related investments across the agency; representing the agency at professional conferences and meetings; providing presentations on the agency's oral health portfolio and key topics of interest to a variety of stakeholders; delivering a webinar for HRSA health centers to increase awareness of the risks associated with HPV (Human Papilloma Virus) and Oral and Pharyngeal Cancer; and developing and directing a cross-agency project to improve the oral health literacy of HRSA constituent populations.

31. **Oral Health Literacy.—**The Committee includes $300,000 to continue the development of an oral health awareness and education campaign across relevant HRSA divisions, including the Health Centers Program, Oral Health Workforce, Maternal and Child Health, Ryan White HIV/AIDS Program, and Rural Health. The Committee directs HRSA to identify oral health literacy strategies that are evidence-based and focused on oral healthcare prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer. The Committee encourages the Chief Dental Officer to play a key role in the design, monitoring, oversight, and implementation of this project. **(Page 60)**

Action to be Taken

HRSA will continue collaboration across relevant agency components/programs and build upon prior work developing evidence-based oral health literacy approaches and messaging 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 awareness and education campaign for health center patients, people living with HIV/AIDS, parents and children, and rural or underserved populations.

Vaccine Injury Compensation TAB

Vaccine Injury Compensation Program
Table of Contents

FY 2022 Budget

Appropriation Language

VACCINE INJURY COMPENSATION PROGRAM TRUST FUND

For payments from the Vaccine Injury Compensation Program Trust Fund (the ‘‘Trust Fund’’), such sums as may be necessary for claims associated with vaccine-related injury or death with respect to vaccines administered after September 30, 1988, pursuant to subtitle 2 of title XXI of the PHS Act, to remain available until expended: Provided, That for necessary administrative expenses, not to exceed [$11,200,000] *$16,200,000* shall be available from the Trust Fund to the Secretary.

Amounts Available for Obligation

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Discretionary Appropriation:	$32,270,000	$38,100,000	$48,103,000
Transfer to Other Accounts	-$10,200,000		
Transfer from Other Accounts	$10,200,000		
Subtotal, adjusted Discretionary Appropriation	**$32,270,000**	**$38,100,000**	**$48,103,000**
Mandatory Appropriation	$218,203,000	$310,567,000	$316,778,000
Transfer to Other Accounts	-$218,203,000		
Transfer from Other Accounts	$218,203,000		
Subtotal, adjusted Mandatory Appropriation	**$218,203,000**	**$310,567,000**	**$316,778,000**
Spending Auth Offsets	--		
Administrative Expenses	32,270,000	38,100,000	48,103,000
Total HRSA Claims	218,203,000	310,567,000	316,778,000
Total New Obligations	**250,473,000**	**348,667,000**	**364,881,000**

Budget Authority by Activity

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Trust Fund Obligations: Post-10/1/88 claims	$218,203,000	$310,567,000	$316,778,000
Administrative Expenses: HRSA Direct Operations	$10,200,000	$11,200,000	$16,200,000
Total Obligations	$228,403,000	$321,767,000	$332,978,000

Budget Authority by Object

	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Insurance claims and indemnities	$310,567,000	$316,778,000	+$6,211,000
Salaries & Expenses/Other Services	$11,200,000	$16,200,000	+$5,000,000
Total	$321,767,000	$332,978,000	+$11,211,000

Authorizing Legislation

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:			
Pre-FY 1989 Claims	---	---	---
Post-FY 1989 Claims	$218,203,000	$310,567,000	$316,778,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):			
HRSA Operations	$10,200,000	$11,200,000	$16,200,000

Appropriation History Table

(Pre-1988 Claims Appropriation)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1996	110,000,000	110,000,000	110,000,000	110,000,000
1997	110,000,000	110,000,000	110,000,000	110,000,000
1998	---	---	---	---
1999	---	---	100,000,000	100,000,000
2000	---	---	---	---
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2021	---	---	---	---
2022	---	---	---	---

Vaccine Injury Compensation Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
Claims BA	$260,400,000	$310,567,000	$316,778,000	+$6,211,000
Admin BA	$10,200,000	$11,200,000	$16,200,000	+$5,000,000
Total BA	$270,600,000	$321,767,000	$281,800,000	+$11,211,000
FTE	17	23	28	+5

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 2022 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, which include supporting documentation. HRSA also contracts with health care professionals for claim reviews and with other medical specialists to provide independent claim reviews and to testify in Court. HRSA medical officers develop preliminary recommendations regarding petitioner eligibility for compensation, and DOJ incorporates these recommendations in Rule 4(b) reports submitted to the Court. Lastly, HRSA processes payments to petitioners and their attorneys based on judgments entered by the Court.

