DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2024

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE ADMINISTRATOR

I am pleased to transmit the Congressional Justification of the Health Resources and Services Administration (HRSA) request for the Fiscal Year (FY) 2024 Budget. Our FY 2024 Budget request includes $15.9 billion to support HRSA's vital work to expand access to health care services in the communities that need them most; grow, diversify, and promote the well-being of the health workforce; reduce maternal mortality; invest in rural health; and increase access to behavioral health care.

Providing Health Care in Underserved and Rural Communities: In thousands of historically underserved and rural communities across the country, HRSA-funded health centers provide primary care services regardless of patients' ability to pay. Through these investments, HRSA helps communities improve their health and well-being, prevent, and manage chronic conditions like diabetes and hypertension; and care for children, families and individuals with low-incomes, individuals experiencing homelessness, individuals with HIV and others who otherwise would not have access to a usual source of care. At the end of FY 2023, the mandatory funding that provides about two-thirds of the health center budget is set to expire. The FY 2024 Budget prioritizes sustaining this vital health care lifeline, renewing the expiring health center mandatory funding, and building on it by expanding health center behavioral health services, extending operating hours, and adding new locations to care for more patients.

Growing the Health Care Workforce: The Budget also focuses on renewing and extending funding for the vital mandatory health care workforce programs – the National Health Service Corps and the Teaching Health Center GME Program – that support the recruitment and development of clinicians to deliver community-based care through loan repayment, scholarships, and residency training. Health care workforce needs are a pressing challenge across the country and the Budget makes a number of important investments to help – including dedicated resources to support innovative workforce programs, grow the nursing workforce, and modernize health workforce training. For example, the Budget would launch a new initiative to jumpstart innovation and support creative, new approaches to workforce development and training. It also includes increased funding to expand the nursing workforce by recruiting and supporting the nurse faculty and clinical preceptors necessary to grow the next generation of nurses and to increase the number of Certified Nurse Midwives to expand maternity care options. The Budget also reflects our focus on growing the behavioral health workforce by making significant investments in training health professionals such as psychiatrists, psychologists, clinical social workers, marriage and family therapists, counselors, and peer support specialists.

Addressing the Maternal Mortality Crisis: The maternal mortality rate for Black women is nearly three times the rate for White women, and the Budget includes several initiatives to help respond to this unacceptable disparity in health outcomes. In addition to increasing the number of Certified Nurse Midwives, new investments include growing, training and employing community-based doulas to provide direct support before, during, and after childbirth. Other initiatives focus on social determinants of maternal health, including screening and connection to services, expanding uptake of evidence-based models of maternity care, investment in state data collection and innovation to improve local response strategies, and growing the recently launched maternal mental health hotline.

Supporting Rural Health: As rural communities work to sustain the health care infrastructure and face growing needs; the Budget makes a number of critical and timely investments to support rural communities. Targeted opioid and substance use disorder response dollars will expand our efforts to establish medication and treatment services in rural communities that are often not served by other programs. These efforts complement the Budget proposal to create a pathway for HRSA to support behavioral health services in rural health clinics. The Budget would also continue to support maternal health services in rural communities to help address the loss of hospital obstetric services that are occurring. To address the larger health care system sustainability challenges that many rural communities are facing, the Budget would support technical assistance to help rural hospitals evaluate and improve their finances as well as develop or enhance their service lines to strengthen care delivery in their community.

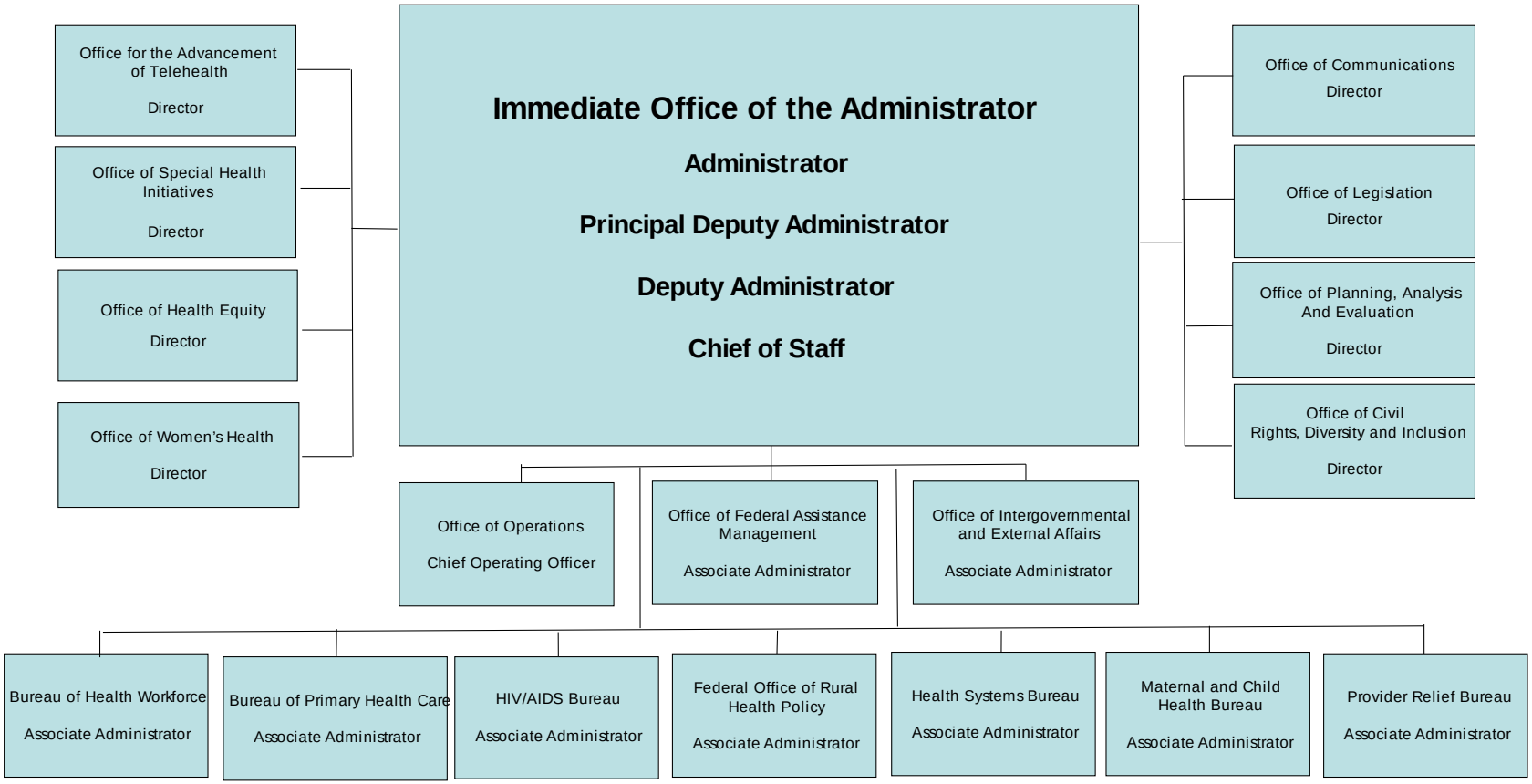
Meeting Behavioral Health Needs: At a time of considerable demand for mental health and substance use disorder care, HRSA's Budget makes strategic investments to improve access to these life-saving and life-sustaining services. As noted above, the Budget would increase mental health and substance use disorder care in community health centers across the country; sustain the historic numbers of National Health Service Corps members – including behavioral health providers – practicing in high need communities in return for loan repayment or scholarships; invest in training new behavioral health providers; support maternal mental health through tools like the maternal mental health hotline; and prioritize behavioral health needs in rural communities.

We look forward to working with Congress on the Budget and its implementation, including these essential programs and initiatives serving the nation's highest need communities.

Carole Johnson
Administrator

Organizational Chart

Health Resources and Services Administration



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Introduction and Mission

The Health Resources and Services Administration (HRSA) is an Agency of the U.S. Department of Health and Human Services. The Department's mission is, in part, to enhance the health and well-being of Americans by providing effective health and human services. In alignment with this mission, HRSA is dedicated to providing equitable health care to the nation's highest-need communities—serving people who are geographically isolated and economically or medically vulnerable. HRSA programs support people with low incomes, people with HIV, pregnant people, children, parents, rural communities, transplant patients, and other communities in need, as well as the health workforce, health systems, and facilities that care for them.

HRSA supports programs and services that improve health equity, for example in FY 2022:

- 30 million people in historically underserved communities
- More than 58 million pregnant women, infants, and children
- 3.6 million infants—nearly every infant in America
- More than 576,000 people with HIV
- More than 1,500 rural counties and municipalities across the country

By focusing on these and other underserved and at-risk groups, HRSA's leadership and programs promote improvements in healthcare access and quality essential to advancing health equity and enabling a healthy nation.

Overview of Budget

The FY 2024 President's Budget request is $15.9 billion for the Health Resources and Services Administration (HRSA). This level is $1.5 billion, or 10.7 percent, above the FY 2023 Enacted level or $3.1 billion above FY 2023 excluding community projects. The Budget invests in the next generation of the health workforce, provides funding to recruit and retain nurses, integrates mental health into primary care, promotes the well-being of the health workforce, provides additional investments in rural health, funds integrated diagnostics support for Long COVID, and provides additional resources for family planning services.

Additionally, the Budget requests an extension and increases mandatory funding for the Health Center Program, the National Health Service Corps, and the Teaching Hospital Graduate Medical Education program. Timely extension of these programs is critical to provide a stable source of funding for these activities.

Listed below are highlights of the major changes to programs:

Health Centers and Free Clinics: +$1.3 billion; total program $7.1 billion – At the request level, Health Centers will serve approximately 33.5 million patients in FY 2024. The Budget lays the path for doubling Health Center program funding with a request of $5.2 billion in mandatory funding in FY 2024 and a total of $19 billion through FY 2026. The Budget also includes $1.9 billion in discretionary funding.

The mandatory request provides resources to more than double the current Health Center Program investments in behavioral health services through a new $700 million behavioral health service expansion funding opportunity and a includes legislative proposal to require all health centers provide mental health and substance use disorder services under Section 330 of the Public Health Service Act. The mandatory request also includes +$250 million to expand operating hours and patient support services to increase access to care; and +$150 million to increase access to primary health care services in targeted areas of highest need using an evidence based, and transparent methodology.

The Budget provides an increase of $80 million in discretionary funding for Health Centers. The increase includes an additional $55 million for the expansion of early childhood screening and development services in 275 additional health centers, and an additional $15 million to increase access to HIV prevention services, as part of the HHS-wide initiative to End the HIV/AIDS Epidemic (EHE), which will support the total participation of approximately 400 health centers in the EHE initiative targeted jurisdictions. The Budget also includes a total of $20 million to support targeted cancer screening awards in 20 additional health centers under the Alcee L. Hastings Cancer Screening Program.

HIV/AIDS: +$125 million; total program $2.7 billion – The Budget provides resources to states, cities, counties, and local community-based organizations for HIV primary medical care, medications, and essential support services for low-income individuals with HIV. This includes $290 million, an increase of $125 million, for 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. This initiative will serve approximately 76,000 clients through FY 2024.

Health Workforce: +$892.5 million; total programs $2.7 billion – The Budget invests in efforts to grow, diversify, and promote the well-being of the health workforce.

- *National Health Service Corps (NHSC): +$547.7 million; total program $965.6 million*
  The Budget proposes to extend and increase funding, which will result in a projected field strength of 20,696 in FY 2024, maintaining the record field strength reached in FY 2022. The Budget proposes to extend mandatory funding with $790 million in FY 2024, for a total investment of $2.4 billion through FY 2026. NHSC funding supports scholarships and loan repayment to primary care, dental, and behavioral health providers in return for their service in underserved urban and rural areas. The discretionary request of $175.6 million, is $50 million above the FY 2023 Enacted level. The request includes an increase of $25 million for mental and behavioral health providers, including peer support specialists, in crisis centers and an additional $25 million for loan repayment for clinicians to provide opioid and substance use disorder treatment.

- *Behavioral Health Training Programs: +$190.3 million; total program $387.4 million*
  The Budget prioritizes investments in the behavioral health workforce, including growing the number of behavioral professionals such as clinicians as well as community health workers, peer support specialists and others at a time when there is growing demand for their services and limited capacity. The request includes an increase of $190 million to train approximately18,000 behavioral health providers.

- *Primary Care Training and Enhancement: +$4 million; total program $53.9 million*
  The Budget provides additional funds to support mental health training for primary care professionals.

- *Nurse Education, Practice and Retention: +$32.5 million; total program $91.9 million*
  The Budget provides additional funding to expand, enhance, and modernize nursing education programs. The additional investment will increase the number of nurse faculty and clinical preceptors and is essential to growing the nation's nurse workforce. The program will emphasis recruiting faculty that are underrepresented in the nursing workforce and expanding nursing student enrollment in Registered Nurse programs in states with the greatest shortages of nurses.

- *Advanced Nursing Education: +$17 million; total program $112.6 million*
  The Budget includes an increase of $17 million to grow and diversify the maternal and perinatal health nursing workforce by increasing the number of Certified Nurse Midwives (CNMs), with a focus on practitioners working in rural and underserved communities.

- *Health Care Workforce Innovation: +$27.5 million; total program $27.5 million*
  The Budget funds new approaches to recruiting, supporting, and training new providers. Innovative awards will jumpstart new strategies to grow the health care workforce at a time of significant concern about workforce shortages across physicians, nursing, behavioral health professionals and other disciplines.

- *Health Professions Training for Diversity +$10.8 million; total program $136.9 million*
  The Budget provides an increase of $10.8 million to expand the diversity of the health professions workforce, including the Nursing Workforce Diversity, Centers of Excellence, Health Careers Opportunity, Faculty Loan Repayment, and Scholarship for Disadvantaged Students programs. The additional funding will increase the diversity of the healthcare workforce and expand access to culturally competent care in medically underserved communities.

- *Preventing Burnout in the Health Workforce: +$25 million; total program $25 million*
  The Budget provides funding to support 23 awards to health care organizations to adopt, promote, implement, and demonstrate an organizational culture of wellness to support the mental health and well-being of the healthcare workforce.

- *Teaching Health Centers Graduate Medical Education Program: +$37.7 million, total program $157 million.* The Budget includes $157 million in mandatory resources for residency training in primary care medicine and dentistry in community-based, ambulatory settings. In FY 2024, the program expects to support 1,469 resident full-time equivalents (FTE). The Budget proposes to extend and increase mandatory funding through FY 2026 to support up to 2,094 resident FTE. The total investment for the program is $841 million for three years.

<u>Maternal and Child Health (MCH): +$205 million; total program $1.9 billion</u>
The Budget supports HRSA's partnership with states and communities by providing resources to improve the health and well-being of mothers, children, and families.

- *MCH Block Grant: +$121.6 million; total program $937.3 million*
  The Budget includes $333.7 million in Special Projects of Regional and National Significance (SPRANS) funding, an increase of $121.6 million. Approximately $145 million will support investments to improve maternal health and address disparities in maternal mortality and morbidity, including proposals to address social determinants of maternal health and grow the doula workforce. The Budget also includes $40 million to support a pilot to integrate behavioral health support in community settings by supporting community-based organizations to promote the healthy social and emotional development and mental health needs of mothers, children, and their families. Overall, the Block Grant will serve an estimated 98 percent of infants.

- *Training for Health Care Providers: +$5 million; total program $5 million*
  The Budget proposes to fund this activity under the authority established in the Consolidated Appropriations Act of 2022. The Budget provides funding to support grants to institutions of higher learning to address perceptions and biases among maternal health care providers that may affect the approach to care and improve maternal health outcomes.

- *Integrated Services for Pregnant and Postpartum Women: +$15 million; total program $25 million*
  The Budget supports and expands projects to foster the development and demonstration of innovative models that integrate care and services to reduce negative maternal health outcomes, pregnancy-related deaths, and maternal health disparities.

- *Healthy Start: +$40 million; total program $185 million*
  The Budget includes an increase of $40 million within the Healthy Start Program to expand the scope of grants by investing in promising practices learned from the "Benefits Bundle" pilots initiated in FY 2023. The focus of this pilot is on developing innovative, family-centered approaches to proactively bring information about public benefits to eligible low-income families. The Budget will also support a recompetition of the program to serve women and families across the Nation.

- *Autism and Other Developmental Disabilities: +$1 million; total program $57.3 million*
  The Budget provides funding to training programs and research with a focus on improving access, quality, and systems of care for underserved children, adolescents, and young adults with autism or other Developmental Disabilities. This program serves approximately 125,000 children.

- *Emergency Medical Services for Children (EMSC): +$3.8 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.

<u>Health Systems: +$36 million; total program $135 million</u>

- *Organ Transplantation Program; +$36 million; total program $67 million*
  The Budget provides additional funding to support HRSA's investment in the modernization of the Organ Procurement and Transplantation Network. The Budget also includes a legislative proposal to modernize the statute that governs the Organ Procurement and Transplantation Network to improve oversight, transparency, accountability, and efficiency in the organ transplantation system.

<u>Rural Health: +$63.4 million; total programs $415.9 million</u>
The Budget provides funding to improve access, quality, and coordination of care in rural communities.

- *Rural Hospital Stabilization Pilot Program; +$20 million; total program $20 million*
  The Budget supports a new pilot program to assist financially vulnerable rural hospitals by enhancing existing service lines and starting new service lines to ensure health care services are retained locally in the communities where people live.

- *Financial and Community Sustainability for At-Risk Rural Hospitals Program; +$10 million; total program $10 million*
  The Budget provides $10 million for targeted, in-depth high quality technical assistance to rural hospitals severely at-risk for imminent closure and struggling to maintain health care services.

- *Rural Health Outreach: +$2.4 million; total program $95.4 million*
  The Budget includes an increase of $2.4 million to support Rural Maternity and Obstetrics Management Strategies (RMOMS) grants to expand access and improve maternal health in rural communities.

- *Rural Communities Opioid Response: +$20 million; total program $165 million*
  The Budget supports grants to provide substance use/opioid use disorder prevention, treatment, and recovery services to rural residents. In FY 2024, HRSA plans to continue funding the FY 2022 behavioral health pilot program that provides behavioral health integration and workforce development support, as well as the expansion of the medications for opioid use disorder program. The additional funding will also enable HRSA to continue expanding RCORP's focus to include emergent behavioral health needs in rural communities.

- *Rural Health Clinic Behavioral Health Initiative; +$10 million; total program $10 million*
  The Budget support a new pilot program to enable Rural Health Clinics (RHCs) to establish new and expanded behavioral health in rural communities.

- *Black Lung and Radiation Exposure Screening and Education programs; +$0.8 million; total programs $14.9 million*
  The Budget provides an increase of $0.8 million to ensure coal miners receive proper screenings, primary care, and other services.

- *Rural Residency Planning and Development; +$0.2 million; total program $12.7 million*
  The Budget provides 15 new Rural Residency Planning and Development awards and additional support for technical assistance to support new rural residency programs to train physicians in rural areas.

<u>HRSA-Wide Activities and Program Support:</u>

- *340B Drug Pricing Program/Office of Pharmacy Affairs: +$5 million; total program $17.2 million*
  The 340B Drug Pricing Program requires drug manufacturers to provide discounts on outpatient prescription drugs to certain safety net providers. The Budget includes an increase of $5 million to expand HRSA's program integrity efforts, including increased audit and oversight efforts. The Budget also proposes a legislative change to enhance 340B Program integrity by requiring covered entities to annually report to HRSA how the savings achieved through the Program benefits the communities they serve and provides HRSA regulatory authority to implement this requirement.

- *Telehealth: +$6.5 million; total program $44.5 million*
  The Budget provides resources to promote the use of telehealth to increase access to health services. The increase will fund the continuation of the HHS Telehealth Hub, which allows for the rapid dissemination of critical telehealth resources for patients, providers, states, researchers, and other stakeholders through Telehealth.HHS.gov.

- *Program Management: +$5.2 million; total program $169 million*
  The Budget supports activities to effectively and efficiently support HRSA's operations. The increase supports the significant program growth over the past few years, including managing over $200 billion in COVID resources, and supports program integrity efforts, enhanced data capabilities, and cutting-edge information technology solutions.

- *Long COVID: +$130 million; total program $130 million*
  The Budget provides $130 million to support patients diagnosed with Long COVID. The request includes $100 million to support awards to states for Long COVID Integrated Diagnostics and Care Units and $30 million for provider training, capacity building, and consultation.

Family Planning: +$225.5 million; total program $512 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 to 4.5 million clients.

Vaccine Injury Compensation Program: +$11 million; total program $26.2 million
The Budget requests additional administrative funding to support the increase in the number of claims filed, largely associated with 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; +$8 million, total program $15 million
The Budget supports both the administrative costs and compensation to eligible individuals for injuries and deaths directly resulting from the use of covered countermeasures. The Budget increases capacity to review 2,000 claims by improving information technology infrastructure and process efficiencies.

Overview of Performance

HRSA's strategic goals are to take actionable steps to achieve health equity and improve public health, improve access to quality health services, foster a health workforce and health infrastructure able to address current and emerging needs, and optimize HRSA operations and strengthen program engagement. The Highlights section below groups key program performance measures by HRSA's goals and includes anticipated measure targets for fiscal year (FY) 2024.

Highlights

HRSA Goal: Take actionable steps to achieve health equity and improve public health.

HRSA programs leverage community partnerships and stakeholder collaborations to promote overall health and disease prevention across the populations served through HRSA programs and support diversity, equity, and inclusion for HRSA funding recipients.

- In FY 2024, 525,000 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, health care access, coordination of care, and integration of services.

- In FY 2024, HRSA expects to have 166,643 cord blood units from underrepresented racial and ethnic populations 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.

In FY 2024, the Maternal and Child Health (MCH) Block Grant program will contribute to decreasing the ratio of the Black infant mortality rate to the White infant mortality rate from 2.4 to 1, to 2 to 1

HRSA Goal: Improve access to quality health 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 2024, the Health Centers Program expects to sustain health centers' provision of affordable, accessible, quality, and cost-efficient care to 33.5 million patients.

- The MCH Block Grant program aims to contribute to the reduction of the national infant mortality rate from 5.4 per 1,000 to 5.3 per 1,000, in FY 2024 by funding state maternal and child health 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 2024, HRSA forecasts serving 24,000 new clients under the *Ending the HIV Epidemic* initiative.

- HRSA will continue its contribution to reducing AIDS-related mortality for low-income and uninsured people living with HIV/AIDS by ensuring the provision of HIV medications and related services to 289,000 persons in FY 2024 through the AIDS Drug Assistance Program.

- HRSA anticipates that in FY 2024, 85 percent of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test will 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 Blood Stem Cell Transplantation Program calculates that it will have nearly 4.02 million adults on the donor registry in FY 2024 from underrepresented racial or ethnic populations.

- The Organ Transplantation program projects that it will facilitate the transplantation of more than 33,994 deceased donor organs in FY 2024.

- HRSA anticipates that 2,150 providers will provide Medication-Assisted Treatment through the Rural Communities Opioid Response program in FY 2024.

HRSA Goal: Foster a health workforce and health infrastructure 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. HRSA also will seek to advance the resiliency of the health workforce and improve the supply, geographic distribution, and diversity of the health workforce.

- HRSA's Bureau of Health Workforce aims to increase the percentage of completers of its supported health profession training programs who are underrepresented minorities and/or from disadvantaged backgrounds to 48 percent in FY 2024.

- Additionally, BHW plans for 40 percent of individuals supported by its programs who complete primary care training programs to be employed in underserved areas.

Performance Management

Performance management is central to the agency's overall management approach and HRSA routinely uses performance-related information to improve HRSA's operations and those of its grantees.

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 Administrators, 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.