HRSA also publishes notices in the Federal Register listing each claim received and promulgates regulations to modify the Vaccine Injury Table that lists injuries and/or conditions associated with covered vaccines. HRSA provides administrative support to the Advisory Commission on Childhood Vaccines (ACCV), which is responsible for advising the HHS Secretary on issues related to VICP operations. The ACCV is composed of nine voting members, including

healthcare professionals, attorneys, and parents or legal representatives of children who have suffered vaccine-related injuries or death, and non-voting HHS officials.

Vaccine Injury Compensation Trust Fund

Congress annually appropriates funding from the Vaccine Injury Compensation Trust Fund (Trust Fund) for VICP administration and for compensating vaccine-related injury or death claims for covered vaccines administered on or after October 1, 1988. The Trust Fund has a current balance of over $3.9 billion. 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/estates applying on behalf of others. Table 1 shows number of petitioners awarded compensation and vaccine injury compensation provided over the last five years.

Table 1. Growth in Families and Individuals Receiving Compensation

Fiscal Year	No. of Petitioners	Compensation ($ in millions)
2016	689	$253
2017	706	$282
2018	521	$227
2019	653	$226
2020	734	$218

VICP Administration

VICP claims have tripled from 386 claims filed in FY 2011 to 1,191 claims filed in FY 2020. In FY 2021 as of March, 1,577 claims had already been filed. If this trend continues, about 2,200 claims will be filed by the end of FY 2021 resulting in an 85 percent increase in claims filed since the end of FY 2020. During the same period, administrative funding has increased by only 72 percent from $6.5 million to $11.2 million, as shown in Table 2.

In FY 2017, HRSA began a backlog of vaccine injury claims awaiting medical review since the volume of claims exceeded resources available to conduct medical reviews. The cumulative claims backlog was 966 claims at the end of FY 2020. Even though the HRSA funding to administer the VICP increased by $1 million from $10.2 in FY 2020 to $11.2 million in FY 2021, the backlog is expected to grow to nearly 2,100 by the end of FY 2021, resulting in delays in compensating petitioners since claims are on the waiting list for about 14 months pending review.

Table 2. 10-Year Trend in Number of Claims Filed and Administrative Costs
(*dollars in millions)*

Fiscal Year	Number of Claims Filed	Administrative Funding
2011	386	$6.50
2012	401	$6.50
2013	504	$6.50
2014	633	$6.50
2015	803	$7.50
2016	1,120	$7.50
2017	1,243	$7.75
2018	1,238	$9.20
2019	1,282	$9.20
2020	1,191	$10.20
2021	2,200[1]	$11.20

1/Significant increase an influx of 800 claims in January 2021 due to expected implementation of the final rule proposed to remove Shoulder Injury Related to Vaccine Administration (SIRVA)

Funding History – VICP Claims Compensation

FY	Amount
FY 2018	$227,082,600
FY 2019	$225,900,000
FY 2020	$260,400,000
FY 2021 Enacted	$310,567,000
FY 2022 President's Budget	$316,778,000

Funding History - VICP Administration

FY	Amount
FY 2018	$9,200,000
FY 2019	$9,200,000
FY 2020	$10,200,000
FY 2021 Enacted	$11,200,000
FY 2022 President's Budget	$16,200,000

Budget Request

VICP Claims Compensation - The FY 2022 Budget Request for the VICP Claims Compensation program of $316.8 million is $6.2 million above the FY 2021 Enacted level. This request will ensure adequate funds are available to compensate petitioners and pay their attorneys' fees and

costs. These funds will also allow the VICP to continue to meet its zero percent target for the percentage of eligible claimants who opt to reject awards and elect to pursue civil action. Prior to the existence of the VICP, civil actions against vaccine manufacturers threatened to cause vaccine shortages and reduce vaccination rates.

VICP Administration - The FY 2022 Budget Request for the VICP Administration program of $16.2 million is $5 million above the FY 2021 Enacted level. This request will support administrative expenses to process approximately 1,480 claims, including costs associated with hiring four additional medical review staff, an adequate number of contractors to conduct medical reviews to reduce the backlog of claims, and medical experts for reviews and expert testimony to the Court. The backlog will be reduced from approximately 2,066 claims at the end of FY 2021 to about 1,886 claims by the end of FY 2022.