All-Purpose Table
Health Resources and Services Administration
(dollars in thousands)

Activity	FY 2022 Final/1	FY 2023 Enacted/2	FY 2024 President's Budget	FY 2024 +/- FY 2023 Enacted
PRIMARY CARE:				
Health Centers:				
Health Centers	1,627,772	1,737,772	1,817,772	+80,000
Health Centers Mandatory	3,905,348	3,905,348	-	-3,905,348
Health Centers Mandatory Proposed	-	-	5,170,000	+5,170,000
Health Center Tort Claims	120,000	120,000	120,000	-
Subtotal, Health Centers	***5,653,120***	***5,763,120***	***7,107,772***	***1,344,652***
Free Clinics Medical Malpractice	1,000	1,000	1,000	-
Subtotal, Bureau of Primary Health Care (BPHC)	**5,654,120**	**5,764,120**	**7,108,772**	**+1,344,652**
Subtotal, Mandatory BPHC (non-add)	*3,905,348*	*3,905,348*	*5,170,000*	*+1,264,652*
Subtotal, Discretionary BPHC (non-add)	*1,748,772*	*1,858,772*	*1,938,772*	*+80,000*
HEALTH WORKFORCE:				
National Health Service Corps (NHSC):				
NHSC	121,600	125,600	175,600	+50,000
NHSC Mandatory	292,330	292,330	-	-292,330
NHSC Mandatory proposed	-	-	790,000	+790,000
Subtotal, NHSC	***413,930***	***417,930***	***965,600***	***+547,670***
Loan Repayment/Faculty Fellowships	1,226	2,310	2,310	-
Health Professions Training for Diversity:				
Centers of Excellence	24,422	28,422	36,711	+8,289
Scholarships for Disadvantaged Students	53,014	55,014	55,014	-
Health Careers Opportunity Program	15,450	16,000	18,500	+2,500
Subtotal, Health Professions Training for Diversity	***92,886***	***99,436***	***110,225***	***+10,789***
Health Care Workforce Assessment	5,663	5,663	5,663	-
Primary Care Training and Enhancement	48,924	49,924	53,924	+4,000
Oral Health Training Programs	40,673	42,673	42,673	-
Medical Student Education	55,000	60,000	60,000	-
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	45,000	47,000	47,000	-
Geriatric Programs	45,245	47,245	47,245	-
Behavioral Health Workforce Development Programs	162,053	197,053	387,374	+190,321
Subtotal, Interdisciplinary, Community-Based Linkages	***252,298***	***291,298***	***481,619***	***+190,321***
Public Health Workforce Development:				-
Public Health/Preventive Medicine	17,000	18,000	18,000	-

Nursing Workforce Development:				
Advanced Nursing Education	85,581	95,581	112,581	+17,000
Nursing Workforce Diversity	23,343	24,343	24,343	-
Nurse Education, Practice and Retention	54,413	59,413	91,873	+32,460
Nurse Faculty Loan Program	28,500	28,500	28,500	-
NURSE Corps Scholarship and Loan Repayment Program	88,635	92,635	92,635	-
Subtotal, Nursing Workforce Development	***280,472***	***300,472***	***349,932***	***+49,460***
Children's Hospital Graduate Medical Education	375,000	385,000	385,000	-
Teaching Health Center Graduate Medical Education (THCGME):				-
THCGME Mandatory	119,290	119,290	-	-119,290
THCGME Mandatory Proposed	-	-	157,000	+157,000
Subtotal, THCGME	***119,290***	***119,290***	***157,000***	***+37,710***
National Practitioner Data Bank (User Fees)	*18,814*	*18,814*	*18,814*	-
Pediatric Subspecialty LRP	5,000	10,000	10,000	-
Supporting the Mental Health of the Health Professions Workforce	-	-	25,000	+25,000
Health Care Workforce Innovation Program	-	-	27,540	+27,540
Subtotal, Bureau of Health Workforce (BHW)	**1,726,176**	**1,820,810**	**2,713,300**	**892,490**
Subtotal, User Fees BHW (non-add)	*18,814*	*18,814*	*18,814*	-
Subtotal, Discretionary BHW (non-add)	*1,295,742*	*1,390,376*	*1,747,486*	*+357,110*
Subtotal, Mandatory BHW (non-add)	*411,620*	*411,620*	*947,000*	*+535,380*
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant/3	733,003	815,700	937,300	+121,600
Grants to States (non-add)	*570,389*	*593,308*	*593,308*	-
SPRANS (non-add)	*152,338*	*212,116*	*333,716*	*+121,600*
CISS (non-add)	*10,276*	*10,276*	*10,276*	-
Innovation for Maternal Health/4	11,775	15,300	15,300	-
Training for Health Care Providers/4	-	-	5,000	+5,000
Integrated Services for Pregnant and Postpartum Women/4	-	10,000	25,000	+15,000
Maternal Mental Health Hotline/5	4,000	7,000	7,000	-
Autism and Other Developmental Disorders	54,344	56,344	57,344	+1,000
Sickle Cell Service Demonstrations	7,010	8,205	8,205	-
Early Hearing Detection and Intervention	17,818	18,818	18,818	-
Emergency Medical Services for Children	22,276	24,334	28,134	+3,800
Healthy Start	131,340	145,000	185,000	+40,000
Heritable Disorders	19,558	20,883	20,883	-
Pediatric Mental Health Care Access Grants	11,000	13,000	13,000	-
Screening and Treatment for Maternal Depression	6,500	10,000	10,000	-
Poison Control Centers	25,846	26,846	26,846	-
Family-to-Family Health Information Centers (F2F HIC)				-

F2F HIC Mandatory	5,658	5,658	5,658	-
F2F HIC Mandatory Proposed	-	-		-
Subtotal, F2F HIC	***5,658***	***5,658***	***5,658***	**-**
Maternal, Infant and Early Childhood Home Visiting (MIECHV):				
MIECHV Mandatory	377,200	500,000	518,650	+18,650
MIECHV Mandatory Proposed	-			-
Subtotal, MIECHV	***377,200***	***500,000***	***518,650***	***+18,650***
Subtotal, Maternal and Child Health Bureau (MCHB)	**1,427,328**	**1,677,088**	**1,882,138**	**+205,050**
Subtotal, Discretionary MCHB (non-add)	*1,044,470*	*1,171,430*	*1,357,830*	*+186,400*
Subtotal, Mandatory MCHB (non-add)	*382,858*	*505,658*	*524,308*	*+18,650*
HIV/AIDS:				
Emergency Relief - Part A	670,458	680,752	680,752	-
Comprehensive Care - Part B	1,344,240	1,364,878	1,364,878	-
AIDS Drug Assistance Program (non-add)	*900,313*	*900,313*	*900,313*	-
Early Intervention - Part C	205,054	208,970	208,970	-
Children, Youth, Women & Families - Part D	77,252	77,935	77,935	-
AIDS Education and Training Centers - Part F	34,358	34,886	34,886	-
Dental Reimbursement Program Part F	13,414	13,620	13,620	-
Special Projects of National Significance (SPNS)	25,000	25,000	25,000	-
Ending HIV Epidemic Initiative	125,000	165,000	290,000	+125,000
Subtotal, HIV/AIDS Bureau	**2,494,776**	**2,571,041**	**2,696,041**	**+125,000**
HEALTH SYSTEMS:				
Organ Transplantation	30,049	31,049	67,049	+36,000
Cell Transplantation Program and Cord Blood Stem Cell Bank	50,275	52,275	52,275	-
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, Health Systems Bureau	**96,009**	**99,009**	**135,009**	**+36,000**
RURAL HEALTH:				
Rural Health Policy Development	11,076	11,076	11,076	-
Rural Health Outreach Grants	85,975	92,975	95,375	+2,400
Rural Hospital Flexibility Grants	62,277	64,277	64,277	-
State Offices of Rural Health	12,500	12,500	12,500	-
Radiation Exposure Screening and Education Program	1,889	1,889	2,734	+845
Black Lung	11,845	12,190	12,190	-
Rural Communities Opioid Response	135,000	145,000	165,000	+20,000
Rural Residency Planning and Development	10,500	12,500	12,700	+200
Rural Health Clinic Behavioral Health Initiative	-	-	10,000	+10,000
The Financial and Community Sustainability for At-Risk Rural Hospitals Program	-	-	10,000	+10,000

The Rural Hospital Stabilization Pilot Program			20,000	+20,000
Subtotal, Federal Office of Rural Health Policy	**331,062**	**352,407**	**415,852**	**+63,445**
HRSA-WIDE ACTIVITIES AND PROGRAM SUPPORT:				
Program Management:				
Program Management	155,300	163,800	168,971	+5,171
Program Management: Community Projects	1,057,896	1,521,681	-	-1,521,681
Subtotal, Program Management	**1,213,196**	**1,685,481**	**168,971**	**-1,516,510**
340B Drug Pricing Program/Office of Pharmacy Affairs	11,238	12,238	17,238	+5,000
Telehealth	35,050	38,050	44,500	+6,450
Long COVID	-	-	130,000	+130,000
Subtotal, HRSA-Wide Activities	**1,259,484**	**1,735,769**	**360,709**	**-1,375,060**
FAMILY PLANNING	286,479	286,479	512,000	+225,521
Appropriation Table Match	**8,556,794**	**9,465,283**	**9,163,699**	**-301,584**
Funds Appropriated to Other HRSA Accounts:				
Vaccine Injury Compensation:				
Vaccine Injury Compensation Trust Fund (HRSA Claims)	230,238	256,370	261,497	+5,127
VICTF Direct Operations - HRSA	13,200	15,200	26,200	+11,000
Subtotal, Vaccine Injury Compensation	**243,438**	**271,570**	**287,697**	**+16,127**
Countermeasures Injury Compensation Program	5,000	7,000	15,000	+8,000
Discretionary Program Level:				
HRSA	8,575,608	9,484,097	9,182,513	-301,584
Vaccine Direct Operations Budget Authority	13,200	15,200	26,200	+11,000
Countermeasures Injury Compensation Program	5,000	7,000	15,000	+8,000
Total, HRSA Discretionary Program Level	**8,593,808**	**9,506,297**	**9,223,713**	**-282,584**
Mandatory Programs:	**4,699,826**	**4,822,626**	**6,641,308**	**+1,818,682**
Total, HRSA Program Level	**13,293,634**	**14,328,923**	**15,865,021**	**+1,536,099**
Less Programs Funded from Other Sources:				
User Fees	*-18,814*	*-18,814*	*-18,814*	-
Mandatory Programs	*-4,699,826*	*-4,822,626*	*-6,641,308*	*-1,818,682*
Total, HRSA Discretionary Budget Authority	**8,574,994**	**9,487,483**	**9,204,899**	**-282,584**

1/Reflects amounts appropriated and any reprogrammings or reallocations notified to Congress. Does not include $140 million in supplemental funding provided in the Bipartisan Safer Communities Act (P.L. 117–159

2/ Does not include $65 million in supplemental funding provided in the Consolidate Appropriations Act, 2023.

3/ Retroactively adjusted to reflect shift in funding from SPRANS for Innovation for Maternal Health, Integrated Services for Pregnant and Postpartum Women, and Implicit Bias Training for Health Care Providers to their own budget lines as new authorities enacted in the Consolidated Appropriations Act, 2022 (PL 117-103). Adjustments also reflect shift in funding for The Maternal Mental Health Hotline from SPRANS to its own budget line as a new authority enacted in the Consolidated Appropriations Act of 2023 (PL 117-328).

4/FY 2022 Consolidated Appropriations Act (PL 117-103) provides new authority outside of SPRANS.

5/FY 2023 Consolidated Appropriations Act (PL 117-328) provides new authority outside of SPRANS.

Budget Exhibits
TAB

Appropriations Language

PRIMARY HEALTH CARE

For carrying out titles II and III of the Public Health Service Act (referred to in this Act as the "PHS Act") with respect to primary health care and the Native Hawaiian Health Care Act of 1988, **[**$1,858,772,000**]** *$1,938,772,000*: 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, **[**$1,390,376,000**]** *$1,747,486,000*: Provided, That section 751(j)(2) 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 section 756(c) of the PHS Act shall apply to paragraphs (1) through (4) of section 756(a) of such Act: [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 the requirement in section 756(c) of the PHS Act shall apply to paragraphs (1) through (4) of section 756(a) of such Act:* Provided further, That **[**$125,600,000**]** *$175,600,000* shall remain available until expended for the purposes of providing primary health services, assigning National Health Service Corps ("NHSC") participants 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, $15,600,000 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 within the amount made available in the proviso preceding the previous proviso, $25,000,000 shall remain available until expended for the purposes of making loan repayment awards to mental and behavioral health providers, including peer support specialists in accordance with section 338B of the PHS Act, notwithstanding the assignment priorities and limitations under sections*

333(a)(1)(D), 333(b), 333A(a)(1)(B)(ii), and 334 of the PHS Act: Provided further, That for purposes of the previous [two] *three* provisos, 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 *and services provided by certified peer support specialists*: Provided further, That of the funds made available under this heading, $6,000,000 shall be available to make grants to establish, expand, or maintain 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: Provided further, That of the funds made available under this heading, $10,000,000 shall remain available until expended for activities under section 775 of the PHS Act: Provided further, That the United States may recover liquidated damages in an amount determined by the formula under section 338E(c)(1) of the PHS Act if an individual either fails to begin or complete the service obligated by a contract under section 775(b) of the PHS Act: Provided further, That for purposes of section 775(c)(1) of the PHS Act, the Secretary may include other mental and behavioral health disciplines as the Secretary deems appropriate: Provided further, That the Secretary may terminate a contract entered into under section 775 of the PHS Act in the same manner articulated in section 206 of this title for fiscal year **[**2023**]** *2024* contracts entered into under section 338B of the PHS Act.

Of the funds made available under this heading, $60,000,000 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, including funding for infrastructure development, maintenance, equipment, and minor renovations or alterations: 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] *half* of States with a projected primary care provider shortage [in 2025], as determined by the Secretary: Provided further, That the minimum amount of a grant so awarded to such an institution shall be not less than $1,000,000 per year: Provided further, That such a grant may be awarded for a period not to exceed 5 years: Provided further, That such a grant awarded with respect to a year to such an institution shall be subject to a matching requirement of non-Federal funds in an amount that is not **[**less**]** *more* 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, **[**$1,171,430,000**]** *$1,357,830,000*: Provided, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than **[**$219,116,000**]** *$333,716,000* 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, **[**$2,571,041,000**]** *$2,696,041,000,* of which $2,045,630,000 shall remain available to the

Secretary through September 30, **[**2025**]** *2026*, 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 **[**$165,000,000**]** *$290,000,000*, 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 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, **[**$99,009,000**]** *$135,009,000*, of which $122,000 shall be available until expended for *facilities renovations and other* facilities-related expenses of the National Hansen's Disease Program**[**.**]**: *Provided, That the second sentence in section 372(a) of the PHS Act and section 372(b)(1)(A) of the PHS Act shall not apply to any contracts awarded by the Secretary for the operation of the Organ Procurement and Transplantation Network.*

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, **[**$352,407,000**]** $*415,852,000*, of which $64,277,000 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, *up to* $20,942,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology, no less than $5,000,000 shall be available to award grants to public or non-profit private entities for the Rural Emergency Hospital Technical Assistance Program, 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 and other efforts to improve health care coordination for rural veterans between rural providers and the Department of Veterans Affairs: 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 **[**$12,500,000**]** *$12,700,000* shall remain available through September 30, **[**2025**]** *2026*, to support the Rural Residency Development Program**[**:**]**. **[**Provided further, That $145,000,000 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**]** *$512,000,000*: 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.

HRSA-WIDE ACTIVITIES AND PROGRAM SUPPORT

For carrying out title III of the Public Health Service Act and for cross-cutting activities and program support for activities funded in other appropriations included in this Act for the Health Resources and Services Administration, **[**$1,735,769,000**]** *$360,709,000*, of which **[**$38,050,000**]** *$44,500,000* shall be for expenses necessary for the Office for the Advancement of Telehealth, including grants, contracts, and cooperative agreements for the advancement of telehealth activities, *and of which $130,000,000 shall be for grants, contracts, and cooperative agreements for Long COVID programs*: 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 Systems", and "Rural Health": **[**Provided further, That of the amount made available under this heading, $1,521,681,000 shall be used for the projects financing the construction and renovation (including equipment) of health care and other facilities, and for the projects financing one-time grants that support health-related activities, including training and information technology, and in the amounts specified in the table titled "Community Project Funding/Congressionally Directed Spending" included for this division in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act): Provided further, That none of the funds made available for projects described in the preceding proviso shall be subject to section 241 of the PHS Act or section 205 of this Act.**]**

GENERAL PROVISIONS

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.

SEC. 206. In lieu of the timeframe specified in section 338E(c)(2) of the PHS Act, terminations described in such section may occur up to 60 days after the effective date of a contract awarded in fiscal year **[**2023**]** *2024* under section 338B of such Act, or at any time if the individual who has been awarded such contract has not received funds due under the contract.

Language Analysis

LANGUAGE PROVISION	EXPLANATION
[Provided further, That no funds shall be available for section 340G-1 of the PHS Act:**]**	Language removed because prohibition is not needed.
Provided further, the requirement in section 756(c) of the PHS Act shall apply to paragraphs (1) through (4) of section 756(a) of the PHS Act:	Language requested to facilitate priority funding of Historically Black Colleges and Universities and Minority Serving Institutions to train behavioral health providers.
Provided further, That within the amount made available in the proviso preceding the prior proviso, $25,000,000 shall remain available until expended for the purposes of making loan repayment awards to mental and behavioral health providers, including peer support specialists in accordance with section 338B of the PHS Act, notwithstanding the assignment priorities and limitations under sections 333(a)(1)(D), 333(b), 333A(a)(1)(B)(ii), and 334 of the PHS Act:	Language recommended to provide a set-aside for peer support specialists. Additionally, language necessary to additionally notwithstand PHS Act Section 334 to facilitate the ability of the Corps to assign mental and behavioral health providers, including peer support specialists, to crisis centers.
Provided further, That for purposes of the previous **[**proviso**]***three provisos* 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 *and services provided by certified peer support specialists.*	Propose adding “certified peer support specialists” to the list of providers covered under the term “primary health services”
Of the funds made available under this heading, $60,000,000 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, including funding for infrastructure development, maintenance, equipment, and minor renovations or alterations: 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	Language provides greater flexibility to the Medical Student Education program.

LANGUAGE PROVISION	EXPLANATION
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]*half* of States with a projected primary care provider shortage [in 2025], as determined by the Secretary: Provided further, That the minimum amount of a grant so awarded to such an institution shall be not less than $1,000,000 per year: Provided further, That such a grant may be awarded for a period not to exceed 5 years: Provided further, That such a grant awarded with respect to a year to such an institution shall be subject to a matching requirement of non-Federal funds in an amount that is not [less] *more* than 10 percent of the total amount of Federal funds provided in the grant to such institution with respect to such year.	
Provided, That the second sentence in section 372(a) of the PHS Act and section 372(b)(1)(A) of the PHS Act shall not apply to any contracts awarded by the Secretary for the operation of the Organ Procurement and Transplantation Network.	Language requested to provide flexibility by removing funding limits and requirements to award a contract to a non-profit entity.
Provided, That of the funds made available under this heading for Medicare rural hospital flexibility grants, *up to* $20,942,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology,	Language amended to provide greater flexibility to fund successful programs that benefit rural populations, including rural veterans.
[Provided further, That $145,000,000 shall be for the Rural Communities Opioids Response Program.]	Language is duplicative and not required for authorization.
and of which $130,000,000 shall be for grants, contracts, and cooperative agreements for Long COVID programs:	Language to provide authority to implement Long COVID program.

LANGUAGE PROVISION	EXPLANATION
[Provided further, That of the amount made available under this heading, $1,521,681,000 shall be used for the projects financing the construction and renovation (including equipment) of health care and other facilities, and for the projects financing one-time grants that support health-related activities, including training and information technology, and in the amounts specified in the table titled "Community Project Funding/Congressionally Directed Spending" included for this division in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act): Provided further, That none of the funds made available for projects described in the preceding proviso shall be subject to section 241 of the PHS Act or section 205 of this Act.]	Language not required as congressionally directed projects are not requested.

Amounts Available for Obligation[1]

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
General Fund Discretionary Appropriation:			
Appropriation	$ 8,556,794,000	$ 9,465,283,000	$ 9,163,699,000
Hurricane Supplemental		+65,000,000	
Appropriation Transfer -Bipartisan Safer Communities	+32,000,000		
Subtotal, adjusted general fund discretionary appropriation	**$8,588,794,000**	**$9,530,283,000**	**$9,163,699,000**
Bipartisan Safer Communities FY 2022 Advanced Appropriation		+32,000,000	+32,000,000
Mandatory Appropriation:[2]			
Family to Family Health Information Centers	+6,000,000	+6,000,000	+6,000,000
Primary Health Care Access:			
Community Health Center Fund	+4,000,000,000	+4,000,000,000	+5,170,000,000
National Health Service Corps	+310,000,000	+310,000,000	+790,000,000
Subtotal Primary Health Care Access	**+4,310,000,000**	**+4,310,000,000**	**+5,960,000,000**
Maternal, Infant, and Early Childhood Home Visiting Program	+400,000,000	+500,000,000	+550,000,000
Teaching Health Centers Graduate Medical Education	+126,500,000	+126,500,000	+157,000,000
Transfer to the Department of Justice	-5,000,000	-5,000,000	-5,000,000
Mandatory Sequestration	-142,675,000	-119,876,000	-31,692,000
Subtotal, adjusted mandatory appropriation	**$ 4,694,825,000**	**$ 4,817,624,000**	**$ 6,636,308,000**
Subtotal, adjusted appropriation	**$ 13,283,619,000**	**$ 14,379,907,000**	**$ 15,832,007,000**
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	+1,874,000,000	+843,000,000	+ 476,000,000
Unobligated balance, end of year	+843,000,000	+476,000,000	+503,000,000
Recoveries from prior year unpaid obligations	+69,000,000	-	-
Unobligated balance, lapsing	-5,000,000	-	-
Total obligations	**$16,083,433,000**	**$15,717,721,000**	**$16,829,821,000**

[1] Excludes the following amounts for reimbursable activities carried out by this account: FY 2022 -$46,000,000 and 50 FTE; FY 2023- $44,000,000 and 50 FTE; FY 2024 $44,000,000 and 50 FTE.