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 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
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 2020: 0% Target: 0% (Target Met)	0%	0%	Maintain
26.II.A.4: Average time settlements are approved from the date of receipt of the DOJ settlement proposal. *(Efficiency)*	FY 2020: 2 days Target: 10 days (Target Exceeded)	10 days	10 days	Maintain
26.II.A.5: Average time that lump sum only awards are paid from the receipt of all required documentation to make a payment. *(Efficiency)*	FY 2020: 3 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 2021 Target	FY 2022 Target	FY 2022 +/- FY 2021
26.II.A.6: Percentage of cases in which court-ordered annuities are funded within the carrier's established underwriting deadline. *(Outcome)*	FY 2020: 100% 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. *(Efficiency)*	FY 2020: 87% Target: 75% (Target Met)	75%	75%	Maintain
26.II.A.8 Percentage of FY 2017 and subsequently filed claims with any medical records assigned for medical review within 4 months of receipt from the Court. *(Outcome)*	FY 2020: 31% Target: 65% (Target Not Met)	65%	65%	Maintain

Countermeasures Injury Compensation TAB

Countermeasures Injury Compensation Program
Table of Contents

FY 2022 Budget

Appropriation Language

COVERED COUNTERMEASURE PROCESS FUND

For carrying out section 319F-4 of the PHS Act, $5,000,000 shall remain available until expended.

Amounts Available for Obligation

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Discretionary Appropriation:			
Direct Appropriation	---	---	$5,000,000
Unobligated Balance:			
Unobligated Balance, start of year	$1,193,821	$1,292,843	---
Unobligated Balance, Transfer from Other Accounts	$2,277,897	$4,167,619	$4,270,381
Subtotal, Unobligated Balance	**$3,471,718**	**$5,460,462**	**$4,270,381**
Administrative Expenses	$3,071,530	$4,691,426	$4,025,000
Compensation Funding	$400,188	$769,036	$5,245,381
Total New Obligations	**$3,471,718**	**$5,460,462**	**$9,270,381**

Budget Authority by Activity

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Countermeasures Injury Compensation Program[291]	---	---	$5,000,000

Authorizing Legislation

	FY 2021 Amount Authorized	FY 2021 Amount Appropriated	FY 2022 Amount Authorized	FY 2022 Amount Appropriated
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	$5,000,000

[291] Since October 2009, CICP has received funding from the Public Health and Social Services Emergency Fund (PHSSEF).

Countermeasures Injury Compensation Program

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
BA	---	---	$5,000,000	+$5,000,000
FTE	---	---	8	+8

Authorizing Legislation: Public Health Service Act, Sections 319F-3 and 319F-4, as amended by Public Laws: 109-148 Sec. 3, 113-5 Sec. 402, 116-123, 116-127, Sec. 6005 and 116-136.

FY 2022 Authorization .....Indefinite

Allocation Method ..... Other

Program Description and Accomplishments

The Countermeasures Injury Compensation Program (CICP) provides benefits to individuals who are seriously injured as a result of the administration or use of a covered countermeasure. A countermeasure is a vaccination, medication, device, or other item recommended to diagnose, prevent or treat a declared pandemic, epidemic or security threat.

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide medical and lost employment income benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of covered countermeasures. The CICP also provides death benefits to certain survivors of eligible deceased injured countermeasure recipients. The countermeasures covered by CICP are identified in PREP Act declarations. Since October 2009, CICP has received funding from the Public Health and Social Services Emergency Fund (PHSSEF).

Since October 2009, the CICP has received 804 claim from individuals who allege injuries from covered countermeasures. Of the 804 claims, 409 were ineligible for compensation, 356 cases are pending review, and 39 claims were eligible for compensation. Of the 39, 29 were compensated, totaling more than $6 million. Ten claims did not receive compensation because they did not have any compensable expenses or losses.

Funding History

FY	Amount
FY 2018	---
FY 2019	---
FY 2020	---
FY 2021 Enacted	---
FY 2022 President's Budget	$5,000,000

Budget Request

The FY 2022 Budget Request of $5.0 million is $5.0 million above the FY 2021 Enacted level. This request will be used to compensate eligible individuals for injuries and deaths directly resulting from the use of covered countermeasures, including non-COVID-19 and COVID-19 claims. It will also support administrative costs associated with reviewing medical claims and determining compensation eligibility. In addition, the CICP funds will support contract costs required to operate and maintain the CICP information system and the contracting of medical experts to review complex cases.