[2] FY 2024 level includes proposed mandatory funding for Health Centers, National Health Service Corps and Teaching Health Centers Graduate Medical Education

Summary of Changes

2023 Enacted	$9,465,283,000
(Obligations)	($9,465,283,000)
2024 Estimate	$9,163,699,000
(Obligations)	($9,163,699,000)
2023 Mandatory	$4,822,626,000
(Obligations)	($4,822,626,000)
2024 Mandatory	$6,641,308,000
(Obligations)	($6,641,308,000)
Net Change	**$1,517,098,000**

No.	Program	FY 2023 Enacted FTE	FY 2023 Enacted Budget Authority	FY 2024 President's Budget Budget Authority	FY 2024+/- FY 2023 FTE	FY 2024+/- FY 2023 Budget Authority
		2,408	$423,761,051	$466,031,041	**+140**	+$42,269,990
	Increases:					
	A. Built in:					
1	January 2024 Civilian Pay Raise		$12,238,124	$15,393,720		+3,155,596
2	January 2024 Military Pay Raise		942,127	1,109,698		+167,571
3	Civilian Annualization of Jan. 2024		2,394,415	4,539,174		+ 2,144,759
4	Military Annualization of Jan. 2024		204,810	327,219		+ 122,409
	Subtotal, built-in increases		**$15,779,476**	**$21,369,811**		**+$5,590,335**
	B. Program:					
	Discretionary Increases					
1	Health Centers	345	$ 1,737,772,000	$1,817,772,000	-	+$80,000,000
2	National Health Service Corps	19	125,600,000	175,600,000	-	+50,000,000
3	Loan Repayment/Faculty Fellowships	1	2,310,000	2,310,000	-	-
4	Centers of Excellence	4	28,422,000	36,711,000	-	+8,289,000
5	Scholarships for Disadvantaged Students	7	55,014,000	55,014,000	-	-
6	Health Careers Opportunity Program	1	16,000,000	18,500,000	-	+2,500,000
7	Health Care Workforce Assessment	3	5,663,000	5,663,000	-	-
8	Primary Care Training and Enhancement	5	49,924,000	53,924,000	-	+4,000,000
9	Oral Health Training	6	42,673,000	42,673,000	-	-
10	Area Health Education Centers	3	47,000,000	47,000,000	-	-
11	Geriatric Programs	5	47,245,000	47,245,000	-	-
12	Behavioral Health Workforce Development Programs	14	197,053,000	387,374,000	+ 15	+190,321,000
13	Public Health/Preventive Medicine	4	18,000,000	18,000,000	-	-
14	NURSE Corps Loan Repayment & Scholarship	28	92,635,000	92,635,000	-	-
15	Advanced Nursing Education	10	95,581,000	112,581,000	-	+17,000,000
16	Nurse Workforce Diversity	4	24,343,000	24,343,000	-	-
17	Nurse Education, Practice and Retention	5	59,413,000	91,873,000	+ 2	+32,460,000
18	Nurse Faculty Loan Program	4	28,500,000	28,500,000	-	-
19	Children's Hospitals GME Program	16	385,000,000	385,000,000	-	-
20	Graduate Medical Student Education	1	60,000,000	60,000,000	-	-
21	Supporting the Mental Health of the Health Professions Workforce	-	-	25,000,000	+ 2	+25,000,000
22	Health Care Workforce Innovation Program	-	-	27,540,000	+ 3	+27,540,000
23	Pediatric Subspecialty LRP	1	10,000,000	10,000,000	-	-
24	Maternal and Child Health Block Grant	66	815,700,000	937,300,000	+ 5	+121,600,000

No.	Program	FY 2023 Enacted FTE	FY 2023 Enacted Budget Authority	FY 2024 President's Budget Budget Authority	FY 2024+/- FY 2023 FTE	FY 2024+/- FY 2023 Budget Authority
25	Innovation for Maternal Health	5	15,300,000	15,300,000	-	-
26	Training for Health Care Providers	-	-	5,000,000	+ 1	+5,000,000
27	Integrated Services for Pregnant and Postpartum Women	1	10,000,000	25,000,000	+ 1	+15,000,000
28	Maternal Mental Health Hotline	1	7,000,000	7,000,000	-	-
29	Autism and Other Developmental Disorders	9	56,344,000	57,344,000	-	+1,000,000
30	Sickle Cell Service Demonstrations	2	8,205,000	8,205,000	-	-
31	Early Hearing Detection and Intervention	5	18,818,000	18,818,000	-	-
32	Emergency Medical Services for Children	6	24,334,000	28,134,000	-	+3,800,000
33	Healthy Start	22	145,000,000	185,000,000	+ 3	+40,000,000
34	Heritable Disorders	5	20,883,000	20,883,000	-	-
35	Pediatric Mental Health Care Access Grants	2	13,000,000	13,000,000	-	-
36	Screening and Treatment for Maternal Depression	2	10,000,000	10,000,000	-	-
37	Poison Control Centers	3	26,846,000	26,846,000	-	-
38	Ryan White Part A	48	680,752,000	680,752,000	-	-
39	Ryan White Part B	66	1,364,878,000	1,364,878,000	-	-
40	Ryan White Part C	56	208,970,000	208,970,000	-	-
41	Ryan White Part D	12	77,935,000	77,935,000	-	-
42	Ryan White Part F	4	34,886,000	34,886,000	-	-
43	Special Project of National Significance (SPNS)	3	25,000,000	25,000,000	-	-
44	Ending HIV Epidemic Initiative	29	165,000,000	290,000,000	-	+125,000,000
45	Organ Transplantation	10	31,049,000	67,049,000	+ 15	+36,000,000
46	Cell Transplantation and Cord Blood Stem Cell Bank	8	52,275,000	52,275,000	-	-
47	Hansen's Disease Center	36	13,706,000	13,706,000	-	-
48	Rural Health Policy Development	3	11,076,000	11,076,000	-	-
49	Rural Health Outreach Grants	12	92,975,000	95,375,000	-	+2,400,000
50	Rural Hospital Flexibility Grants	3	64,277,000	64,277,000	-	-
51	Radiation Exposure Screening and Education Program	1	1,889,000	2,734,000	-	+845,000
52	Rural Communities Opioid Response	21	145,000,000	165,000,000	-	+20,000,000
53	Rural Residency Planning and Development	2	12,500,000	12,700,000	-	+200,000
54	Rural Health Clinic Behavioral Health Initiative	-	-	10,000,000	+ 1	+10,000,000
55	The Financial and Community Sustainability for At-Risk Rural Hospitals Program	-	-	10,000,000	+ 2	+10,000,000
56	The Rural Hospital Stabilization Pilot Program	-	-	20,000,000	+ 2	+20,000,000
57	Family Planning	35	286,479,000	512,000,000	+ 2	+225,521,000
58	Program Management	801	163,800,000	168,971,000	+ 10	+5,171,000
59	Telehealth	9	38,050,000	44,500,000	-	+6,450,000
60	340B Drug Pricing Program/Office of Pharmacy Affairs	23	12,238,000	17,238,000	-	+5,000,000
61	Long COVID	-	-	130,000,000	+ 16	+130,000,000
	Subtotal Discretionary Program Increases	**1,797**	**$7,782,313,000**	**$ 9,002,410,000**	**+ 80**	**+$1,220,097,000**
				-		
	Mandatory Increases					
1	Health Centers	285	$3,905,348,000	$5,170,000,000	+ 60	+$1,264,652,000
2	National Health Service Corps	254	292,330,000	790,000,000	-	+497,670,000
3	Teaching Health Centers GME	16	119,290,000	157,000,000	-	+37,710,000
4	Family to Family Health Info Centers	1	5,658,000	5,658,000	-	-
5	Maternal Child Health Home Visiting	55	500,000,000	518,650,000	-	+18,650,000
	Subtotal Mandatory Program Increases	**611**	**$4,822,626,000**	**$6,641,308,000**	**+60**	**+$1,818,682,000**
				-		
	Decreases:			-		
	A. Built in:			-		
1	Pay Costs	2,408	$ 423,761,051	$ 466,031,041	+140	+$42,269,990
	B. Program:					

	Discretionary Decreases					
1	Program Management: Community Projects	-	1,521,681,000	-	-	-$1,521,681,000
	Subtotal Discretionary Program Decreases	-	**1,521,681,000**	**-**	**-**	**-$1,521,681,000**
	Mandatory Decreases	-	-	-	-	-
	Subtotal Mandatory Program Decreases	-	-	-	-	-
	Net Change Discretionary	**+1,797**	**$ 9,303,994,000**	**$ 9,002,410,000**	**+80**	**-$301,584,000**
	Net Change Mandatory	**+611**	**$ 4,822,626,000**	**$6,641,308,000**	**+60**	**+$1,818,682,000**
	Net Change Discretionary and Mandatory	**2,408**	**$14,126,620,000**	**$15,643,718,000**	**+140**	**+$1,517,098,000**

Authorizing Legislation[3],[4]

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
PRIMARY HEALTH CARE:				
Health Centers (Discretionary): Public Health Service (PHS) Act, Section 330, as amended (and specifically subsection 330(r)(1)), 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 Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle G, Section 2601	Authorized for FY 2023 (and each subsequent year), an amount equal to the previous year's funding adjusted by the product of one plus the average percentage increase in costs incurred per patient served and one plus the average percentage increase in the total number of patients served	$1,737,722,000	Authorized for FY 2024 (and each subsequent year), an amount equal to the previous year's funding adjusted by the product of one plus the average percentage increase in costs incurred per patient served and one plus the average percentage increase in the total number of patients served	$1,817,722,000
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 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	$4,000,000,000	$3,905,348,000[4]	Expired	$5,170,000,000

[3] 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.
[4] Post-sequestration funding level.

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
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)	Authorizes a fund of an amount equal to the amount estimated under paragraph (k)(1) that is attributable to entities receiving funds under each of the grant programs described in paragraph (g)(4), not to exceed a total of $10,000,000 for each fiscal year. Appropriations for purposes of this paragraph shall be made separate from appropriations made for purposes of sections 254b, 254b and 256a of this title.	$120,000,000	Authorizes a fund of an amount equal to the amount estimated under paragraph (k)(1) that is attributable to entities receiving funds under each of the grant programs described in paragraph (g)(4), not to exceed a total of $10,000,000 for each fiscal year. Appropriations for purposes of this paragraph shall be made separate from appropriations made for purposes of sections 254b, 254b and 256a of this title.	$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	Authorizes a fund of an amount equal to the amount estimated under paragraph (k)(1) that is attributable to entities receiving funds under each of the grant programs described in paragraph (g)(4), not to exceed a total of $10,000,000 for each fiscal year. Appropriations for purposes of this paragraph shall be made separate from appropriations made for purposes of sections 254b, 254b and 256a of this title	$1,000,000	Authorizes a fund of an amount equal to the amount estimated under paragraph (k)(1) that is attributable to entities receiving funds under each of the grant programs described in paragraph (g)(4), not to exceed a total of $10,000,000 for each fiscal year. Appropriations for purposes of this paragraph shall be made separate from appropriations made for purposes of sections 254b, 254b and 256a of this title	$1,000,000

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
Liability Protections for Health Professional Volunteers at Community Health Centers: PHS Act, Section 224(q), as added by P.L. 114-255, Section 9025; as amended by Continuing Appropriations and Ukraine Supplemental Appropriations Act 2023, Title III, section 301	Not Specified	---	Not Specified	---
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 2023 (and each subsequent year), based on previous year's funding, subject to adjustment formula	$125,600,000	Authorized for FY 2024 (and each subsequent year), based on previous year's funding, subject to adjustment formula	$175,600,000
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 (through FY 2023)	$292,330,000[5]	Expired	$790,000,000

[5] Post-sequestration funding level.

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
Mental Health and Substance Use Disorder Training for Health Care Professionals, Paraprofessionals, and Public Safety Officers: American Rescue Plan Act, Section 2705 (P.L. 117-2)	---	---	---	---
Grants for Health Care Providers to Promote Mental Health Among Their Health Professional Workforce: American Rescue Plan Act, Section 2705 (P.L. 117-2)	---	---	---	---
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	---
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 American Rescue Plan Act (P.L. 117-2), Section 2602(b) set-aside $100,000,000 to the SLRP (to remain available until expended) from the $800,000,000 appropriated to the National Health Service Corps (Section 2602(a))	---	Expired Note: The American Rescue Plan Act (P.L. 117-2), Section 2602(b) set-aside $100,000,000 to the SLRP (to remain available until expended) from the $800,000,000 appropriated to the National Health Service Corps (Section 2602(a))	---
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 (through FY 2025)	$2,310,000	$1,190,000 (through FY 2025)	$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 (through FY 2025)	$28,422,000	$23,711,000 (through FY 2025)	$36,711,000

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
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 (through FY 2025)	$55,014,000	$51,470,000 (through FY 2025)	$55,014,000
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 (through FY 2025)	$16,000,000	$15,000,000 (through FY 2025)	$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 (through FY 2025)	$5,663,000	$5,663,000 (through FY 2025	$5,663,000
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 340; as amended by the Bipartisan Safter Communities Act (BSCA) P.L. 117-159	$60,000,000 (through FY 2026)	$49,924,000	$60,000,000 (through FY 2026)	$53,924,000
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 (through FY 2025)	$42,673,000	$28,531,000 (through FY 2025)	$42,673,000
Graduate Medical Education for Physicians: as added by P.L. 115-245, Division B, Title II; as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Division H, Title II	--	$60,000,000	--	$60,000,000
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 (through FY 2025)	$47,000,000	$41,250,000 (through FY 2025)	$47,000,000

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 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 (through FY 2025)	$47,245,000	$40,737,000 (through FY 2025)	$47,245,000
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; as amended by the Consolidated Appropriations Act, 2023, Pub. L. 117-328, Section 1311 Mental and Behavioral Health Education and Training Programs (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(b); as amended by Consolidated Appropriations Act, 2023, Pub. L. 117-328, Section 1311 Note: PHS Act, Section 781(j) provides the authorization of appropriations for Substance Use Disorder Treatment Workforce (STAR) Loan Repayment Program (LRP) • Graduate Psychology Education (GPE) • Opioid Workforce Expansion Program (OWEP) • Opioid Impacted Family Support Program (OIFSP) • Behavioral Health Workforce Technical Assistance and Evaluation (BHWD TAE) Program • Addiction Medicine Fellowship (AMF) • Integrated Substance Use Disorder Training Program (ISTP) • Substance Use Disorder Treatment Workforce (STAR) Loan Repayment Program (LRP)	BHWET: $50,000,000 (through FY 2027) MBHET: (through FY 2027) 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 PHS Act, Section 781, Subsection (j): $25,000,000	$197,053,000	BHWET: $50,000,000 (through FY 2027) MBHET: (through FY 2027) 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 PHS Act, Section 781, Subsection (j): $25,000,000	$387,374,000

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
Public Health /Preventive Medicine: PHS Act, Sections 765-768, 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	$18,000,000	$17,000,000	$18,000,000
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.	$95,581,000	See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D.	$112,581,000
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.	$24,343,000	See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D.	$24,343,000
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.	$59,413,000	See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D.	$91,873,000

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
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(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D.	$28,500,000
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(b) provides an authorization of appropriations of $117,135,000 for all programs under Title VIII Part E, 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	$92,635,000	See PHS Act, Section 871(b), which authorized appropriations of $117,135,000 for all programs under Title VIII Part E	$92,635,000
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 (through FY 2023)	$385,000,000	Expired	$385,000,000

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
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; as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Title III, Subtitle A, Section 301	$126,500,000 (through FY 2023, to remain available until expended)	$119,290,000[6]	Expired	$157,000,000
Teaching Health Centers (THC) Development Grants: PHS Act, Section 749A, as added by P.L. 111-148, Section 5508)	Such sums as may be- necessary (permanent)	---	Such sums as may be- necessary (permanent)	---
National Practitioner Data Bank (User Fees) Social Security Act (SSA) sections 1921 and 1128E Title IV, P.L. 99-660; Section 5, P.L. 100-93, SSA Section 1921; Section 221(a), P.L. 104-191, 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"	----	---	---	---

[6] Post-sequestration funding level.

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
Grants for Innovative Programs: PHS Act, Section 340G, as amended by P.L. 115-302, Section 3	$13,903,000 (through FY 2023)	---	Expired	---
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 (through FY 2025)	$10,000,000	Such sums as may be necessary (through FY 2025)	$10,000,000
Supporting the Mental Health of the Health Professions Workforce: PHS Act, Section 764, as amended by P.L. 117-105	$35,000,000 (through FY 2024)	---	$35,000,000 (through FY 2024)	$25,000,000
Health Care Workforce Innovation: PHS Act, Section 741, 807	Expired	---	Expired	$27,450,000
MATERNAL AND CHILD HEALTH:				
Maternal and Child Health Block Grant: Social Security Act, Title V, as amended by P.L. 106-554, Section 921	$850,000,000 (permanent)	$815,700,000	$850,000,000 (permanent)	$937,300,000
Innovation for Maternal Health (AIM): PHS Act, Section 330O as added by P.L. 117-103, Consolidated Appropriations Act, 2022, Section 131	$9,000,000 (through FY 2027)	$15,300,000	$9,000,000 (through FY 2027)	$15,300,000
Integrated Services for Pregnant and Postpartum Women: PHS Act, Section 330P as added by P.L. 117-103, Consolidated Appropriations Act, 2022, Section 134(a)	$10,000,000 (through FY 2027)	$10,000,000	$10,000,000 (through FY 2027)	$25,000,000
Training for Health Care Providers: PHS Act, Section 763 as added by P.L. 117-103, Consolidated Appropriations Act, 2022, Section 132	$5,000,000 (through FY 2027)	---	$5,000,000 (through FY 2027)	$5,000,000
Maternal Mental Health Hotline: PHS Act, Section 399V–7 as added by P.L. 117-328, Consolidated Appropriations Act, 2023, section 1112	$10,000,000 (through FY 2027)	$7,000,000	$10,000,000 (through FY 2027)	$7,000,000
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)	$56,344,000	$50,599,000 (through FY 2024)	$57,344,000

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
Sickle Cell Service Demonstration Grants: P.L. 108-357, American Jobs Creation Act of 2004, Section 712(c), as amended by P.L. 115-327, Section 3 (which transferred Section 712(c) of P. L. 108–357, and re-designated it as PHS Act, Section 1106)	$4,455,000 (through FY 2023)	$8,205,000	Expired	$8,205,000
Early Hearing Detection and Intervention: 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; as amended by P.L. 117-241, Early Hearing Detection and Intervention Act of 2022, Section 2	$17,818,000 (through 2027)	$18,818,000	$17,818,000 (through 2027)	$18,818,000
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 P.L. 116-49, Emergency Medical Services for Children Program Reauthorization Act of 2019, Section 2	$22,334,000 (through FY 2024)	$24,334,000	$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 (through FY2025)	$145,000,000	$125,500,000 (through FY2025)	$185,000,000
Heritable Disorders: PHS Act, Sections 1109-1112, 1114, and 1117, 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	Expired	$20,883,000	Expired	$20,883,000
Pediatric Mental Health Care Access Grants: PHS Act, Section 330M, as added by P.L. 114-255, Section 10002; as amended by P.L. 117-159, Bipartisan Safer Communities Act, Section 11005	$31,000,000 (through FY 2027)	$13,000,000	$31,000,000 (through FY 2027)	$13,000,000
Screening and Treatment for Maternal Mental Health and Substance Use Disorders (formerly Screening and Treatment for Maternal Depression): PHS Act, Section 317L-1, as added by P.L. 114-255, Section 10005; as amended by P.L. 117-328, Consolidated Appropriations Act, 2023, section 1111	$24,000,000 (through FY 2027)	$10,000,000	$24,000,000 (through FY 2027)	$10,000,000

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 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 (through FY 2024)	$26,846,000	Toll-free number: $700,000 Media campaign: $800,000 Grant program: $28,600,000 (through FY 2024)	$26,846,000
Family to Family Health Information Centers: Social Security Act, Section 501(c)(1)(A), as added by P.L. 109-171, Section 6064; reauthorized by P.L. 111-148, 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 (through FY 2024)	$5,658,000[7]	$6,000,000 (through FY 2024)	$5,658,000[8]
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); as amended by the Continuing Appropriations and Ukraine Supplemental Appropriations Act, P.L. 117-180); as amended by P.L. 117-328, Consolidated Appropriations Act, 2023, section 6101	$500,000,000	$500,000,000	$550,000,000	$518,650,000[9]
HIV/AIDS:				
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	$680,752,000	Expired	$680,752,000

[7] Post-sequestration funding level.
[8] Post-sequestration funding level.
[9] Post-sequestration funding level.

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
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	$1,364,878,000	Expired	$1,364,878,000
AIDS Drug Assistance Program (Non-Add) PHS Act, Sections 2611-31 and 2616, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	$900,313,000	Expired	$900,313,000
Early Intervention Services – Part C: PHS Act, Sections 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	$208,970,000	Expired	$208,970,000
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	$77,935,000	Expired	$77,935,000
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	$34,886,000	Expired	$34,886,000
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	$13,620,000	Expired	$13,620,000
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	$165,000,000	Expired	$290,000,000
HEALTH 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	$31,049,000	Expired	$67,049,000

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
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; as amended by TRANSPLANT Act of 2021, Section 3, P.L. 117-15	$23,000,000 (through FY 2026)		$23,000,000 (through FY 2026)	
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; TRANSPLANT Act of 2021, Section 2, P.L. 117-15	$31,009,000 (through FY 2026)	$52,275,000	$31,009,000 (through FY 2026)	$52,275,000
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
RURAL HEALTH:				
Rural Health Policy Development: Social Security Act, Section 711, as amended through P.L. 108-173, Section 432; and PHS Act, Section 301; as amended through P.L. 114-255, Sections 2012, 2013, 2035, and 2043	Not Specified	$11,076,000	Not Specified	$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 and Social Security Act, Section 711, as amended through P.L. 108-173	$79,500,000 (through FY 2025)	$92,975,000	$79,500,000 (through FY 2025)	$95,375,000

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
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) and Social Security Act, Section 711, as amended through P.L. 108-173	Expired	$64,277,000	Expired	$64,277,000
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; as amended by the State Offices of Rural Health Program Reauthorization Act of 2022, P.L. 117-356	$12,500,000 (through FY 2027)	$12,500,000	$12,500,000 (through FY 2027)	$12,500,000
Radiogenic Diseases (Radiation Exposure Screening and Education Program): PHS Act, Section 417C, as amended by P.L. 106-245, Section 4, as amended by P.L. 109-482, Sections. 103, 104	Not Specified	$1,889,000	Not Specified	$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	$10,000,000	$12,190,000	$10,000,000	$12,190,000
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	$145,000,000	Not Specified	$165,000,000
Rural Residency: SSA, Section 711(b)(5), as added by P.L. 108-173, Section 432	Not Specified	$12,500,000	Not Specified	$12,700,000
Rural Health Clinic Behavioral Health: SSA, Section 711, as amended by Public Law 108-173.	Not Specified	---	Not Specified	$10,000,000
The Financial and Community Sustainability for At-Risk Rural Hospitals: Social Security Act, Section 711, as amended by 21st Century Cures Act, Sections 2012 2013 2035, and 2043, Public Law 114-255	Not Specified	---	Not Specified	$10,000,000
Rural Hospital Stabilization Pilot: Social Security Act, Section 711, as amended by 21st Century Cures Act, Sections 2012 2013 2035, and 2043, Public Law 114-255	Not Specified	---	Not Specified	$20,000,000

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
OTHER PROGRAMS:				
Family Planning: Grants: PHS Act Title X	Expired	$286,479,000	Expired	$512,000,000
Program Management	Indefinite	$163,800,000	Indefinite	$168,971,000
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)	Such sums as may be necessary (permanent)	$12,238,000	Such sums as may be necessary (permanent)	$17,238,000
Telehealth: PHS Act, Section 330I, Section 330L, Section 330N, 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 (through FY 2025)	$38,050,000	$29,000,000 (through FY 2025)	$44,500,000
Vaccine Injury Compensation Program (VICP) (funded through the VICP Trust Fund): PHS Act, Title XXI, Subtitle 2, Sections 2110-2134, as amended by P.L. 114-255, Section 3093(c).	Indefinite	$271,570,000	Indefinite	$287,697,000
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	$7,000,000	Not Specified	$15,000,000
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)	----	---	----	---

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
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; as amended by Consolidated Appropriations Act, 2023 Pub. L. 117-328, section 1401	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; as amended by Consolidated Appropriations Act, 2023 Pub. L. 117-328, section 1401	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)	---
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	---

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
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)	---	Expired	---
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	---
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	---

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 President's Budget
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	---
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	---

Budget Authority by Activity
Health Resources and Services Administration

(dollars in thousands)

Activity	FY 2022 Final/1	FY 2023 Enacted/2	FY 2024 President's Budget	FY 2024 +/- FY 2023 Enacted
1. PRIMARY CARE:				
Health Centers:				
Health Centers	1,627,772	1,737,772	1,817,772	+80,000
Health Centers Mandatory	3,905,348	3,905,348	-	-3,905,348
Health Centers Mandatory Proposed	-	-	5,170,000	+5,170,000
Health Center Tort Claims	120,000	120,000	120,000	-
Subtotal, Health Centers	***5,653,120***	***5,763,120***	***7,107,772***	***1,344,652***
Free Clinics Medical Malpractice	1,000	1,000	1,000	-
Subtotal, Bureau of Primary Health Care	**5,654,120**	**5,764,120**	**7,108,772**	**+1,344,652**
2. HEALTH WORKFORCE:				
National Health Service Corps (NHSC):				
NHSC	121,600	125,600	175,600	+50,000
NHSC Mandatory	292,330	292,330	-	-292,330
NHSC Mandatory proposed	-	-	790,000	+790,000
Subtotal, NHSC	***413,930***	***417,930***	***965,600***	***+547,670***
Loan Repayment/Faculty Fellowships	1,226	2,310	2,310	-
Health Professions Training for Diversity:				
Centers of Excellence	24,422	28,422	36,711	+8,289
Scholarships for Disadvantaged Students	53,014	55,014	55,014	-
Health Careers Opportunity Program	15,450	16,000	18,500	+2,500
Subtotal, Health Professions Training for Diversity	***92,886***	***99,436***	***110,225***	***+10,789***
Health Care Workforce Assessment	5,663	5,663	5,663	-
Primary Care Training and Enhancement	48,924	49,924	53,924	+4,000
Oral Health Training Programs	40,673	42,673	42,673	-
Medical Student Education	55,000	60,000	60,000	-
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	45,000	47,000	47,000	-
Geriatric Programs	45,245	47,245	47,245	-
Behavioral Health Workforce Development Programs	162,053	197,053	387,374	+190,321
Subtotal, Interdisciplinary, Community-Based Linkages	***252,298***	***291,298***	***481,619***	***+190,321***

Public Health Workforce Development:				-
Public Health/Preventive Medicine	17,000	18,000	18,000	-
Nursing Workforce Development:				
Advanced Nursing Education	85,581	95,581	112,581	+17,000
Nursing Workforce Diversity	23,343	24,343	24,343	-
Nurse Education, Practice and Retention	54,413	59,413	91,873	+32,460
Nurse Faculty Loan Program	28,500	28,500	28,500	-
NURSE Corps Scholarship and Loan Repayment Program	88,635	92,635	92,635	-
Subtotal, Nursing Workforce Development	***280,472***	***300,472***	***349,932***	***+49,460***
CHGME	375,000	385,000	385,000	-
Teaching Health Center Graduate Medical Education (THCGME):				-
THCGME Mandatory	119,290	119,290	-	-119,290
THCGME Mandatory Proposed	-	-	157,000	+157,000
Subtotal, THCGME	***119,290***	***119,290***	***157,000***	***+37,710***
National Practitioner Data Bank (User Fees)	*18,814*	*18,814*	*18,814*	-
Pediatric Subspecialty LRP	5,000	10,000	10,000	-
Supporting the Mental Health of the Health Professions Workforce	-	-	25,000	+25,000
Health Care Workforce Innovation Program	-	-	27,540	+27,540
Subtotal, Bureau of Health Workforce	**1,726,176**	**1,820,810**	**2,713,300**	**+892,490**
3. <u>MATERNAL & CHILD HEALTH:</u>				
Maternal and Child Health Block Grant	733,003	815,700	937,300	+121,600
Innovation for Maternal Health	11,775	15,300	15,300	-
Training for Health Care Providers	-	-	5,000	+5,000
Integrated Services for Pregnant and Postpartum Women/3	-	10,000	25,000	+15,000
Maternal Mental Health Hotline	4,000	7,000	7,000	-
Autism and Other Developmental Disorders	54,344	56,344	57,344	+1,000
Sickle Cell Service Demonstrations	7,010	8,205	8,205	-
Early Hearing Detection and Intervention	17,818	18,818	18,818	-
Emergency Medical Services for Children	22,276	24,334	28,134	+3,800
Healthy Start	131,340	145,000	185,000	+40,000
Heritable Disorders	19,558	20,883	20,883	-
Pediatric Mental Health Care Access Grants	11,000	13,000	13,000	-
Screening and Treatment for Maternal Depression	6,500	10,000	10,000	-
Poison Control Centers	25,846	26,846	26,846	-
Family-to-Family Health Information Centers (F2F HIC)				-
F2F HIC Mandatory	5,658	5,658	5,658	-
F2F HIC Mandatory Proposed	-	-		-

Subtotal, F2F HIC	***5,658***	***5,658***	***5,658***	***-***
Maternal, Infant and Early Childhood Home Visiting (MIECHV):				
MIECHV Mandatory	377,200	500,000	518,650	+18,650
MIECHV Mandatory Proposed	-			-
Subtotal, MIECHV	***377,200***	***500,000***	***518,650***	***+18,650***
Subtotal, Maternal and Child Health Bureau	**1,427,328**	**1,677,088**	**1,882,138**	**+205,050**
4. HIV/AIDS:				
Emergency Relief - Part A	670,458	680,752	680,752	-
Comprehensive Care - Part B	1,344,240	1,364,878	1,364,878	-
AIDS Drug Assistance Program (non-add)	*900,313*	*900,313*	*900,313*	-
Early Intervention - Part C	205,054	208,970	208,970	-
Children, Youth, Women & Families - Part D	77,252	77,935	77,935	-
AIDS Education and Training Centers - Part F	34,358	34,886	34,886	-
Dental Reimbursement Program Part F	13,414	13,620	13,620	-
Special Projects of National Significance (SPNS)	25,000	25,000	25,000	-
Ending HIV Epidemic Initiative	125,000	165,000	290,000	+125,000
Subtotal, HIV/AIDS Bureau	**2,494,776**	**2,571,041**	**2,696,041**	**+125,000**
5. HEALTH SYSTEMS:				
Organ Transplantation	30,049	31,049	67,049	+36,000
Cell Transplantation Program and Cord Blood Stem Cell Bank	50,275	52,275	52,275	-
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, Health Systems Bureau (HSB)	**96,009**	**99,009**	**135,009**	**+36,000**
6. RURAL HEALTH:				
Rural Health Policy Development	11,076	11,076	11,076	-
Rural Health Outreach Grants	85,975	92,975	95,375	+2,400
Rural Hospital Flexibility Grants	62,277	64,277	64,277	-
State Offices of Rural Health	12,500	12,500	12,500	-
Radiation Exposure Screening and Education Program	1,889	1,889	2,734	+845
Black Lung	11,845	12,190	12,190	-
Rural Communities Opioid Response	135,000	145,000	165,000	+20,000
Rural Residency Planning and Development	10,500	12,500	12,700	+200
Rural Health Clinic Behavioral Health Initiative	-	-	10,000	+10,000
The Financial and Community Sustainability for At-Risk Rural Hospitals Program	-	-	10,000	+10,000
The Rural Hospital Stabilization Pilot Program			20,000	+20,000
Subtotal, Federal Office of Rural Health Policy	**331,062**	**352,407**	**415,852**	**+63,445**

7. HRSA-WIDE ACTIVITIES AND PROGRAM SUPPORT:				
Program Management:				
Program Management	155,300	163,800	168,971	+5,171
Program Management: Community Projects	1,057,896	1,521,681	-	-1,521,681
Subtotal, Program Management	**1,213,196**	**1,685,481**	**168,971**	**-1,516,510**
340B Drug Pricing Program/Office of Pharmacy Affairs	11,238	12,238	17,238	+5,000
Telehealth	35,050	38,050	44,500	+6,450
Long COVID	-	-	130,000	+130,000
Subtotal, HRSA-Wide Activities	**1,259,484**	**1,735,769**	**360,709**	**-1,375,060**
8. FAMILY PLANNING	286,479	286,479	512,000	+225,521
Total, HRSA Discretionary Budget Authority/3	**8,556,794**	**9,465,283**	**9,163,699**	**-301,584**
FTE/3	**2,424**	**2,631**	**2,771**	**+140**

1/Reflects amounts appropriated and any reprogrammings or reallocations notified to Congress. Does not include $140 million in supplemental funding provided in the Bipartisan Safer Communities Act (P.L. 117–159

2/ Does not include $65 million in supplemental funding provided in the Consolidate Appropriations Act, 2023.

3/Excludes Vaccine Injury Compensation and Countermeasures Injury Compensation

Appropriations History Table

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

Activity	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2020				
General Fund Appropriation:				
Base	5,841,352,000	7,326,109,000	6,928,714,000	7,037,259,000
Advance				
Supplemental				975,000,000
Rescissions				
Transfers				
Subtotal	5,841,352,000	7,326,109,000	6,928,714,000	8,012,259,000
FY 2021				
General Fund Appropriation:				
Base	6,289,085,000	7,195,758,000	7,104,535,000	7,207,234,000
Advance				
Supplemental				9,430,000,000
Rescissions				
Transfers				-21,671,000
Subtotal	6,289,085,000	7,195,758,000	7,104,535,000	16,615,563,000
FY 2022				
General Fund Appropriation:				
Base	7,813,294,000	8,740,422,000		8,556,794,000
Advance				
Supplemental				140,000,000
Rescissions				
Transfers				
Subtotal	7,813,294,000	8,740,422,000		8,696,794,000
FY 2023				
General Fund Appropriation:				
Base	8,485,044,000	9,295,951,000		9,465,283,000
Advance				
Supplemental				65,000,000
Rescissions				
Transfers				
Subtotal	8,485,044,000	9,295,951,000		9,530,283,000
FY 2024				
General Fund Appropriation:				
Base	9,163,699,000			
Advance				
Supplemental				
Rescissions				
Transfers				
Subtotal	9,163,699,000			

Appropriations Not Authorized by Law[10]

HRSA Program	Last Fiscal Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2024
NHSC – PHS Act, Sections 331-338 Authorization of appropriations ("Field"): Section 338(a)	2012	Such Sums As May Be Necessary	---	---
Nursing Workforce Development • Comprehensive Geriatric Education – PHS Act, Section 865	2014	Such Sums As May Be Necessary	$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	$680,752,000
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	$1,364,878,000
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	$208,970,000
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	$77,935,000
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	$34,886,000
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	$13,620,000
Minority AIDS Initiative – Part F – PHS Act section 2693	2013	---	Varies by Part	---

[10] 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 Fiscal Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2024
Heritable Disorders: PHS Act, Sections 1109-1112, 1114, and 1117, 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	2019	$11,900,000 (Sections 1109-1112); $8,000,000 (Section 1113)	$18,883,000	$20,883,000
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	2009	Section 377— $5,000,000 Section 377A— Such Sums As May Be Necessary Section 377B— Such Sums As May Be Necessary	$2,767,000	$67,049,000
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	Such Sums As May Be Necessary	$41,040,000	$64,277,000
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	2022	$12,500,000	$12,500,000	$12,500,000
Family Planning Grants – PHS Act, Title X	1985	158,400,000	$142,500,000	$512,000,000
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 American Rescue Plan Act (P.L. 117-2), Section 2602(b) set-aside $100,000,000 to the SLRP (to remain available until expended) from the $800,000,000 appropriated to the National Health Service Corps (Section 2602(a))	---	Expired Note: The American Rescue Plan Act (P.L. 117-2), Section 2602(b) set-aside $100,000,000 to the SLRP (to remain available until expended) from the $800,000,000 appropriated to the National Health Service Corps (Section 2602(a))	---
Graduate Medical Education for Physicians: as added by P.L. 115-245, Division B, Title II; as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Division H, Title II	---	$50,000,000	---	$60,000,000

PRIMARY HEALTH CARE

TAB

PRIMARY HEALTH CARE

Health Centers

(dollars in thousands)

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$1,627,772	$1,737,772	$1,817,772	+$80,000
Current Law Mandatory Funding	$3,905,348	$3,905,348	---	-$3,905,348
Proposed Law Mandatory Funding	---	---	$5,170,000	+$5,170,000
FTCA Program	$120,000	$120,000	$120,000	---
Total	$5,653,120	$5,763,120	$7,107,772	+$1,344,652
FTE	608	630	690	+60

Authorizing Legislation (discretionary): Public Health Service Act, Section 330, as amended by Public Law 116-260, Consolidated Appropriations Act 2021, Division BB, Title III, Section 311

Authorizing Legislation (mandatory): Patient Protection and Affordable Care Act, Section 10503, as amended by Public Law 116-260, Consolidated Appropriations Act 2021, Section 301.

FY 2024 Authorization (discretionary): FY 2023 appropriation 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 2024 Community Health Center Fund Authorization (mandatory)..... Expires end of FY 2023

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

Program Description

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 nearly 15,000 service delivery sites that provide care to approximately 30 million patients across every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

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, to ensure our nation's underserved communities and those disproportionately affected by COVID-19 are equitably vaccinated against COVID-19. Through this program, millions of people living in the nation's medically underserved communities and those disproportionately affected by COVID-19 have received vaccines. In addition, HRSA provided at-home self-tests, point of care testing equipment and supplies, and National Institute for Occupational Safety approved N95 respirator masks for health center patients and individuals in their communities. HRSA, in partnership with HHS partners, also administer a program to directly allocate oral antiviral pills for the outpatient treatment of mild to moderate COVID-19 in health centers.

Health centers continue to deliver high quality and value-based care by using key quality improvement practices, including health information technology. Seventy-eight 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.

Populations served: Health centers serve a diverse patient population. In 2021:

- People of all ages: Approximately 29 percent of patients were children (age 17 and younger); approximately 11 percent were 65 or older. Over 62 percent were adult patients (18-64), an increase of 1.7 percent.

- People in poverty: Approximately 90 percent of health center patients are individuals or families living at or below 200 percent of the Federal Poverty Guidelines as compared to approximately 27.5 percent of the U.S. population.

- Health insurance status: Over 20 percent were without health insurance. Those patients that are insured are covered by Medicaid (48%), Medicare (11%), other public insurance (1%), or private insurance/marketplace (20%).

- Special Populations: More than one third of health centers received specific funding in FY 2022 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 nearly 1.3 million individuals experiencing homelessness, almost 1 million agricultural workers and their families, approximately 5.7 million people living in or near public housing, and almost 6,800 Native Hawaiians.

    - Health Care for the Homeless Program: The Health Care for the Homeless Program supports coordinated, comprehensive, integrated primary care including substance use disorder and mental health services for homeless persons in the United States, serving patients that live in unsheltered locations, in shelters, or in transitional housing. In 2021, HRSA-funded health centers provided primary care

services for nearly 1.3 million persons in supportive housing and/or experiencing homelessness.

- Migrant Health Center Program: 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. HRSA-funded health centers provided primary care services for over 1 million migratory and seasonal agricultural workers and their families, nearly half of the estimated 2.2 million active migratory and seasonal agricultural workers in the United States.

- Public Housing Primary Care Program: The Public Housing Primary Care Program increases access for residents of public housing to comprehensive, integrated primary care services by providing services that are responsive to identified needs of residents and in coordination with public housing authorities. Health centers deliver care at locations on the premises of public housing developments or immediately accessible to residents. HRSA-funded health centers provided primary care services for nearly 5.7 million people living in or near public housing.

- Native Hawaiian Health Care Program: The Native Hawaiian Health Care Program, funded within the Health Center Program, 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 6,800 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: The number of health center patients served in 2021 was 30.2 million; an increase of nearly 10 million, or 49 percent, above the 20.2 million patients served in 2011. Of

the 30.2 million patients served and for those for whom income status is known, approximately 90 percent were at or below 200 percent of the Federal poverty level and approximately 20 percent were uninsured. Success in increasing the number of patients served has been due in large part to increased Health Center Program investments in the development of new health centers, new satellite sites, and expanded capacity at existing clinics.

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. These ongoing annual investments remained in health center continuation awards in FY 2022 and are projected to continue in future fiscal years. This funding supports 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.

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.

Budget Request

The FY 2024 Budget Request for the Health Center Program is $7.1 billion, an increase of $1.3 billion above the FY 2023 Enacted Level and proposes a pathway to doubling the program's funding with a critical three-year down payment on this goal. This total consists of $1.9 billion in discretionary resources and includes $5.2 billion in mandatory funding. Current mandatory resources of $4 billion for each fiscal year expire at the end of FY 2023.

As a result of this expanded investment, approximately 3 million more patients will be served by health centers in FY 2024. All health centers will have the funding necessary to provide mental health and substance use services and expand hours of operations. HRSA will also be able to award grants to hundreds of new health center sites to address barriers to primary care for high-need communities.

<u>Mandatory Funding</u>
The Budget proposes to require that all health centers provide mental health and substance use disorder services under Section 330 of the Public Health Service Act. Currently, health centers are meeting approximately 27 percent of the estimated demand for mental health services, and

approximately six percent of the estimated demand for substance use disorder services among their patients. The new mandatory funding included in the Budget will provide resources to implement this new requirement. Specifically, HRSA proposes to more than double the current Health Center Program investments in behavioral health services through a new $700 million behavioral health service expansion funding opportunity to support expanded behavioral health services in the nearly 1,400 existing health centers across the country.

The Budget will also support increased hours of operations. Extended or weekend hours are proven methods for increasing access to necessary primary health care services for medically underserved populations, including for those who work nontraditional hours, live in rural or remote areas, or face other obstacles to primary health care. In addition, expanded hours of operations also help prevent unnecessary and more expensive visits to hospital emergency rooms or urgent care centers. To address these needs, HRSA proposes a new $250 million investment to extended hours for health centers.

In FY 2024, HRSA will also fund a new access point competition for new health center organizations and sites. Up to 24 million individuals below 200 percent of the Federal Poverty Level are experiencing significant primary medical care access barriers. Increasing access to the health center model of care in these high need areas will assure that medically underserved populations have access to affordable, comprehensive, high quality primary health care services. HRSA proposes to invest $150 million in a New Access Point Funding opportunity targeted to areas of highest need using an evidence based, transparent methodology. There is significant need and demand for a New Access Point competition across the country, as the last such funding opportunity was held in FY 2019 and HRSA was only able to fund 75 out of more than 550 applications. The Budget will support approximately 230 new access point awards.

Proposed Mandatory Funding	**FY 2024** $5.170 billion	**FY 2025** $6.340 billion	**FY 2026** $7.510 billion

Discretionary Funding

As part of the Ending the HIV Epidemic (EHE) Initiative, the HRSA Health Center Program provides HIV testing and prevention services, HIV care and treatment where appropriate, and assists with responding quickly to HIV cluster detection efforts. The HRSA Health Center Programs' primary focus in the EHE initiative is on expanding HIV prevention services, including 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 2024, the Budget includes a total of $172 million, an increase of $15 million above the FY 2023 Enacted level, which will support the total participation of approximately 400 health centers in the EHE initiative targeted jurisdictions. The Health Center Program will continue to provide prevention and treatment services to people at high risk for HIV transmission, including Pre-Exposure Prophylaxis (PrEP)-related services, outreach, and care coordination through new grant awards in areas currently served by health centers.

The FY 2024 Budget provides a total of $85 million, an increase of $55 million, to support the expansion of early childhood screening and development (ECD) services in 275 additional health centers. Children undergo rapid physical, cognitive, linguistic, and emotional growth and

development at this stage, and screening efforts help identify developmental or behavioral conditions, language delays, or other needs, such as food insecurity and housing instability, that can contribute to gaps in school readiness and impact a student's ability to succeed. Health centers that receive these awards will use the funding to strengthen their capacity to provide more children with recommended developmental screenings and follow-up services, including by developing the health center workforce necessary to deliver these services and focusing on the patient and caregiver experience. Health center recipients of ECD funding may increase capacity to provide ECD services through training of current staff and/or hiring or contracting with additional staff with ECD expertise.

The Budget includes a total of $20 million to support targeted cancer screening awards in 20 additional health centers under the Alcee L. Hastings Cancer Screening Program. The program focuses on leveraging outreach specialists and patient navigators to conduct patient outreach in underserved communities served by health centers to promote early detection of cancer, connect patients to screening services, and provide hands-on assistance with accessing high quality cancer care and treatment as needed, in partnership or coordination with National Cancer Institute (NCI)-designated Cancer Centers.

The Budget also supports $120 million for the FTCA Program, which is equal to the FY 2023 Enacted level. The request supports costs associated with the grant review and award process, operational site visits, information technology, and other program support costs.

Health centers continue to be a critical element of the health system, largely because they can provide an accessible and dependable source of high quality, affordable, and cost-effective primary health care services in underserved communities. 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 health information technology. The health center model also addresses 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.[11] 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 percent lower spending on specialty care, 25 percent fewer inpatient admissions, and 24 percent 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.

[11] 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

The FY 2024 Budget 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 2024, and has added measures for depression screening, HIV linkage to care, and the provision of substance use disorder services.

The Health Center Program will continue to promote efficient, value-based care, and aims to maintain the ratio of 1,734 medical patients per medical physician. The FY 2024 Request also supports efforts to improve the value, quality, and program integrity in all HRSA-funded programs that deliver direct health care. Health centers annually report on a core set of clinical performance measures that are consistent with Healthy People 2030, 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 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 health information technology 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, ongoing communication with grantees, 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). In FY 2024, health centers will begin reporting de-identified patient level data to further improve the delivery of care and develop more targeted interventions to improve health outcomes.

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 to maximize the impact and efficient use of federal resources.
The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Funding History

Fiscal Year	Amount	Supplemental Funding
FY 2020	$1,625,522,000	$700,000,000
FY 2020 Mandatory	$4,000,000,000	$1,320,000,000
FY 2021	$1,674,203,000	---
FY 2021 Mandatory	$4,000,000,000	$7,600,000,000
FY 2022	$1,627,772,000	---
FY 2022 Mandatory	$3,905,348,000[12]	---
FY 2023	$1,857,772,000	---
FY 2023 Mandatory	$3,905,348,000[13]	---
FY 2024 President's Budget	$1,937,772,000	---
FY 2024 President's Budget Mandatory	$5,170,000,000	---

Program Accomplishments

In 2021, health centers served 30.2 million patients, an increase of approximately 1.6 million patients, or 6 percent from Calendar Year (CY) 2020. Health centers served one in every eleven people living in the United States and provided approximately 124 million patient visits (a 9 percent increase from CY 2020). In 2021, about 42 percent of all health centers served rural areas providing care to over 9.5 million patients. 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. Health centers successfully expanded telehealth and introduced new critical service lines, including COVID-19 testing, vaccinations, and treatment. In 2021, health centers reported increased levels of medical visits (6.5 percent), mental health (7.5 percent), enabling services (10.8 percent), vision care (25.5 percent), and oral health (21.5 percent).

Despite treating a sicker, poorer, and more diverse population than other health care providers, health centers exceeded numerous national averages and benchmarks in 2021, including the Healthy People 2030 objective baselines for dental sealant services, HIV linkage to care, and hypertension control. In 2021, 89 percent of health centers met or exceeded the Healthy People 2030 hypertension control baseline, 71 percent met or exceeded the dental sealant baseline, and 66 percent met or exceeded the HIV linkage to care baseline[14]. Health centers also reduce costs

[12] FY 2022 reflects the post-sequestration amount of current law mandatory funding.
[13] FY 2023 reflects the post-sequestration amount of current law mandatory funding.
[14] HP2030 objectives: https://health.gov/healthypeople/objectives-and-data/browse-objectives

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[15].

Patient Care: Health centers focus on integrating care for their patients across the full range of services – not just medical but services like oral health, vision, and pharmacy as well. Health centers also deliver crucial services such as case management, transportation, and health education, which enable target populations to access care. Nearly 93 percent of health centers provide dental services either directly or via contract. In 2021, health centers provided oral health services to approximately 5.7 million patients, an increase of over 40 percent since 2011.

Screening for substance use disorders has increased over 100 percent since 2016, with the number of patients receiving screening, brief intervention, referral and treatment (SBIRT) increasing from 716,677 in 2016 to 1,484,857 in 2021. From 2016–2021, the number of health center providers eligible to prescribe medication assisted treatment (MAT) increased 422 percent (from 1,699 in 2016 to 8,869 in 2021) and the number of patients receiving MAT increased 372 percent (from 39,075 in 2016 to 184,379 in 2021).

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 2021, meeting the program target. Additional targeted maternal health efforts, including Quality Improvement Fund investments, will continue to advance performance on this goal and improve health outcomes.

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 2021. In 2021, the health center rate was 8.57 percent, and has consistently been lower than the national rate (not yet known for 2021) during the past several years, despite health centers serving a higher risk prenatal population than represented nationally in terms of socio-economic status, health status and other factors.

[15] 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 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 2021, 60 percent of adult health center patients with diagnosed hypertension had blood pressure under adequate control (less than 140/90), and 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).

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. In FY 2021, 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 2021.

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 2019, the number of medical patients per physician in health centers was 1,779. In 2020, the number decreased to 1,713, likely due to the impacts of COVID-19 on the total patient number in health centers; and in 2021, the number of medical patients per physician in health centers was 1,734.

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 that receive supplemental substance use disorder-specific HRSA grants had increased substance abuse disorder service capacity and utilization. Pourat N, O'Masta B, Chen X, Lu C, Zhou W, Daniel M, Hoang H, Sripipatana A. Examining trends in substance use disorder capacity and service delivery by Health Resources and Services Administration-funded health centers: A time series regression analysis. PLoS One. 2020 Nov 30;15(11):e0242407. doi: 10.1371/journal.pone.0242407. PMID: 33253263; PMCID: PMC7703936.

- Co-locating mental health staff, particularly psychiatrists, at health centers increases patients' likelihood to receive timely, on-site mental health treatment. Bonilla AG, Pourat

N, Chuang E, Ettner S, Zima B, Chen X, Lu C, Hoang H, Hair BY, Bolton J, Sripipatana A. Mental Health Staffing at HRSA-Funded Health Centers May Improve Access to Care. Psychiatr Serv. 2021 Jun 2:appips202000337. doi: 10.1176/appi.ps.20

- Culturally-sensitive patient-provider communication – i.e., provider was knowledgeable about patient medical history, provided information in a manner that was easily understandable, and spent adequate time with the patient –positively influences patient adherence to treatment for cholesterol management. Hair BY, Sripipatana A. Patient-Provider Communication and Adherence to Cholesterol Management Advice: Findings from a Cross-Sectional Survey. Popul Health Manag. 2021 Jan 7. doi: 10.1089/pop.2020.0290. Epub ahead of print. PMID: 33416441.

- A larger dental workforce at the health centers is significantly associated with increased health center visits and patient access. Pourat N, Chen X, Lu C, Zhou W, Hoang H, Hair B, Bolton J, Sripipatana A. The role of dentist supply, need for care and long-term continuity in Health Resources and Services Administration-funded health centers in the United States. Community Dent Oral Epidemiol. 2021 Jun;49(3):291-300. doi: 10.1111/cdoe.12601. Epub 2020 Nov 23. PMID: 33230861.

- Organizational advances in Health Information Technology have led to improved quality of care that augments HCs patient care capacity for disease prevention, health promotion, and chronic care management. Baillieu R, Hoang H, Sripipatana A, Nair S, Lin SC. Impact of health information technology optimization on clinical quality performance in health centers: A national cross-sectional study. PLoS One. 2020 Jul 15;15(7):e0236019. doi: 10.1371/journal.pone.0236019. PMID: 32667953; PMCID: PMC7363086.

- 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).

- Enabling services were associated with more health center visits, higher probability of getting a routine checkup, a higher likelihood of having had a flu shot, and a higher probability of patient satisfaction. Systematic delivery of enabling services in health centers improve access to care and patient satisfaction. Yue D, Pourat N, Chen X, Lu C, Zhou W, Daniel M, Hoang H, Sripipatana A, Ponce NA. Enabling Services Improve Access To Care, Preventive Services, And Satisfaction Among Health Center Patients. Health Aff (Millwood). 2019 Sep;38(9):1468-1474. doi: 10.1377/hlthaff.2018.05228. PMID: 31479374.

- 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.

Federal Tort Claims Act (FTCA) Program: In accordance with the statute, HRSA implemented FTCA coverage for volunteers in FY 2018. Over 430 volunteers were covered under the FTCA Program in FY 2021. Overall, in FY 2020, 117 claims were paid totaling $93.5 million; in FY 2021, 115 claims were paid totaling $72.5 million; and in FY 2022, 151 claims were paid totaling $158.3 million.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
1010.01 Number of patients served by health centers (Output)	FY 2021: 30.2 million Target: 29.8 million (Target Exceeded)	30.4 million	33.5 million	+3.1 million
1010.05 Number of medical patients per medical physician in health centers (Efficiency)	FY 2021: 1,734 Target: 1,775 (Target Not Met)	1,734	1,734	Maintain
1010.06 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 2021: 8.57% below national rate Target: below national rate (Target Exceeded)	Below national rate	Below national rate	Maintain
1010.07 Percentage of adult health center patients with diagnosed hypertension whose blood pressure is under adequate control (less than 140/90) (Outcome)	FY 2021: 60% Target: 63% (Target Not Met but Improved)	61%	62%	+1 percentage point
1010.08 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 2021: 68% Target: 67% (Target Exceeded)	67%	68%	+1 percentage point
1010.09 Percentage of pregnant health center patients beginning prenatal care in the first trimester (Output)	FY 2021: 74% Target: 73% (Target Exceeded)	73%	74%	+1 percentage point
1010.10 Percentage of health center patients who are at or below 200 percent of poverty (Output)	FY 2021: 90% Target: 91% (Target Not Met)	90%	91%	+1 percentage point

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
1010.11 Percentage of health centers with at least one site recognized as a patient centered medical home (Output)	FY 2021: 77% Target: 75% (Target Exceeded)	75%	76%	+1 percentage point
1010.12 Percentage of health center grantees providing additional dental treatment services either on-site or by paid referral (Output)	FY 2021: 84% Target: Not Defined (Historical Actual)	84%	85%	+1 percentage point
1010.13 Percentage of health center patients 12 years of age and older screened for depression and had a follow up plan documented as appropriate (Output)	FY 2021: 67% Target: Not Defined (Historical Actual)	67%	68%	+1 percentage point
1010.14 Percentage of health center grantees that provide substance use disorder services (Output)	FY 2021: 58% Target: Not Defined (Historical Actual)	58%	90%	+32 percentage point(s)
1010.15 Percentage of health center patients seen within 30 days of first HIV diagnosis (Outcome)	FY 2021: 83% Target: Not Defined (Historical Actual)	83%	84%	+1 percentage point
1010.16 Percentage of health center patients 3-16 years of age receiving weight assessment and counseling (Output)	FY 2021: 69% Target: Not Defined (Historical Actual)	69%	70%	+1 percentage point
1010.17 Percentage of health center patients 18 years of age and older screened for tobacco use and provided intervention if appropriate (Output)	FY 2021: 82% Target: Not Defined (Historical Actual)	82%	83%	+1 percentage point
1010.02 Percentage of grantees that provide the following services either on-site or by paid referral: (b) Preventive Dental Care (Output)	FY 2021: 93% Target: 90% (Target Exceeded)	91%	Discontinued	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
1010.03 Percentage of grantees that provide the following services either on-site or by paid referral: (c) Mental Health/Substance Abuse (Output)	FY 2021: 98% Target: 93% (Target Exceeded)	97%	Discontinued	N/A
1010.04 Number of HIV tests conducted (Output)	FY 2021: 3.3 million Target: 2.8 million (Target Exceeded)	3 million	Discontinued	N/A

Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	1,376	1,376	1,468
Average Award	$3.7 million	$3.8 million	$4.22 million
Range of Awards	$400,000 – $23 million	$400,000 – $23 million	$400,000 – $25 million

Free Clinics Medical Malpractice

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$1,000,000	$1,000,000	$1,000,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 224(o), as amended by Patient Protection and Affordable Care Act, Section 10608, Public Law 111-148.

FY 2024 Authorization ..... Indefinite

Allocation Method ..... Other

Program Description

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.

Budget Request

The FY 2024 Budget Request for the Free Clinics Medical Malpractice Program is $1 million, which is equal to the FY 2023 Enacted level. In FY 2022, there was one paid claim under the Free Clinics Medical Malpractice Program. The Program Fund has a current balance of approximately $4 million. 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 2024 focus on maintaining FY 2023 target levels for the number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage at 16,530, while also maintaining the number of free clinics operating with FTCA deemed clinicians at 255. 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 2024.

The FY 2024 Budget will also support the Program's continued coordination and collaboration with related Federal programs 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 funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Funding History

Fiscal Year	Amount
FY 2020	$1,000,000
FY 2021	$1,000,000
FY 2022	$1,000,000
FY 2023	$1,000,000
FY 2024 President's Budget	$1,000,000

Program Accomplishments

Increasing Access: In FY 2021, 16,530 health care providers received Federal malpractice insurance through the Free Clinics Medical Malpractice Program, exceeding the Program target. In FY 2019, 236 clinics operated with FTCA deemed clinicians; in FY 2020, 230 clinics participated, and in FY 2021, 255 clinics participated, exceeding the program target in each year. Free clinics realized a significant increase in patient visits in FY 2021, with nearly 818,000

reported. The increase was due to the impact of COVID-19 on the demand for services at free clinics in FY 2021, which is expected to return to pre-COVID-19 levels.

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.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
1020.01 Number of free clinic health care providers deemed eligible for Free Clinics Federal Tort Claims Act malpractice coverage (Output)	FY 2021: 16,530 Target: 11,000 (Target Exceeded)	11,000	Discontinued	N/A
1020.02 Patient visits provided by free clinics sponsoring Federal Tort Claims Act deemed clinicians. (Output)	FY 2021: 817,642 Target: 500,000 (Target Exceeded)	500,000	500,000	Maintain
1020.03 Number of free clinics operating with Free Clinics Federal Tort Claims Act deemed clinicians (Output)	FY 2021: 255 Target: 220 (Target Exceeded)	220	Discontinued	N/A
1020.04 Administrative costs of the program per Federal Tort Claims Act covered provider. (Efficiency)	FY 2021: $29 Target: $75 (Target Exceeded)	$75	$75	Maintain

Health Workforce TAB

HEALTH WORKFORCE

National Health Service Corps (NHSC)

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$121,600,000	$125,600,000	$175,600,000	+$50,000,000
Mandatory Funding	$292,330,000	$292,330,000	---	-$292,330,000
NHSC Mandatory proposed	---	---	$790,000,000	+$790,000,000
Total	**$413,930,000**	**$417,930,000**	**$965,600,000**	**$547,670,000**
FTE	231	273	273	---

Authorizing Legislation:
Public Health Service Act, Sections 338 and 338(H), as amended by Health Care Safety Net Act, Section 3, Public Law 110-355 and Patient Protection and Affordable Care Act, Section 5207, Public Law 111-148.

Mandatory Funding: Patient Protection and Affordable Care Act, Section 10503(b)(2), Public Law 111-148, as amended by Consolidated Appropriations Act, 2021, Division BB, Title III, Section 301, Public Law No:116-260.

FY 2024 Authorization: Authorized for FY 2024 (and each subsequent year), based on previous year's funding, subject to adjustment formula.

FY 2024 Mandatory Funding..... Expires end of FY 2023

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

Program Description

Since its inception in 1972, the National Health Service Corps (NHSC) has worked to increase access to care in underserved areas by supporting 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) – areas that meet criteria for having a greater need for primary, dental, or mental health care providers. Through the use of scholarships and loan repayments, the NHSC incentivizes primary care clinicians to serve in many of the 22,000 primary, dental and mental health HPSAs across the nation. The majority of these providers continue to provide service in HPSA after the service commitment has been completed.

Section 332(k)(1) of the Public Health Service Act directed HRSA to identify Maternity Care Target Areas (MCTAs), or geographic areas within HPSAs that have a shortage of maternity

care health professionals and 6,383 MCTAs have been identified. In FY 2023, HRSA will begin using MCTA scores, which are generated for each Primary Care HPSA using its service area, to distribute all awards to maternity care health professionals to serve in MCTAs. Maternity providers are defined as obstetricians and gynecologists (OB/GYN), Family Practice with OB, and Certified Nurse Midwives (CNMs).

The NHSC operates seven programs to place clinicians at NHSC-approved sites in underserved communities across the nation. These health care delivery sites must meet certain requirements such as providing care to individuals regardless of their ability to pay through the use of a sliding fee schedule.

NHSC Scholarship Program (SP): The NHSC SP provides financial support through scholarships that cover tuition and other reasonable education expenses, and a monthly living stipend, to health professions students committed to providing primary care in underserved communities of greatest need. 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 Scholars will provide a one-year service commitment for each year of scholarship support received. There is a two-year minimum service commitment and awardees can receive a maximum of four years of scholarship support.

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. For an initial two years of service, participants receive up to $50,000 in loan repayment assistance, with the option of continuing to serve for up to three additional years for $20,000 in loan repayment per year. The NHSC LRP recruits clinicians as they complete training and are immediately available for service, as well as seasoned professionals.

NHSC Substance Use Disorder (SUD) Workforce LRP: The NHSC received a dedicated appropriation to expand and improve access to quality opioid and SUD treatment in rural and underserved areas nationwide in a variety of settings 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. In exchange for three years of service at an NHSC-approved SUD treatment facility, providers receive up to $75,000 in loan repayment assistance to reduce their educational financial debt.

NHSC Rural Community LRP: A portion of the appropriations provides 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 loan repayment awards in coordination with the Rural Communities Opioid Response Program initiative funded by 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. In exchange for three years of service, providers receive up to $100,000 in loan repayment assistance to reduce their educational financial debt in exchange for service at SUD treatment facilities.

NHSC and the Indian Health Service (IHS): Funding has been directed to support awards in the aforementioned NHSC LRPs, to fully-trained medical, nursing, dental, and behavioral clinicians including SUD treatment 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 programs, and dually-funded Tribal Health Clinics/Community Health Centers are automatically designated as HPSAs. With this directed funding, the NHSC has awarded all eligible clinicians serving in ITUs who have applied to the NHSC LRPs. In exchange for an initial two years of service, providers receive up to $50,000 in loan repayment assistance with the option of continuing to serve for up to three additional years for $20,000 in loan repayment per continuing year.

NHSC Students to Service (S2S) LRP: The NHSC S2S LRP provides loan repayment assistance of up to $120,000 to health professions students committed to providing primary care in their last year of school in return for a three-year commitment to provide primary health care in rural and urban HPSAs of greatest need.

State Loan Repayment Program (SLRP): The SLRP is a federal-state partnership grant program that has traditionally required 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. States receiving funding from this opportunity are encouraged to allow health professionals to practice to the full extent of their license.

In FY 2022, HRSA made 50 new awards through additional flexibilities authorized by the American Rescue Plan (ARP) Act of 2021. These flexibilities included waiving the matching funds requirement and allowing up to 10 percent of grant funds to be spent on administrative costs, which provided further incentives for states to participate in the program. These funds support a three-year grant cycle that began in FY 2022.

Eligible Entities:

NHSC SP and S2S: 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.

NHSC LRPs: Participants must be practicing in a NHSC-eligible discipline with qualified student loan debt for education that led to their degree.

NHSC SUD Workforce LRP and Rural Community LRP: Participants must be working, or have accepted a position to work, at an NHSC-approved SUD treatment facility.
SLRP: 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.

Budget Request

The FY 2024 Budget Request of $965.6 million is $547.7 million above the FY 2023 Enacted level. The Budget proposes a three-year extension of mandatory funding through FY 2026 totaling $2.4 billion. The request will result in a projected field strength of 20,696 in FY 2024. This request will fund an estimated 406 new and 6 continuation scholarship awards, 10,501 new and 3,129 continuation loan repayment awards, and 166 Students to Service loan repayment awards. The request includes $25 million in discretionary funding specifically for behavioral health providers, including peer support specialists and providers in crisis centers.

HRSA dedicated all ARP Act funding as of September 30, 2022. ARP Act resources enabled the NHSC to recruit the largest primary care workforce in the program's 50-year history. The NHSC increased the number of initial two-year contracts it awarded in FY 2021 and FY 2022. As a result, the program expects that many NHSC LRP participants first awarded in FY 2021 and FY 2022 will seek one-year continuation awards in FY 2024. To preserve continuity of services in communities, the NHSC uses its resources to award current participants continuation contracts prior to awarding contracts to new participants. The significant increase in demand for continuation contracts for providers who received ARP-funded awards will reduce the remaining amount available to make new awards and result in a decrease in the NHSC field strength in FY 2023. The proposed level of $965.6 million will allow the NHSC to maintain its current field strength in FY 2024 by recruiting primary care, behavioral health, and dental health providers to areas of greatest need. The NHSC will also work to address language access barriers to care.

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

Activity	FY 2024	FY 2025	FY 2026	Total Funding
Proposed Mandatory Funding	$790 million	$790 million	$790 million	$2.370 billion

Funding History

Fiscal Year	Amount	Supplemental Amount
FY 2020 Enacted Discretionary	$120,000,000	---
FY 2020 Current Law Mandatory	$310,000,000	---
FY 2021 Discretionary Enacted	$119,526,000	---
FY 2021 Current Law Mandatory	$310,000,000	$800,000,000
FY 2022 Discretionary	$121,600,000	---
FY 2022 Current Law Mandatory	$292,330,000[16]	---
FY 2023 Discretionary	$125,600,000	---

[16] Fiscal year mandatory funding reflects the post-sequestration amount.

Fiscal Year	Amount	Supplemental Amount
FY 2023 Current Law Mandatory	$292,330,000[17]	---
FY 2024 Discretionary President's Budget	$175,600,000	---
FY 2024 Mandatory President's Budget	$790,400,000	---

Program Accomplishments

As of September 30, 2022, there are more than 20,000 primary care medical, dental, and mental and behavioral health practitioners – the largest cohort ever – serving in the NHSC across more than 20,000 approved sites across the United States. Eligible sites include facilities such as Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes, American Indian and Alaska Native health clinics, rural health clinics, school-based clinics, and community mental health centers.

In FY 2021, the ARP Act appropriated $800 million to the NHSC, $700 million of which is for the NHSC SP, LRPs, and S2S LRP; these funds enabled the NHSC to award all eligible applicants to these programs. The remainder of the $700 million was fully obligated in FY 2022. The ARP Act provided the remaining $100 million to the SLRP; these funds are supporting a three-year grant cycle that began in FY 2022.

NHSC Students in Pipeline by Program as of 09/30/2022

Programs	Students
Scholarship Program	2,978
Students to Service Program	515
Total	**3,493**

NHSC Students in Pipeline by Discipline as of 09/30/2022

Disciplines	Students
Allopathic/Osteopathic Physicians	1,191
Dentists	932
Nurse Practitioners	345
Physician Assistants	962
Certified Nurse Midwives	63
Total	**3,493**

[17] *Ibid.*

NHSC Field Strength by Program as of 09/30/2022

Programs	Clinicians
Scholarship Program Clinicians	701
Loan Repayment Program Clinicians	12,151
State Loan Repayment Program Clinicians	2,093
SUD Workforce Loan Repayment Program Clinicians	2,998
Rural Community Loan Repayment Program Clinicians	1,704
Students to Service Loan Repayment Program Participants	568
Total	**20,215**

NHSC Field Strength by Discipline as of 09/30/2022

Disciplines	Clinicians
Allopathic/Osteopathic Physicians	2,587
Dentists	1,580
Dental Hygienists	421
Nurse Practitioners	4,031
Physician Assistants	1,558
Nurse Midwives	249
Mental and Behavioral Health Professionals	9,610
Other State Loan Repayment Program Clinicians	179
Total	**20,215**

Average NHSC New Award by Program as of 09/30/2022

Program	Average Award Amount
Scholarship Program	$249,452[18]
Students to Service Loan Repayment Program	$105,329[19]
Loan Repayment Programs	$51,184[20]

Retention among NHSC clinicians – which is a measure of participants who continue to provide care in a HPSA at the end of their service commitment - continues to be high. The two-year retention rate among NHSC participants who completed their service obligation in FY 2020 is 86 percent. The one-year retention rate among NHSC participants who completed their service obligation in FY 2021 is 84 percent.

[18] Scholarship Program awards are for two to four years of service.
[19] Students to Service awards are for three years of service.
[20] Loan Repayment Programs are for two to three years of service.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 Target +/- FY 2023 Target
2010.01: Default rate of National Health Service Corps Scholarship and Loan Repayment Program participants (Efficiency)	FY 2022:0.89% Target: < 2.0% (Target Exceeded)	≤ 2.0%	≤ 2.0%	Maintain
2010.02: Number of individuals served by National Health Service Corps clinicians (Outcome)	FY 2022: 21.23 million Target: 20.73 million (Target Exceeded)	15.36 million	21.73 million	+600,000
2010.03: Field strength (participants in service) of the National Health Service Corps (Outcome)	FY 2022: 20,215 Target: 19,739 (Target Exceeded)	14,630	20,696	+6,066
2010.04: Percentage of National Health Service Corps clinicians retained in service to the underserved for at least one year beyond the completion of their National Health Service Corps service	FY 2021: 84% Target: 80% (Target Exceeded)	82%	85%	+3 percentage points

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 Target +/- FY 2023 Target
commitment (Outcome)				
2010.05: Number of National Health Service Corps sites (Output)	FY 2021: 19,565 Target: 18,000 (Target Exceeded)	18,500	20,970	+2,470

Performance Narrative

In FY 2023, the majority of funding will support the continuation of the ARP-funded new placements that were awarded in FY 2021 and FY 2022, which is reflected in the Field Strength. The FY 2023 target for Measure 2010.03 (14,630) is larger than the FY 2023 field strength number in the field strength table (14,090) because the field strength projections for FY 2023 were revised based on FY 2022 actuals. Measure 2010.03 is established prior to field strength data becoming available, which occurs at the end of the fiscal year.

Loan Repayments/Scholarships Awards Table

Activity	FY 2022	FY 2023	FY 2024 President's Budget
Loan Repayments	$196,917,627	$259,997,285	$633,164,457
State Loan Repayments	---[21]	---[22]	---[23]
Scholarships	$108,312,924	$31,158,339	$117,405,932
Students to Service Loan Repayment	$20,000,000	$20,000,000	$20,000,000
Peer Support Workforce	---	---	$25,000,000

[21] SLRP will be funded by the $100 million set aside for the program in the American Rescue Plan through FY 2024.
[22] SLRP will be funded by the $100 million set aside for the program in the American Rescue Plan through FY 2024.
[23] SLRP will be funded by the $100 million set aside for the program in the American Rescue Plan through FY 2024.

NHSC Awards Table

Program:	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Scholarships	196	205	181	222	200	251	1,192	1,199	85	406
Scholarship Continuation	11	8	7	7	11	12	7	25	95	6
Scholarships Subtotal	*207*	*213*	*188*	*229*	*211*	*263*	*1,199*	*1,224*	*180*	*412*
Loan Repayment	2,934	3,079	2,554	3,262	4,012	5,963	6,553	5,229	3,144[24]	10,501
Loan Repayment Continuations	1,841	2,111	2,259	2,384	2,385	2,355	2,277	2,476	3,416	3,129
Loan Repayment Subtotal	*4,775*	*5,190*	*4,813*	*5,646*	*6,397*	*8,318*	*8,830*	*7,705*	*6,560*	*13,630*
State Loan Repayment	620	634	535	625	812	712	1,628	1,465[25]	806	806
Students to Service Loan Repayment	96	92	175	162	127	148	257	368	166	166
Peer Support Workforce	-	-	-	-	-	-	-	-	-	333
Total Awards	**5,698**	**6,129**	**5,711**	**6,662**	**7,547**	**9,441**	**11,914**	**10,762**	**7,712**	**15,347**

NHSC Field Strength Table

Program:	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Scholars	458	437	405	463	506	573	671	701	744	712
Loan Repayment	8,062	8,593	8,362	8,849	10,221	13,122	16,613	16,853	10,638[26]	17,609
Students to Service Loan Repayment	1,136	1,378	179	277	369	388	454	568	437	430
State Loan Repayment	27	85	1,233	1,350	1,957	2,146	2,246	2,093	2,271	1,612
Peer Support Workforce	-	-	-	-	-	-	-	-	-	333
Total Field Strength	**9,683**	**10,493**	**10,179**	**10,939**	**13,053**	**16,229**	**19,984**	**20,215**	**14,090**	**20,696**

[24] In FY 2023, the majority of funding will provide for the continuation of the ARP-funded new placements that were awarded in FY 2021 and 2022, which is reflected in the Field Strength.
[25] SLRP will be funded by the $100 million set aside for the program in the American Rescue Plan through FY 2024.
[26] In FY 2023, the majority of funding will provide for the continuation of the ARP-funded new placements that were awarded in FY 2021 and 2022, which is reflected in the Field Strength.

Faculty Loan Repayment Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$1,226,000	$2,310,000	$2,310,000	---
FTE	---	1	1	---

Authorizing Legislation: Public Health Service Act, Sections 738(a) and 740(b), as amended by CARES Act, Section 3401, Public Law No: 116-136.

FY 2024 Authorization $1,190,000

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

Program Description

The Faculty Loan Repayment Program (FLRP) supports and recruits health professionals into faculty positions in accredited health professions schools. The goal of the FLRP is to decrease the economic barriers associated with pursuing careers as academic faculty. The FLRP provides loan repayment to health profession graduates who serve as faculty at eligible health professions colleges or universities for a minimum of two years. In return, the federal government agrees to pay up to $20,000 of the outstanding principal and interest on the individual's health professions education loans for each year of service. The 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.

Budget Request

The FY 2024 Budget Request for the FLRP of $2.3 million is equal to the FY 2023 Enacted Level. The FY 2024 funding will be used to continue to support 40 awards. The funding will continue to support 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.
The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Funding History

Fiscal Year	Amount
FY 2020	$1,190,000
FY 2021	$1,186,000
FY 2022	$1,226,000
FY 2023	$2,310,000
FY 2024 President's Budget	$2,310,000

Program Accomplishments

In FY 2022, the FLRP made 20 new loan repayment awards. For FY 2023 and FY 2024, the FLRP anticipates supporting 40 new awards.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	20	40	40

Health Professions Training for Diversity

Centers of Excellence

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$24,422,000	$28,422,000	$36,711,000	+$8,289,000
FTE	1	4	4	--

Authorizing Legislation: Public Health Service Act, Section 736, as amended by CARES Act Section 3401, Public Law 116-136.

FY 2024 Authorization $23,711,000

Allocation Method .....Competitive Grant

Program Description

The Centers of Excellence (COE) Program strengthens the national capacity to produce a health care workforce whose racial and ethnic diversity more closely represents the U.S. population. The 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 addition, the COE Program aims to improve clinical education and cultural competence for minority health issues and social determinants of health. Through strategic partnerships, grant recipients increase the applicant pool of URM students within health professions schools, establish and expand programs to enhance academic performance of these students, and utilize stipends to assist URM students and faculty with financial support.

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.

Budget Request

The FY 2024 Budget Request of $36.7 million is $8.3 million above the FY 2023 Enacted Level. In FY 2024, HRSA will support, through a new competition, 8 new grant recipients and 26 existing grant recipients, through non-competing continuations. The new grant recipients will extend the reach of the COE Program and expand the number of underrepresented minority

(URM) students and faculty in health professions further supporting health equity. Grant recipients serve as innovative resources and education centers for the recruitment, training, and retention of URM students and faculty. Grant recipients improve information resources, clinical education, curricula, and cultural competence as they relate to minority health issues and social determinants of health. Also, the COE Program will continue to support health workforce activities that strengthen the national capacity to produce a high quality, diverse healthcare workforce.

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

Funding History

Fiscal Year	Amount
FY 2020	$23,711,000
FY 2021	$23,510,000
FY 2022	$24,422,000
FY 2023	$28,422,000
FY 2024 President's Budget	$36,711,000

Program Accomplishments

In Academic Year (AY) 2021-2022, the most recent year for which performance data is available, the COE Program trained 4,027 students. A total of 1,958 students completed a COE program. Eighty-nine percent of these program completers were underrepresented minorities.

COEs provided in-depth support to a subset of 1,854 students through structured training programs over 99 percent of these trainees were underrepresented minorities and 72 percent were from disadvantaged backgrounds. By the end of the academic year, 1,193 students completed a structured COE program. Forty-six percent of students who received academic retention support successfully maintained enrollment in a health professions program. Of the 872 structured program completers from the prior academic year with one-year follow-up data, 266 had intended to remain enrolled in their health professions training program after completing their COE program. One year later, 89 percent of those who had intended to remain enrolled were still enrolled, and only one percent had withdrawn.

BHW conducted a five-year evaluation of the COE Program[27] and found that its structured programs trained approximately nine percent of all U.S. dental students from underrepresented minority backgrounds[28] and eight percent of all U.S. medical students from underrepresented

[27] Health Resources and Service Administration. (2022). Centers of Excellence Program Outcomes: Academic Years 2015-2020. Retrieved November 22, 2022, from https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/COE%20Outcomes%20%20Academic%20Years%202015-2020.pdf

[28] American Dental Education Association. 2022. "U.S. Dental School Applicants and Enrollees, 2021 Entering Class." https://www.adea.org/data/students/Applicants-2021-Entering-Class/.

minority backgrounds[29] during AY 2015-2020. Of the 1,067 students who had intended to remain enrolled in their health professions training program after completing a COE structured program and provided follow-up data, 82 percent remained enrolled one year later, and less than one percent had withdrawn. In addition, of the 502 students who had intended to apply to a health professions school after completing a COE structured program and provided follow-up data, 49 percent had applied and been admitted one year later.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2030.01 Number of individuals in the health career pipeline trained by the Centers of Excellence Program (Output)	FY 2021: 4,027 Target: 4,027 (Baseline)	5,000	5,000	Maintain
2030.02 Percentage of program completers who are also underrepresented minorities (Outcome)	FY 2021: 89% Target: 89% (Baseline)	55%	65%	+10 percentage points
6.I.C.21 Percent of program participants who received academic retention support and maintained enrollment in a health professions degree program (Outcome)	FY 2021: 46% Target: 40% (Target Exceeded)	40%	Discontinued	N/A

[29] Association of American Medical Colleges. 2022. "2021 FACTS: Enrollment, Graduates, and MD-PhD Data." https://www.aamc.org/data-reports/students-residents/interactive-data/2021-facts-enrollment-graduates-and-md-phd-data.

COE Program Outputs	Year and Most Recent Result	FY 2022 Target	FY 2023 Target	FY 2024 Target
Number of health professions students participating in research on minority health-related issues	FY 2021: 633	600	935	935
Number of faculty members participating in research on minority health-related issues	FY 2021: 474	500	780	780

Performance Narrative

Most recent results are for activities in Academic Year 2021-2022 funded in FY 2021.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	20	26	34
Average Award	$1,173,423	$1,025,491	$945,610
Range of Awards	$556,775 - $3,177,641	$503,475 - $3,177,641	$673,705 - $3,177,641

Scholarships for Disadvantaged Students

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023 PB
BA	$53,014,000	$55,014,000	$55,014,000	---
FTE	7	7	7	---

Authorizing Legislation: Public Health Service Act, Sections 737, as amended by CARES Act, Section 3401, Public Law 116-136.

FY 2024 Authorization $51,470,000

Allocation Method .....Competitive Grant

Program Description

The Scholarships for Disadvantaged Students (SDS) Program 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. The SDS Program exposes students to primary care and placements in Medically Underserved Communities (MUCs) to: improve distribution, diversity, and supply of primary care providers; improve and strengthen the health profession and nursing workforce by facilitating the entry of individuals from disadvantaged backgrounds into those professions; and enhance quality and access to healthcare to individuals in MUCs. The SDS Program directs funds to educate midwives to address the national shortage of maternity care providers, and specifically to address the lack of diversity in the maternity care workforce.

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

Budget Request

The FY 2024 Budget Request of $55.0 million is equal to the FY 2023 Enacted Level. In FY 2024, HRSA will continue to support the 85 grantees previously awarded in FY 2023. These funds promote diversity among the health professions and nursing schools by supporting scholarships to students from disadvantaged backgrounds. The SDS Program will continue to direct funds to educate midwives to address the lack of diversity in the maternity care workforce. Additionally, to combat health workforce shortages, approximately 24 percent of funds have

been designated for graduate programs in behavioral and mental health and 23 percent have been designated for programs in allied health.

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

Funding History

Fiscal Year	Amount
FY 2020	$51,470,000
FY 2021	$51,390,000
FY 2022	$53,014,000
FY 2023	$55,014,000
FY 2024 President's Budget	$55,014,000

Program Accomplishments

In Academic Year (AY) 2021-2022, the most recent year for which performance data is available, the SDS Program provided scholarships to 2,676 health professions students from disadvantaged backgrounds. Sixty-nine percent of SDS scholarship recipients were considered underrepresented minorities in their prospective professions.

SDS trainees included 847 nursing students, 587 behavioral health students, 583 allied health students, 148 medical students, 131 dental students, 100 physician assistant students, 75 public health students, and 205 other types of students.

A total of 1,193 SDS students graduated from their degree programs in AY 2021-2022. Of the 560 prior year graduates with one-year follow-up data, 54 percent currently work in medically underserved communities and 28 percent currently work in primary care settings. SDS awardees offered academic and social supports to help students progress through the health professions pipeline, such as career advising (used by 75 percent of students) and peer support groups (used by 42 percent of students). SDS students also trained in a variety of clinical settings: 67 percent trained in medically underserved communities, 37 percent trained in primary care settings, and 15 percent trained in rural areas. Furthermore, SDS students received additional training on topics such as health equity (50 percent) and integrating behavioral health into primary care (30 percent).

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2040.01 Number of health professions students from disadvantaged backgrounds who received financial support through the Scholarships for Disadvantaged Students Program (Output)	FY 2021: 2,676 Target: 2,390 (Target Exceeded)	2,600	2,600	Maintain

SDS Program Outputs	Year and Most Recent Result	FY 2022 Target	FY 2023 Target	FY 2024 Target
Number of students from underrepresented minority backgrounds with scholarships	FY 2021: 1,834	1,500	1,500	1,800
Percentage of students who are from underrepresented minority backgrounds	FY 2021: 69%	62%	62%	64%

Performance Narrative

Most recent results are for activities in Academic Year (AY) 2021-2022 funded in FY 2021.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	86	85	85
Average Award	$678,114	$609,069	$609,069
Range of Awards	$221,866 - $899,980	$230,000 - $1,000,276	$150,000 $1,000,276

Health Careers Opportunity Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$15,450,000	$16,000,000	$18,500,000	+$2,500,000
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Sections 739 as amended by CARES Act, Section 3401, Public Law 116-136.

FY 2024 Authorization $15,000,000

Allocation Method .....Competitive Grant

Program Description

The Health Careers Opportunity Program (HCOP) provides individuals from economically and educationally disadvantaged backgrounds an opportunity to develop the skills needed to successfully compete for, enter, and graduate from, schools of health professions or allied health professions. The National HCOP Academies, a component of the program, provides 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. The support provided includes 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. The goal of HCOP is to provide a pathway for disadvantaged individuals to enter the health professions and equip them to deliver high quality, culturally competent care to underserved individuals.

HCOP activities are an integral part of structured programming for students throughout the academic year. Activities of HCOP grantees include post-baccalaureate, summer, and other programs that provide students with 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 assistance to students from disadvantaged backgrounds while matriculating through the educational pipeline.

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

Budget Request

The FY 2024 Budget Request of $18.5 million is $2.5 million above the FY 2023 Enacted Level. In FY 2023, HRSA will hold a new HCOP competition with a five-year project period with up to 21 awards anticipated. The FY 2024 Request will be used to continue to fund 21 existing grantees

and fund an additional 3 new awards that will further expand opportunities for individuals from disadvantaged backgrounds to enter a health profession.

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

Funding History

Fiscal Year	Amount
FY 2020	$15,000,000
FY 2021	$14,449,000
FY 2022	$15,450,000
FY 2023	$16,000,000
FY 2024 President's Budget	$18,500,000

Program Accomplishments

In Academic Year 2021-2022, the most recent year for which performance data is available, HCOP trained 4,640 students pursuing health careers, and 68 percent of HCOP trainees were underrepresented minorities. A total of 2,696 students completed an HCOP program.

HCOP provided additional support to a subset of 3,023 students through structured programs such as the HCOP National Ambassadors Program. By the end of the academic year, 1,409 students completed an HCOP structured program. Of the 503 structured program completers from the prior academic year who reported follow-up data, 193 intended to apply to a health professions training program. One year later, 56 percent of those program completers had both applied and been accepted to a health professions training program, and an additional 29 percent had been accepted to an associate's degree program.

HCOP awardees also partnered with 211 health care delivery sites to provide 2,906 clinical training experiences. Fifty-one percent of these sites were in medically underserved communities and/or rural settings.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2050.01 Number of Health Careers Opportunity Program trainees from disadvantaged backgrounds participating	FY 2021: 4,640 Target: Not Defined	4,000	4,500	+ 500

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
in academic programming, clinical training and/or student support services (Outcome)	(Historical Actual)			

HCOP Outputs	Year and Most Recent Result	FY 2022 Target	FY 2023 Target	FY 2024 Target
Total number of students from underrepresented minority backgrounds participating in all HCOP programs	FY 2021: 3,169	3,200	3,200	3,200

Performance Narrative

Most recent results are for activities in Academic Year 2021-2022 funded in FY 2021.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	21	21	24
Average Award	$637,133	$623,579	$770,833
Range of Awards	$622,466 - $640,000	$577,146 - $670,012	$577,146 - $670,012

Health Care Workforce Assessment

The National Center for Health Workforce Analysis

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$5,663,000	$5,663,000	$5,663,000	---
FTE	3	3	3	---

Authorizing Legislation: Public Health Service Act, Sections 761, as amended by CARES Act, Section 3401, Public Law 116-136.

FY 2024 Authorization $5,663,000

Allocation Method .....Competitive Grant/Contract

Program Description

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.

The National Center for Health Workforce Analysis (NCHWA) collects and analyzes health workforce data and information to provide national and state policymakers, researchers, and the public with information on health workforce supply and demand. NCHWA also evaluates the effectiveness of HRSA's workforce investments. To that end, 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.

Budget Request
The FY 2024 Budget Request of $5.6 million is equal to the FY 2023 Enacted Level. This request will fund continued work on health occupation projections and their visualization for the public, nine Health Workforce Research Centers (HWRCs), the development and publication of the Area Health Resources Files (AHRF), and the publication and analyses of the 2022 National Sample Survey of Registered Nurses (NSSRN).

In FY 2024, NCHWA will continue to model supply and demand of health professionals across a range of health occupations, years, and metro and non-metro geographies, making these assessments of the adequacy of the health workforce available through briefs and online tools. These data are publicly released in an interactive projection visualization tool. As in prior years, projections data on dozens of different health care occupations will continue to be published at the same time, including:

- Physicians by type
- Nurses including APRNs
- Behavioral health providers
- Primary care providers
- Women's health providers

These projections will also include alternative scenarios to show how the projected supply and demand changes if certain key inputs change. One alternative scenario examines how demand would change for an occupation if everyone used its services at the same rate as the insured population.

In FY 2024, NCHWA will continue to enhance its projection model to allow for even more sophisticated analysis and projection of health workforce supply and demand, taking into account changing national demographics, the demand for health care services, and the impact those changes have on the delivery of health care.

In FY 2024, NCHWA will continue to oversee nine HWRCs that conduct 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.[30] 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, public health, 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:

[30] In FY 2024, one Health Workforce Research Center (HWRC) administered by NCHWA will be funded from the Substance Abuse and Mental Health Services Administration, one HWRC will be partially funded from the Centers for Disease Control and Prevention, and several HWRCs will be partially funded from the Bureau of Primary Health Care.

- 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 and overdose crisis.
- Investigating 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 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 2024, NCHWA will continue to maintain the Area Health Resource Files (AHRF) dataset on behalf of the Department of Health and Human Services. The AHRF is updated annually and contains detailed information on health professions, health facilities, and population demographics from a variety of sources. NCHWA will also continue to maintain the AHRF dashboard, which is an interactive dashboard that allows members of the public to easily access information about topics such as the diversity of the health care workforce.

In FY 2024, NCHWA will publish updated results of the National Sample Survey of Registered Nurses (NSSRN), which will be also be available in visualized formats in the recently released NCHWA Nursing Workforce Dashboard. The updated NSSRN, which is being collected in FY 2023 in partnership with the U.S. Census Bureau and represents the nation's largest sample survey of registered nurses and nurse practitioners, will provide an unprecedented look at the state of the registered nurse workforce – particularly how the workforce was impacted by the COVID-19 pandemic.

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

Funding History

Fiscal Year	Amount
FY 2020	$5,663,000
FY 2021	$5,646,000
FY 2022	$5,663,000
FY 2023	$5,663,000
FY 2024 President's Budget	$5,663,000

Program Accomplishments

In 2022, NCHWA released updated projections for the years 2020-2035 for over 100 occupations in a publicly accessible an interactive projection visualization tool. In addition to the release in a customizable tool, NCHWA also issued a series of briefs that were aimed at interpreting the data in a more accessible format on key trends in the workforce for policymakers

and the general public. These included five projections briefs on behavioral health, long-term services and support, nursing, physicians, and primary care. NCHWA also developed and disseminated a brief on the State of the Maternal Health Workforce.

In FY 2022, NCHWA also improved the projections methodology and expanded the number of occupations with projections. The methodology was enhanced to capture the effects of the pandemic on the supply and demand projections and incorporate the most current sources of data. These enhancements allow for even 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. The documentation for the methodology was also converted from PDF to HTML, which makes it more accessible to those using assistive technology. NCHWA increased the number of occupations with projections from 46 to over 100. These improvements made during FY 2022 were incorporated in projections released in FY 2023.

In FY 2022, NCHWA recompeted the Health Workforce Research Center Cooperative Agreement Program. This program funds nine academic research centers that support and disseminate rigorous and state-of-the-art applied research that strengthens evidence-based policy and enhances the Federal Government's and the public's understanding of issues and trends in the health workforce. Theses nine centers are distributed all over the country and focus on key facets of workforce policy including (but not limited to): health equity, allied health, long-term care, emerging issues, behavioral health, public health, and technical assistance to support workforce planning and development.

In FY 2022, NCHWA deployed a new diversity module of the AHRF dashboard, which is one of the most comprehensive, publicly available sources of county, state, and national data on health care demographics. This allows users to access detailed data on the race/ethnicity, age, and sex of providers via an intuitive interface.

In FY 2023, NCHWA created and publicly released a visualization tool, the NCHWA Nursing Workforce Dashboard. This tool visualizes data covering over 100,000 unique data points from the most recently available NSSRN and allows the public to view data on the nursing workforce landscape, including demographics, employment, and education of the nursing workforce. Additionally, in FY 2022, NCHWA also finalized the questionnaire for the 2022 NSSRN and is partnering with the U.S. Census Bureau to begin data collection in FY 2023. The forthcoming data will provide an unprecedented look at the state of the registered nurse workforce – particularly how the workforce was impacted by the COVID-19 pandemic.

Finally, in an effort to better understand and demonstrate the outcomes of BHW programs, NCHWA develops and publicly releases Program Accomplishment and Outcomes reports for grant programs overseen by the Bureau of Health Workforce. Between FY 2020 and FY 2022, NCHWA released fifteen, retrospective evaluation reports as well as annual program accomplishment reports for graduate medical education programs. These reports highlight the ways in which BHW programs impact access, supply, distribution, and quality of the health workforce.

Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 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

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$48,924,000	$49,924,000	$53,924,000	+$4,000,000
Supplemental	$60,000,000	---	---	---
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Section 747, as amended by CARES Act, Section 3401, Public Law 116-136 and Public Law 117-159

FY 2024 Authorization $48,924,000

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

Program Description

The Primary Care Training and Enhancement (PCTE) Program aims to strengthen the primary care workforce by supporting training for future primary care clinicians and faculty and promoting primary care practice, particularly in rural and underserved areas. The focus of the program is to produce primary care providers who are prepared to practice in, teach, and lead transforming health care systems that work to improve access to care, quality of care, and cost effectiveness.

HRSA is investing in strategies to train primary care providers by:

- Enhancing 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;
- Focusing on the training of Physician Assistants and clinical preceptors to expand access to primary care services nationally;
- Supporting innovative training programs that integrate behavioral health care into primary care;
- Training primary care physicians in maternal health care clinical services and population health to improve maternal health outcomes; and
- Increasing access to care for patients with special needs such as individuals with intellectual and physical disabilities and individuals with limited English proficiency by training primary care residents to provide language assistance services.

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.

Budget Request

The FY 2024 Budget Request of $53.9 million is $4 million above the FY 2023 Enacted Level. The requested increase will fund new awards to support training for primary care professionals in the prevention, identification, diagnosis, treatment, and referral services for behavioral health conditions, supporting the Administration's goal to integrate behavioral health care into primary care. Students will experience clinical rotations in rural and underserved settings where they can practice integrating behavioral health with primary care services.

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

Funding History

Fiscal Year	Amount	Supplemental Amount
FY 2020	$48,924,000	---
FY 2021	$48,777,000	---
FY 2022	$48,924,000	$60,000,000
FY 2023	$49,924,000	---
FY 2024 President's Budget	$53,924,000	---

Program Accomplishments

In AY 2021-2022, the most recent year for which performance data is available, the PCTE programs trained 12,178 health professionals, residents, students, and faculty to strengthen the public health workforce. A total of 2,917 graduated or completed their training program. Trainees from other programs within the PCTE portfolio included:

- Over 2,500 clinicians integrating behavioral health and primary care; 40 percent of these clinicians were from disadvantaged backgrounds.
- 496 residents learning to practice comprehensive, primary care medicine in medically underserved and/or rural areas.
- 345 community prevention and maternal health residents and fellows, who reached over 376,000 patients.
- 23 faculty expanding the capacity to train primary care providers.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 Target +/-FY 2023 Target
2070.01 Number of physicians completing a residency or fellowship through a Primary Care Training and Enhancement Program (Outcome)	FY 2021: 463 Target: 200 (Target Exceeded)	700	500	-200
2070.02 Number of physician assistants graduating from a Bureau of Health Workforce-funded program (Outcome)	FY 2021: 199 Target: 100 (Target Exceeded)	900	500	-400

PCTE Program Outputs	Year and Most Recent Result	FY 2022 Target[31]	FY 2023 Target	FY 2024 Target
Number of physicians training in a Bureau of Health Workforce-funded residency or fellowship	FY 2021: 1,059	400	400	400
Number of physician assistant students training in a Bureau of Health Workforce-funded program	FY 2021: 508	400	900	900
Percent of physician and physician assistant graduates and program completers who are minority and/or from disadvantaged backgrounds	FY 2021: 43%	30%	30%	30%
Percent of physician and physician assistant trainees receiving at least a portion of their clinical training in an underserved area	FY 2021: 32%	50%	50%	50%

Performance Narrative

Starting in FY 2022, metrics related to physicians and physician assistants will be calculated based on trainees/graduates of the PCTE-RTPC and the PCTE-PAR programs. Targets were adjusted accordingly.

Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	114	105	112
Average Award	$321,744	$373,707	$401,307
Range of Awards	$146,644 - $600,000	$103,670 - $600,000	$101,625 - $600,000

Oral Health Training Programs

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$40,673,000	$42,673,000	$42,673,000	---
FTE	6	6	6	---

Authorizing Legislation: Public Health Service Act, Sections 748,[32] as amended by CARES Act, Section 3401, Public Law 116-136.

FY 2024 Authorization: $28,531,000

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

Program Description

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 through the following activities:

Predoctoral Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program: This program provides grants to fund the planning, development, operation of, and participation in, approved professional training programs in general, pediatric, or public health dentistry and dental hygiene for students. It also provides financial assistance to these participating students. In FY 2022, HRSA funded 15 new awards. In FY 2023, HRSA will provide continued support through 15 non-competing continuation awards.

Postdoctoral Oral Health Training Program in General, Pediatric and Public Health Dentistry: This program provides grants to fund the planning, development, operation of, and participation in, approved professional training programs in general, pediatric, or public health dentistry for dental residents, practicing dentists, or other approved primary care dental trainees. Grantees may also provide financial assistance to dental residents or practicing dentists. In FY 2022, HRSA supported 27 non-competing continuation awards. In FY 2023, HRSA will provide continued support through 27 non-competing continuation awards.

Dental Clinician Educator Career Development Program: The Dental Clinician Educator Career Development Program supports the development of primary care dental faculty within academic institutions. Specifically, it focuses on improving the competence of full-time, part-time, and community-based faculty to develop and enhance training focused on improving care for vulnerable and underserved populations. In FY 2022, HRSA supported the 5 Dental Clinician

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

Educator Career Development Program awardees addressing the well-documented need to develop primary care dental faculty. In FY 2023, HRSA will provide continued support through 4 non-competing continuation awards.

Primary Care Dental Faculty Development Program: In FY 2021, HRSA created the Primary Care Dental Faculty Development Program, which produced a National Center to serve as a resource and training hub to support the development of primary care dental faculty within academic institutions. In FY 2022, HRSA supported 1 non-competing continuation award. In FY 2023, HRSA will provide continued support through 1 non-competing continuation award.

Dental Faculty Loan Repayment Program: The Dental Faculty Loan Repayment Program (DFLRP) provides grants to fund the planning, development, and operation of a program to provide loan repayment to dental faculty engaged in general, pediatric, and public health dentistry and dental hygiene in exchange for a commitment to serve as full-time faculty members. The purpose of this program is to enhance recruitment and retention of dental and dental hygiene faculty through loan repayment. In FY 2022, HRSA supported 9 new awards and 20 non-competing continuation awards. In FY 2023, HRSA will re-compete the DFLRP and anticipates supporting 8 new awards and 18 non-competing continuation awards.

State Oral Health Workforce Improvement Grant Program: The State Oral Health Workforce Improvement Grant Program (SOHWP) seeks to enhance dental workforce planning and development, through the support of innovative programs, to meet the individual needs of each funded state. The aim is to encourage and support state innovation of sustainable and effective programs that will increase the accessibility and quality of oral health services within Dental Health HPSAs. In FY 2022, HRSA supported 33 new awards and 3 non-competing continuation awards. In FY 2023, HRSA will provide continued support to 33 non-competing continuation awards, as well as issuing 4 new awards with additional funding.

Program	FY 2022	FY 2023 Enacted	FY 2024 President's Budget
Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene and Dental Faculty Loan Repayment	$26,675,000	$27,675,000	$27,675,000
State Oral Health Workforce Improvement Grant	$13,998,000	$14,998,000	$14,998,000

Eligible Entities

Predoctoral Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program; Postdoctoral Oral Health Training Program in General, Pediatric and Public Health Dentistry; Dental Clinician Educator Career Development Program; Primary Care Dental Faculty Development Program: 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.

Dental Faculty Loan Repayment Program: 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.

State Oral Health Workforce Improvement Grant Program: Eligible applicants include Governor-appointed, state governmental entities. A 40 percent match by the state is required for this program.

Budget Request

The FY 2024 Budget Request of $42.7 million is equal to the FY 2023 Enacted Level. In FY 2024, HRSA will continue increasing access to high-quality dental health services in rural and other underserved communities by supporting oral health care providers working in underserved areas and improving training programs for these providers. Specifically, HRSA's maintenance of its existing 110 awards will 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.

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

Funding History

Fiscal Year	Amount
FY 2020	$40,673,000
FY 2021	$40,673,000
FY 2022	$40,673,000
FY 2023	$42,673,000
FY 2024 President's Budget	$42,673,000

Program Accomplishments

In Academic Year (AY) 2021-2022, the most recent year for which performance data is available, the Predoctoral Dental Training Program trained 7,132 dental and dental hygiene students. A total of 1,870 students graduated from their training programs.

In AY 2021-2022, the most recent year for which performance data is available, the Postdoctoral Dental Program trained 711 dental residents and fellows. A total of 575 residents and fellows completed their Postdoctoral training programs during AY 2021-2022. Of the 109 graduates who reported employment data at the end of the academic year, 79 percent were already working in primary care settings and 35 percent were already working in medically underserved communities. Of the 104 prior year graduates with one-year follow-up data, 41 percent currently work in primary care settings and 26 percent currently work in medically underserved

communities and/or rural areas. Through the Postdoctoral Program, dental residents and fellows accumulated over one million patient encounters in primary care dental settings and almost 900,000 patient encounters in medically underserved communities.

In AY 2021-2022, the most recent year for which performance data is available, the DFLRP provided loan repayment to 100 dental faculty. The program relieved over $2.1 million in debt, which was approximately 15 percent of the student loan debt reported by participating faculty. Thirty-nine percent of the faculty were underrepresented minorities, 29 percent were from disadvantaged backgrounds, and 15 percent were from rural backgrounds. Awardees also sponsored 50 faculty development programs for 170 dental faculty. Since receiving their DFLRP funding, awardees have recruited and retained 55 faculty.

In AY 2021-2022, the most recent year for which performance data is available, the SOWHP trained 124 dental students, 29 advanced dental residents, and two dental hygiene students; 30 percent were underrepresented minorities, 27 percent were from disadvantaged backgrounds, and 25 percent were from rural backgrounds. A total of 132 students and residents completed their training programs. Of the 34 prior year program completers with one-year follow-up data, 38 percent currently work in medically underserved communities and/or rural areas; and 26 percent currently work in Federally Qualified Health Centers, Look-alikes, Rural Health Clinics, or Community Health Centers. Awardees also established 14 new oral health facilities and expanded seven oral health facilities in Dental Health HPSAs that served 10,435 patients.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2080.01 Number of dental students trained through the Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program (Output)	FY 2021: 7,132 Target: 4,000 (Target Exceeded)	6,000	7,500	+ 1,500
2080.02 Number of dental residents trained through the Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program (Output)	FY 2021: 711 Target: 520 (Target Exceeded)	650	650	Maintain
2080.03 Number of dental faculty trained through a Bureau of	FY 2021: 170 Target: 160	200	170	-30

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
Health Workforce Oral Health Training Program (Output)	(Target Exceeded)			

Oral Health Training and Workforce Program Outputs	Year and Most Recent Result	FY 2022 Target	FY 2023 Target	FY 2024 Target
Percent of students and residents trained from underrepresented minority backgrounds	FY 2021: 27%	20%	20%	20%
Number of dentists completing a Bureau of Health Workforce-funded dental residency or fellowship	FY 2021: 575	300	550	550
Number of dentists graduating from a Bureau of Health Workforce-funded dental school	FY 2021: 1,870	1,000	2,500	2,500

Performance Narrative

Most recent results are for activities in Academic Year (AY) 2021-2022 funded in FY 2021.

Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	113	110	110
Average Award	$355,276	$349,916	$356,820
Range of Awards	$32,400 - $699,681	$48,600 - $664,042	$64,800 - $664,042

Medical Student Education Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$55,000,000	$60,000,000	$60,000,000	---
FTE	1	1	1	---

Authorizing Legislation: As added by Title II, Public Law 115-245, as amended by Public Law 116-260

FY 2024 Authorization .....…$50,000,000

Allocation Method .....Grants

Program Description

The purpose of the Medical Student Education (MSE) Program is to provide grants to public institutions of higher education to 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.[33] The Program was established in FY 2019 and 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.

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. Current awards are limited to the 12 public colleges of medicine in Mississippi, Alabama, Kentucky, Oklahoma, Utah, Arkansas, Missouri, and Indiana.

Budget Request

The FY 2024 Budget Request of $60 million is equal to the FY 2023 Enacted Level. This request will support a new competition for applicants in the top quintile of states with a projected primary care provider shortage. In For FY 2024, HRSA is proposing enhancements to strengthen the program by expanding eligibility, removing the matching requirement, and

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

aligning it with other HRSA opportunities to support the health workforce. In FY 2024, HRSA is planning a new competition to provide grants to public institutions of higher education to expand or support education for medical students preparing to become physicians in states with a projected primary care provider shortage. HRSA anticipates funding 12 grants for a 4-year period of performance.

This funding will continue current activities that prepare and encourage medical students to choose residencies and careers in primary care and serve tribal, rural, and/or medically underserved communities in those states after they graduate from residency, thereby increasing the number of primary care physicians practicing in states with a projected primary care provider shortage. In addition, this request will further strengthen the program by expanding or creating pipeline activities that increase the diversity of enrolled students.

In FY 2023, HRSA will hold a new competition and solicit applications from 12 eligible colleges of medicine in eight states with projected primary care provider shortages in FY 2025. The new competition will enhance the program by adding additional activities to expand medical education. The activities include development and implementation of postbaccalaureate premedical (PBPM) programs that support the transition from undergraduate to medical school; development and implementation of pipeline and pathway programs that encourage and mentor students to choose further study in medicine and medical schools to develop and implement best practices for selective admissions for students who are under-represented in medicine (URIM); and scholarships for medical students in years 3-4 who are applying to a primary care residency program and intend to practice in primary care following completion of residency. HRSA anticipates funding 12 programs for a four-year period of performance.

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

Funding History

Fiscal Year	Amount
FY 2020	$50,000,000
FY 2021	$50,000,000
FY 2022	$55,000,000
FY 2023	$60,000,000
FY 2024 President’s Budget	$60,000,000

Program Accomplishments

In FY 2020, HRSA made five awards. These grants are fully funded for their four-year project

In Academic Year (AY) 2021-2022, the most recent year for which performance data is available, the MSE Program trained 2,553 medical students in medically underserved states. Thirty-seven percent of MSE students were underrepresented minorities and/or from disadvantaged backgrounds and 32 percent were from rural backgrounds. MSE trained 81 students who self-identified solely as American Indian or Alaskan Natives (AI/AN). This

represented 47 percent of U.S. Doctor of Medicine (MD) program enrollees from AI/AN-only backgrounds and 28 percent of AI/AN-only matriculants/first-year students.[34,35]

By the end of the academic year, 372 trainees graduated from medical school. The MSE Program's 23 AI/AN-only graduates accounted for 88 percent of all AI/AN-only MD program graduates in the U.S. from AY 2021-2022. A total of 354 medical students matched to residency programs, including 177 graduates who matched to primary care residency programs. Primary care specialties included family medicine (23 percent), internal medicine (15 percent), and pediatrics (12 percent). The 177 non-primary care graduates matched to general or specialty surgery (14 percent), emergency medicine (six percent), psychiatry (five percent), obstetrics and gynecology (three percent), and other specialties (22 percent). Of the 25 graduates from the prior academic year with one-year follow-up data, 24 percent are enrolled in residency programs located in medically underserved communities and/or rural areas.

MSE awardees collaborated with 383 health care delivery sites to provide 4,875 clinical training experiences. Sixty-eight percent of these sites were in medically underserved communities and/or rural settings; 56 percent offered interprofessional, team-based training that involved 1,615 other trainees. Collectively, MSE students accumulated over 150,000 contact hours in primary care settings, over 120,000 contact hours in medically underserved communities, and over 70,000 contact hours in rural areas.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2090.01 Number of medical students trained in underserved states (Output)	FY 2021: 2,553 Target: Not Defined (Historical Actual)	1,000	2,500	+1,500
2090.02 Number of medical students matched to primary care residencies (Output)	FY 2021: 177 Target: Not Defined (Historical Actual)	20	400	+380

[34] Association of American Medical Colleges. 2022. Total U.S. MD-Granting Medical School Enrollment by Race/Ethnicity (Alone) and Gender, 2018-2019 through 2022-2023. https://www.aamc.org/media/6116/download
[35] Association of American Medical Colleges. 2022. Race/Ethnicity Responses (Alone and In Combination) of Matriculants to U.S. MD-Granting Medical Schools, 2018-2019 through 2022-2023. https://www.aamc.org/media/8826/download?attachment

Performance Narrative

Most recent results are for activities in Academic Year (AY) 2021-2022 funded in FY 2021.

Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	10	12	12
Average Award	$6,877,021	$1,000,000-$1,250,000	$1,000,000-$1,250,000
Range of Awards	$6,553,174-7,200,869	$1,225,000	$1,225,000

Interdisciplinary, Community-Based Linkages

Area Health Education Centers Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$45,000,000	$47,000,000	$47,000,000	---
FTE	3	3	3	---

Authorizing Legislation: Public Health Service Act, Section 751, as amended by CARES Act, Section 3401, Public Law 116-136.

FY 2024 Authorization $41,250,000

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

Program Description

The Area Health Education Centers (AHEC) Program develops and enhances education and training networks within communities, academic institutions, and community-based organizations. In turn, these networks broaden the distribution of the health workforce, enhance health care quality, and improve health care delivery to rural and underserved areas and populations. AHECs must establish and maintain community-based training programs with an emphasis on primary care in rural and underserved areas. The redesigned AHEC Program invests in interprofessional networks that address the social determinants of health of surrounding communities and incorporates community-based field placement programs. The AHEC Program also provides continuing education, simulation education and training activities, and information dissemination to practicing health professionals to increase their effectiveness in providing quality health care.

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.

Budget Request

The FY 2024 Budget Request of $47 million is equal to the FY 2023 Enacted Level. This request will support non-competing continuation awards to the 49 current AHEC grantees to increase the number of students in health professions who pursue careers in primary care and are prepared to practice in rural and underserved areas and populations. In FY 2022, HRSA held a new competition for the AHEC Program with a five-year project period; 49 awards were made. In FY 2023 and FY 2024, HRSA will support these 49 awardees through non-competing continuation awards.

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

Funding History

Fiscal Year	Amount
FY 2020	$41,250,000
FY 2021	$43,250,000
FY 2022	$45,000,000
FY 2023	$47,000,000
FY 2024 President's Budget	$47,000,000

Program Accomplishments

In Academic Year (AY) 2021-2022, the most recent year for which performance data is available, the AHEC Program trained 283,140 health care trainees and professionals, including 30 percent from rural areas. A total of 266,344 health care trainees and professionals completed their AHEC program. AHEC awardees offered 1,560 unique continuing education courses to 150,349 practicing professionals nationwide – 45 percent of whom were employed in medically underserved communities. They also developed or enhanced 2,972 courses for 34,564 AHEC Scholars and health professionals. In addition, AHEC awardees partnered with 4,892 health care delivery sites to provide 28,307 clinical training experiences to student trainees. Approximately 70 percent of these training sites were in medically underserved communities, 57 percent were in primary care settings, and 46 percent were in rural areas.

A subset of 8,429 trainees participated in the structured AHEC Scholars Program. Fifty-eight percent of AHEC Scholars were underrepresented minorities and/or from disadvantaged backgrounds and 41 percent were from rural areas. A total of 2,355 AHEC Scholars completed their program by the end of the academic year. Of the 975 prior year completers with one year follow-up data, 70 percent currently practice in primary care settings, medically underserved communities, and/or rural areas. All 8,429 AHEC Scholars trained in medically underserved communities and/or rural settings in AY 2021-2022. Collectively, AHEC Scholars accumulated 465,207 contact hours in medically underserved communities, 351,559 contact hours in primary care settings, and 211,965 contact hours in rural settings. They also received training on integrating behavioral health into primary care (47 percent) and health equity (42 percent).

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2100.01 Number of Area Health Education Centers Scholars trained in medically underserved communities and/or rural areas (Output)	FY 2021: 8,429 Target: Not Defined (Historical Actual)	5,060	7,500	+ 2,440
2100.02 Percentage of Area Health Education Centers participants practicing in primary care, medically underserved communities, and/or rural areas one year after program completion (Outcome)	FY 2021: 70% Target: Not Defined (Historical Actual)	48%	65%	+17 percentage points

AHEC Program Outputs	Year and Most Recent Result	FY 2022 Target	FY 2023 Target	FY 2024 Target
Number of medical students who participated in community-based clinical training	FY 2021: 10,345	11,500	11,500	11,500
Number of other health professions trainees who participated in community-based clinical training	FY 2021: 11,806	11,000	11,000	11,000
Number of trainees who received continuing education on topics including cultural competence, women's health, diabetes, hypertension, obesity, and health disparities	FY 2021: 150,349	140,000	140,000	140,000

Performance Narrative

Most recent results are for activities in Academic Year (AY) 2021-2022 funded in FY 2021.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	49	49	49
Average Award	$805,101	$857,244	$857,244
Range of Awards	$288,500 - $1,731,000	$288,500 - $2,106,000	$288,500 - $2,106,000

Geriatrics Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$45,245,000	$47,245,000	$47,245,000	---
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Sections 753, as amended by CARES Act, Section 3403, Public Law 116-136.

FY 2024 Authorization $40,737,000

Allocation Method ..... Cooperative Agreement

Program Description

HRSA's Geriatrics Programs aim to (1) improve health care for older adults by developing a health workforce to provide value-based care that improves health outcomes for older adults by integrating geriatrics and primary care delivery sites/systems and (2) support the career development of junior faculty in geriatrics at accredited schools of allopathic medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or allied health.

Geriatric Program Breakout

Program	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Geriatrics Workforce Enhancement Program (GWEP)	$43,126,144	$45,141,205	$45,141,205
Geriatrics Academic Career Awards (GACA) Program	$2,118,856	$2,103,795	$2,103,795

Eligible Entities

GWEP: Accredited schools of health professions representing various health disciplines, health care facilities, and programs leading to certification as a certified nursing assistant.

GACA: Accredited health professions schools of allopathic medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or allied health who apply on behalf of individuals where the individuals have a full-time junior faculty appointment.

Budget Request

The FY 2024 Budget Request of $47.2 million is equal to the FY 2023 Enacted Level. The request will fund approximately 43 new GWEP awards and 26 GACA non-competing continuation awards to improve outcomes for older adults by integrating geriatrics and primary care delivery sites/systems, and by supporting the career development of junior faculty in geriatrics. The Programs provide 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).

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

Funding History

Fiscal Year	Amount
FY 2020	$40,737,000
FY 2021	$42,859,000
FY 2022	$45,245,000
FY 2023	$47,245,000
FY 2024 President's Budget	$47,245,000

Program Accomplishments

GWEP: In Academic Year (AY) 2021-2022, the most recent year for which performance data is available, GWEP trained over one million health care professionals, students, patients, and caregivers through 7,160 courses that awardees developed or enhanced with GWEP funding. GWEP's geriatrics-related training included 1,889 continuing education courses, which reached 501,431 individuals and provided 4,825 hours of training. A total of 673 continuing education courses (36 percent) focused on Alzheimer's Disease and related dementias. This subset of courses trained 130,012 health care professionals, students, patients, and caregivers. GWEP's trainees included 71,870 health professions students who received geriatric-focused training in settings across the care continuum. Forty-five percent of these trainees were underrepresented minorities and/or from disadvantaged backgrounds. By the end of the academic year, 64,152 students completed a GWEP program.

In FY 2021 GWEP received an additional $2 million in annual appropriations for which HRSA awarded 12 grant recipients through a limited competition for current grant recipients. The purpose of the funding was to provide COVID-19 specific education and training to the nursing home workforce in order to improve care to nursing home residents. As a result of the additional funding, the 12 grant recipients partnered with 12 other GWEP recipients on the COVID-19 project. These GWEP COVID-19 grant recipients educated and trained the nursing home primary care workforce (which consists of primary care workforce includes patients, families, caregivers, direct care workers, and health professions students, residents, fellows, faculty, and providers who live or work in nursing homes). This training took place within the context of the age-friendly health systems framework and addressed best practices regarding the management

and treatment of medically frail older persons who are at risk of contracting COVID-19, are currently ill with COVID-19, or families of persons with COVID-19 who have died. In FY 2022, HRSA received an additional $2 million in annual appropriations with which HRSA provided a second year of supplemental funding to the 12 COVID-19 grant recipients.

In FY 2022, funding was awarded to each GWEP grantee to develop or enhance nursing curricula on nursing home care using an age-friendly health systems framework. Each GWEP grantee will partner with at least one School of Nursing, one accredited Certified Nurse Assistance program and at least one nursing home to accomplish the goals of this supplemental funding. In addition, in FY 2022, HRSA funded 48 non-competing continuation awards. A total of 1,124 nursing homes receiving education and training by all 48 GWEP grantees in FY 2022. In FY 2023, HRSA will support 48 non-competing continuation awards for the GWEP Program, through which the GWEP grantees will continue to address their goals and objectives.

GACA: In Academic Year (AY) 2021-2022, the GACA Program directly supported 24 faculty, including 14 physicians specializing in geriatrics or geriatric psychiatry and two nurse practitioners specializing in gerontology. GACA-supported faculty gave 94 conference presentations, received 35 research or education grants, and published 32 articles in peer-reviewed journals. GACA fellows also delivered 14,142 hours of education through 325 unique training programs and workshops. These courses reached 14,458 faculty, health professionals, and students specializing in medicine (35 percent), public health (15 percent), nursing (14 percent), behavioral health (12 percent), and other disciplines (24 percent).

In FY 2022, there were 24 grant recipients. However, three grant recipients relinquished their GACA awards due to being promoted. The GACA Program is for instructors and assistant professors only. GACA candidates that are promoted within the grant's period of performance are required to relinquish their grant. Therefore, HRSA funded 21 non-competing continuation awards. In FY 2023, HRSA is planning a new competition to fund 26 grant recipients.

Outcomes and Outputs Measures

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 Target +/-FY 2023 Target
2110.01 Number of Bureau of Health Workforce-sponsored educational courses and activities offered on topics related to Alzheimer's disease and related dementias (Output)	FY 2021: 673 Target: 150 (Target Exceeded)	700	670	- 30

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 Target +/-FY 2023 Target
2110.02 Number of trainees participating in educational courses and activities offered on topics related to Alzheimer's disease and related dementias (Output)	FY 2021: 130,012 Target: 10,000 (Target Exceeded)	180,000	130,000	- 50,000
2110.03 Number of continuing education trainees in geriatrics programs (Output)	FY 2021: 501,431 Target: 50,000 (Target Exceeded)	500,000	500,000	Maintain
2110.04 Number of students who received geriatric-focused training in settings across the care continuum (Output)	FY 2021: 71,870 Target: 10,000 (Target Exceeded)	60,000	60,000	Maintain

Geriatrics Program Outputs	Year and Most Recent Result	FY 2022 Target	FY 2023 Target	FY 2024 Target
Number of continuing education offerings delivered by grantees	FY 2021: 1,889	2,000	2,000	2,000
Number of faculty members participating in geriatrics trainings offered by grantees	FY 2021: 10,029	10,500	10,500	10,500
Number of individuals trained in new or enhanced curricula relating to the treatment of health problems of elderly individuals	FY 2021: 1,070,794	200,000	700,000	700,000

Performance Narrative

Most recent results are for activities in AY 2021-2022 funded in FY 2021. GWEP outperformed its FY 2021 targets because grantees leveraged their COVID-related supplemental funding to expand the reach of their regular funding. Anticipating that these programmatic changes will continue beyond the pandemic, HRSA set an ambitious target for FY 2023. The effect appears to have tapered off, so the FY 2024 target has been adjusted downward to align with the most recent results.

GWEP Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	48	48	43
Average Award	$848,973	$868,245	$1,000,000
Range of Awards	$611,584 - $1,086,363	$788,892 - $1,030,930	$1,000,000

GACA Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	21	26	26
Average Award	$81,746	$81,746	$81,746
Range of Awards	$81,746	$81,746	$81,746

Behavioral Health Workforce Development Programs

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$162,053,000	$197,053,000	$387,374,000	+$190,321,000
FTE	18	27	42[36]	---

Authorizing Legislation: Public Health Service Act, Sections 755, 756, 760 and 781 as amended by Public Law 117-328

FY 2024 Authorization:
BHWET: $50,000,000
MBHET: Public Health Service 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 Public Health Service Act, Section 781, Subsection (j): $25,000,000

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

Program Description

HRSA's behavioral health workforce programs support the training of behavioral health providers and seek to place these providers in rural and underserved communities across the United States and its territories. The Behavioral Health Workforce Development (BHWD) Programs expand the number of behavioral health professionals and paraprofessionals, improve the quality of care by recruiting a diverse behavioral health workforce and training them to work collaboratively on interprofessional teams, and promote the integration of behavioral health into primary care settings to further increase access to behavioral health services.

The United States is currently facing a shortage of behavioral health providers. HRSA's 2022 Behavioral Health Workforce Projections Report estimated national level health workforce needs for several behavioral health occupations between 2020 and 2035.[37] The report estimated the demand for addiction counselors, for example, is expected to increase 10 percent by 2035, with demand exceeding supply and leading to a deficit of addiction counselors of approximately 920 Full-Time Equivalents. Also, the report estimated that by 2035, the supply of psychiatrists is expected to decrease by approximately 8 percent. The COVID-19 pandemic has exacerbated the existing imbalance in supply of and demand for behavioral health providers across the U.S. There were over 104,000 drug overdose deaths in the United States during the 12-month period ending in September 2021. Such deaths have increased approximately ten-fold since 1980. Opioids, particularly fentanyl, are the chief drug involved in these deaths, though non-opioid drugs also contribute.

[36] FTE totals include FTE from Supplemental Funding.
[37] Health Resources and Services Administration 2022. "Behavioral Health Workforce Projections, 2020-2035." https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Projections-Factsheet.pdf.

Behavioral Health Workforce Development Programs

The BHWD Programs support several activities that increase the behavioral health workforce and expand access to behavioral health services. Programs/activities include the Behavioral Health Workforce Education and Training (BHWET), Opioid-Impacted Family Support Program (OIFSP), the Graduate Psychology Education (GPE) Program, the Addiction Medicine Fellowship (AMF) Program, the Integrated Substance Use Disorder Training Program (ISTP), and the Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR LRP).

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Behavioral Health Workforce Development	$142,053,000	$172,053,000	$362,374,000
Graduate Psychology Education	$20,000,000	$25,000,000	$25,000,000
Total Behavioral Health Workforce Development Programs[38]	**$162,053,000**	**$197,053,000**	**$387,374,000**

Eligible Entities

Program/Activity	Entities
BHWET for Professionals, Paraprofessionals, and Opioid-Impacted Family Support Program	• Accredited masters and doctoral level behavioral health institutions of higher education or professional training programs • Accredited doctoral, internship, and post-doctoral residency programs of health service psychology • State-licensed mental health non-profit and for-profit organizations • Nationally recognized accrediting agency, as specified by the U.S. Department of Education • 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
GPE	• APA-accredited health service psychology doctoral level schools and programs, internships and post-doctoral residency programs • PCSAS-accredited doctoral level schools of psychology
AMF	• Accredited ACGME Addiction Medicine (AM) or Addiction Psychiatry (AP) fellowship programs. • Consortium (teaching health center and at least one sponsor AM or AP fellowship program

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

Program/Activity	Entities
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
STAR LRP	• Fully licensed clinicians, credentialed in an eligible discipline; and registered substance use disorder (SUD) treatment professionals

Budget Request

The FY 2024 Budget Request of $387.4 million is $190.3 million more than the FY 2023 Enacted Level for Behavioral Health Workforce Development Programs, which will support the training of 18,000 students in behavioral degree or certificate programs.

The increased resources will support an additional 263 training programs through the BHWET for Professionals and Paraprofessionals Program. The BHWET Program for Professionals seeks to increase the supply of behavioral health professionals while also improving distribution of a quality behavioral health workforce and thereby increasing access to behavioral health services. The BHWET Program for Paraprofessionals seeks to develop and expand community-based experiential training to increase the supply of students preparing to become peer support specialists and other behavioral health-related paraprofessionals while also improving distribution of a quality behavioral health workforce. Both programs will include a focus on children, adolescents, and transitional-aged youth at risk for behavioral health disorders.

In FY 2024, HRSA will re-compete the Opioid-Impacted Family Support Program, which trains paraprofessionals to support children and families impacted by opioid use disorder (OUD) and substance use disorder (SUD) in underserved areas. HRSA will also provide new loan repayment awards through the STAR Loan Repayment Program, which recruits and retains medical, nursing, behavioral/mental health clinicians and paraprofessionals who provide direct treatment or recovery support of patients with or in recovery from a SUD.

In FY 2024, HRSA will also fund continuation awards in:

- Graduate Psychology Education: to support 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.
- Addiction Medicine Fellowship Program: 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 Training Program: to foster clinical training and augment expertise among clinicians who will see patients at access points of care and provides addiction prevention, treatment, and recovery services.

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

Funding History

Fiscal Year	Amount
FY 2020	$138,916,000
FY 2021	$149,207,000
FY 2022	$162,053,000
FY 2023	$197,053,000
FY 2024 President's Budget	$397,374,000

Program Accomplishments

In Academic Year (AY) 2021-2022, the most recent year for which performance data is available, BHWD program*s trained 4,874 behavioral health professionals and 3,052 behavioral health paraprofessionals. Trainees included:

- 4,314 behavioral health professionals and 1,671 behavioral health paraprofessionals trained through BHWET.
- 373 graduate-level students in practica, internships, or post-doctoral residency programs in psychology trained through GPE.
- 140 Addiction Medicine fellows and 29 Addiction Psychiatry fellows through AMF.

Key program outcomes included the following:

- Of the 2,129 BHWET AY 2021-2022 graduates who provided employment data at the end of the academic year:
    - 58 percent were already working medically underserved communities.
    - 28 percent were already working in Health Professional Shortage Areas.
- Of the 1,832 prior year BHWET graduates with one-year follow-up data:
    - 46 percent work or train in medically underserved communities.
    - 40 percent work or train serving at-risk youth.
- Of GPE's 121 graduates who reported employment data:
    - 64 percent were already working in medically underserved communities.
    - 36 percent were already working in primary care settings at graduation.
- Of the 135 GPE prior year graduates with one-year follow-up data:
    - 55 percent currently work or train in medically underserved communities.
- Of the 116 AMF completers who reported employment information:
    - 67 percent were already working in medically underserved communities.
    - 40 percent were already working in primary care settings.
    - 20 percent were already working in Mental Health Professional Shortage Areas.
- Of the 54 AMF prior year graduates with one-year follow-up data:
    - 74 percent currently treat patients with opioid/substance use disorders.
    - 48 percent currently work in medically underserved communities.
    - 41 percent currently work in primary care settings.

    - 22 percent currently work in Federally Qualified Health Centers/Look-Alikes, Community Health Centers, or Community Mental or Behavioral Health Centers.
- 445 STAR providers offered behavioral health services, including 208 participants with newly issued STAR awards.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 Target +/-FY 2023 Target
2120.01 Number of graduates from behavioral degree or certificate programs supported by through HRSA's behavioral health workforce development programs (Outcome)	FY 2021: 4,042 Target: 3,000 (Target Exceeded)	9,000	4,000	- 5,000
2120.02 Number of students in behavioral degree or certificate programs supported by Bureau of Health Workforce behavioral health workforce development programs (Output)	FY 2021: 5,985 Target: 4,500 (Target Exceeded)	20,000	18,000	- 2,000
2120.03 Number of graduate-level psychology students supported by the Graduate Psychology Education Program (Output)	FY 2021: 373 Target: 200 (Target Exceeded)	350	375	+ 25
2120.04 Number of interprofessional students trained in psychology field placement settings through the Graduate Psychology Education Program (Output)	FY 2021: 3,832 Target: 1,900 (Target Exceeded)	3,800	4,000	+ 200
2120.05 Number of new addiction medicine and addiction psychiatry fellowship graduates entering workforce (Outcome)	FY 2021: 139 Target: Not Defined (Historical Actual)	63	130	+ 67
2120.06 Number of substance use disorder treatment providers receiving student loan repayment in exchange for providing behavioral health services in Health Professional Shortage Areas (Output)	FY 2022: 445 Target: 255 (Target Exceeded)	350	800	+ 450

Program Outputs	Year and Most Recent Result	FY 2022 Target	FY 2023 Target	FY 2024 Target
Number of Graduate Psychology Education clinical training experiences that incorporated interprofessional team-based care training	FY 2021: 962	600	600	600

Performance Narrative

The ambitious FY 2023 targets for Measures 2120.01 and 2120.02 were set based on projected funding that the program did not ultimately receive. The FY 2024 targets for those measures have been adjusted to align with requested resources and recent results.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	343	380	636
Average Award	$601,525	$453,889	$450,571
Range of Awards	$75,948 - $2,258,032	$93,166 - $800,000	$93,166 - $800,000

STAR LRP Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	208	160	160
Average Award	$107,808	$250,000	$250,000
Range of Awards	$8,581.86 - $262,739	$50,000 - $250,000	$50,000 - $250,000

Public Health Workforce Development

Public Health and Preventive Medicine Training Grant Programs

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$17,000,000	$18,000,000	$18,000,000	---
FTE	4	4	4	---

Authorizing Legislation: Public Health Service Act, Sections 765-768 and 770, as amended by CARES Act, Section 3401, by Public Law 116-136.

FY 2024 Authorization $17,000,000

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

Program Description

The Preventive Medicine and Public Health Training Grant Programs train the current and future workforce through the development and delivery of new public health training content, 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.

Public Health Workforce Development Breakout

Program	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Public Health Training Centers Program	$9,700,258	$10,000,000	$10,000,000
Preventive Medicine Residency Program	$7,299,742	$8,000,000	$8,000,000

Eligible Entities

Public Health Training Centers (PHTC) Program: 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.

Preventive Medicine Residency (PMR) Program: 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.

Budget Request

The FY 2024 Budget Request of $18 million is equal to the FY 2023 Enacted Level. This request will fund 10 Public Health Training Centers and 17 Preventive Medicine Residencies through non-competing continuation awards.

Specifically, the Public Health Training Centers will continue to fund the current 10 regional awardees and support the development and implementation of training focused on regional public health needs 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 fund 17 continuation awards. The continuations will support enhanced experiential activities that align with their grant objectives and 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 Federally Qualified Health Centers (FQHCs) in rural areas.

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

Funding History

Fiscal Year	Amount
FY 2020	$17,000,000
FY 2021	$17,000,000
FY 2022	$17,000,000
FY 2023	$18,000,000
FY 2024 President's Budget	$18,000,000

Program Accomplishments

Public Health Training Centers (PHTC) Program: In FY 2022, HRSA made 10 new awards to the Regional Public Health Training Centers to develop and implement training focused on regional public health needs and that aligns with agency priorities. 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. In FY 2023 HRSA will supplement the 10 non-competing continuation awards.

In Academic Year (AY) 2021-2022, the most recent year for which performance data is available, the PHTC Program supported 10 regional PHTCs. The PHTCs reached 317,142 public health professionals through 7,621 hours of training across 3,188 unique continuing education courses. Sixty-four percent of courses were for front-line or entry-level workers, 31 percent were tailored to project managers or mid-level supervisors, and five percent were designed for senior executives.

PHTCs also trained 415 public health students, 45 percent of whom were underrepresented minorities and/or from disadvantaged backgrounds. The PHTC Program's public health students accumulated nearly 50,000 contact hours in medically underserved communities. By the end of the academic year, 346 public health students completed the PHTC Program. Of the 182 prior year program completers with one-year follow-up data, 40 percent currently work in or are pursuing further training in medically underserved communities, 26 percent currently work in public health or prevention-focused settings, and 11 percent currently work at health departments.

Preventive Medicine Residency (PMR) Program: In FY 2022, HRSA funded 17 non-competing continuation awards increase the number of preventive medicine physicians and promote greater access to preventive medicine. In FY 2023, HRSA anticipates 17 new PMR awards through a new competition. The new competition will increase the number, quality, and diversity of preventive medicine residents and physicians to support access to preventive medicine and to integrate population health with primary care to improve the health of communities. enhance the quality of the preventive medicine residencies through residents having one of their rotations in a FQHC in rural and/or medically underserved communities.

In Academic Year (AY) 2021-2022, the most recent year for which performance data is available, the PMR Program provided financial support to 118 residents. Thirty-one percent of PMR residents were underrepresented minorities, and 28 percent came from disadvantaged and/or rural backgrounds. Residents engaged in 72,133 patient encounters during the academic year. A total of 55 residents completed their residency programs. Of the 49 AY 2021-2022 graduates who reported employment data at the end of the academic year, 57 percent were already working in primary care settings, 14 percent were already working in medically underserved communities, and ten percent were already working in Health Professional Shortage Areas (HPSAs). In addition, of the 57 prior year graduates with one-year follow-up data, 35 percent currently work in public health/prevention settings, 30 percent currently work in primary care settings, and 19 percent currently work in medically underserved communities.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2130.01 Number of individuals trained in continuing education courses offered by Public Health Training Centers (Output)	FY 2021: 317,142 Target: 160,000 (Target Exceeded)	350,000	300,000	-50,000
2130.02 Number of hours of public health-related continuing education offered by Public Health Training Centers (Output)	FY 2021: 7,621 Target: 6,000 (Target Exceeded)	5,700	5,700	Maintain
2130.03 Number of public health students completing field placement practicums coordinated by Public Health Training Centers (Outcome)	FY 2021: 346 Target: 180 (Target Exceeded)	275	275	Maintain

PMR Program Outputs	Year and Most Recent Result	FY 2022 Target	FY 2023 Target	FY 2024 Target
Number of preventive medicine residents participating in residencies	FY 2021: 118	80	80	80
Number of preventive medicine residents completing training	FY 2021: 55	50	50	50
Percent of program completers who are from underrepresented minority backgrounds	FY 2021: 27%	20%	20%	20%

Performance Narrative

Most recent results are for activities in Academic Year (AY) 2021-2022 funded in FY 2021. The PHTC Program outperformed its FY 2021 target for 2130.01 due to increased demand for public health-related continuing education during the COVID-19 pandemic. Anticipating that PHTC grantees will leverage their expanded reach to continue providing more training than in prior years, HRSA set ambitious FY 2023 and FY 2024 targets. The FY 2024 targets are lower than the FY 2023 targets to align with FY 2021 results. For 2130.02, the program did not meet last year's target, so FY 2023 and 2024 targets were reduced based on historical results.

Grant Awards Table – Public Health Training Centers Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	10	10	10
Average Award	$899,746	$924,973	$896,873
Range of Awards	$771,267 – $1,092,628	$794,094 – $1,122,858	$768,804 – $1,105,215

Grant Awards Table – Preventive Medicine Residency Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	17	17	17
Average Award	$380,069	$400,000	$400,000
Range of Awards	$362,247 – $397,247	$400,000	$400,000

Nursing Workforce Development

Advanced Nursing Education Programs

Activity	FY 2022 Final	FY2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$85,581,000	$95,581,000	$112,581,000	+$17,000,000
FTE	9	10	10	---

Authorizing Legislation: Public Health Service Act, Section 811 and 871 as amended by Public Law 116-136.

FY 2024 Authorization $137,837,000

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

Program Description

The Advanced Nursing Education Programs increase the number of qualified nurses in the primary care workforce by funding enhancements of training and practice of advanced nurses and traineeships for nursing students. By statute, grant applications with projects that substantially benefit rural or underserved populations, or help public health nursing needs in state or local health departments, receive a funding preference.

Eligible Entities: Schools of nursing, nursing centers, academic health centers, State or local governments, and other non-profit public or private entities determined appropriate by the Secretary such as Federally Qualified Health Centers (FQHCs) and rural health clinics. Domestic faith-based and community-based organizations and Tribes and Tribal organizations may apply for these funds, if otherwise eligible.

Budget Request

The FY 2024 Budget Request of $112.6 million is $17.0 million above the FY 2023 Enacted Level. The request supports 17 new awards for the Maternity Care Nursing Workforce Expansion Program. The Program will grow and diversify the maternal and perinatal health nursing workforce by increasing the number of trained Certified Nurse Midwives (CNMs) including preparing them to serve in rural and underserved communities nationwide with and the goal of reducing maternal mortality and morbidity.

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

Funding History

Fiscal Year	Amount
FY 2020	$80,581,000
FY 2021	$80,581,000
FY 2022	$85,581,000
FY 2023	$95,581,000
FY 2024 President's Budget	$112,581,000

Program Accomplishments

In Academic Year (AY) 2021-2022, the Advanced Nursing Education Workforce (ANEW) Program trained 3,964 nursing students. This exceeded the FY 2021 target of 3,700 students because grantees' capacity to train students was greater than anticipated. Forty percent of ANEW nursing students were underrepresented minorities and/or from disadvantaged backgrounds. Awardees partnered with more than 2,000 clinical training sites in primary care settings, medically underserved communities, and rural communities to provide clinical training experiences to nursing students. By the end of the academic year, the ANEW program produced 1,468 graduates ready to enter the nursing workforce. This exceeded the FY 2021 target of 1,000 graduates because grantees outperformed expectations.

The Advanced Nursing Education Program also provided specialized training to meet national needs, including:

- Training 2,930 nurses as sexual assault nurse examiners, including 39 percent who were from rural areas;
- Supporting 1,457 nurse anesthetist students to become Certified Registered Nurse Anesthetists (CRNAs) who are well prepared and well positioned to practice independently and collaboratively within interprofessional teams delivering evidence-based, high quality, safe anesthesia care, and acute and chronic pain management services; and
- Supporting 487 nurse practitioners in new and expanded nurse practitioner residency programs to prepare new providers to practice independently, with a focus on the integration of behavioral health and/or maternal health into primary care.

The targets for the number of students trained in advanced nursing degree programs and the number of graduates from advanced nursing degree programs were reduced because COVID affected attrition rates in nursing programs. The number of trainees and graduates has not returned to anticipated levels, so FY 2024 targets were adjusted based on FY 2021 results and trend data.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 Target +/-FY 2023 Target
2140.01 Number of students trained in advanced nursing degree programs (Output)	FY 2021: 3,964 Target: 3,700 (Target Exceeded)	4,800	3,800	- 1,000
2140.02 Percentage of advanced nursing degree students who are underrepresented minorities and/or from disadvantaged backgrounds (Outcome)	FY 2021: 40% Target: 36% (Target Exceeded)	38%	38%	Maintain
2140.03 Number of graduates from advanced nursing degree programs (Outcome)	FY 2021: 1,468 Target: 1,000 (Target Exceeded)	2,000	1,200	- 800

ANE Program Outputs	Year and Most Recent Result	FY 2022 Target	FY 2023 Target	FY 2024 Target
Number of new nurse anesthetists produced through the Nurse Anesthetist Training Program	FY 2021: 1,350	1,200	1,200	1,250
Percentage of nurse anesthetists working in medically underserved communities and/or rural areas one year after completing the Nurse Anesthetist Training Program	FY 2021: 50%	50%	50%	50%
Number of new sexual assault nurse examiners produced through the Advanced Nursing Education-Sexual Assault Nurse Examiners Program	FY 2021: 580	300	850	900
Percentage of sexual assault nurse examiners working in medically underserved communities and/or rural areas one year after completing the Advanced Nursing Education-Sexual Assault Nurse Examiners Program	FY 2021: 29%	40%	40%	40%
Number of nurse practitioner residency or fellowship program completers	FY 2021: 245	150	160	170
Percentage of new nurse practitioners working in medically underserved communities and/or rural areas after completing a HRSA-funded nurse practitioner residency or fellowship program	FY 2021: 83%	50%	60%	70%

Grants Awards Table

Activity	FY 2022 *Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	211	212	229
Average Award	$439,788	$553,785	$537,135
Range of Awards	$3,785 - $1,096,957	$3,785 - $1,000,000	$3,785 - $1,000,000

Nursing Workforce Diversity

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$23,343,000	$24,343,000	$24,343,000	---
FTE	4	4	4	---

Authorizing Legislation: Public Health Service Act, Sections 821, as amended by CARES Act, Section 3404, by Public Law 116-136.

FY 2024 Authorization $137,837,000

Allocation Method .....Competitive Grant/Contract

Program Description

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.

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

Budget Request

The FY 2024 Budget Request of $24.3 million is the same as the FY 2023 Enacted Level. This request will fund 42 continuation awards to increase nursing education opportunities for individuals from disadvantaged backgrounds.

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

Funding History

Fiscal Year	Amount
FY 2020	$18,343,000
FY 2021	$19,843,000
FY 2022	$23,343,000
FY 2023	$24,343,000
FY 2024 President's Budget	$24,343,000

Program Accomplishments

In FY 2022, HRSA supported 32 NWD non-competing continuation awards and nine new awards. In FY 2023, HRSA will continue to support 41 non-competing continuation NWD awards and one new award. In Academic Year (AY) 2021-2022, the most recent year for which performance data is available, the NWD Program trained 10,981 students. Sixty-seven percent of the NWD trainees were from disadvantaged backgrounds and 56 percent were underrepresented minorities. NWD trainees included 7,809 nursing students enrolled in degree programs and other 3,172 NWD trainees academic support programs. A total of 3,848 students completed their NWD programs.

The NWD Program provided scholarships and stipends to a subset of 1,210 nursing students. One hundred percent of these nursing students were underrepresented minorities and/or from disadvantaged backgrounds. By the end of the academic year, 626 of these nursing students graduated from their degree programs. Of the 242 prior year graduates with one-year follow-up data, 54 percent currently work in or pursuing further training in medically underserved communities.

In AY 2021-2022, the NWD-Eldercare Enhancement Program trained 1,471 students. NWD-Eldercare Enhancement trainees included 1,055 nursing students enrolled in college-level degree programs and 416 students participating in academic support programs. By the end of the academic year, 576 students graduated or completed their NWD-Eldercare Enhancement programs.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2150.01 Percentage of Nursing Workforce Diversity participants who are underrepresented minorities and/or from disadvantaged backgrounds (Outcome)	FY 2021: 100% Target: 98% (Target Exceeded)	98%	98%	Maintain
2150.02 Number of Nursing Workforce Diversity participants who participated in academic support programs during the academic year (Outcome)	FY 2021: 3,172 Target: 4,500 (Target Not Met)	4,500	3,000	-1,500
2150.03 Number of Nursing Workforce Diversity participants who are enrolled in a nursing degree program (Outcome)	FY 2021: 7,809 Target: 2,500 (Target Exceeded)	6,000	6,250	+250

NWD Program Outputs	Year and Most Recent Result	FY 2022 Target	FY 2023 Target	FY 2024 Target
Percentage of students from underrepresented minority backgrounds	FY 2021: 56%	60%	50%	50%
Number of nursing students graduating from nursing programs	FY 2021: 2,216	2,500	3,570	3,570

Performance Narrative

Most recent results are for activities in Academic Year (AY) 2021-2022 funded in FY 2021. NWD did not meet the FY 2021 target of 4,500 students for Measure 2150.02. A new cohort of NWD awardees began in AY 2021-2022 and they were not yet operating at full capacity.

Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	41	42	42
Average Award	$524,395	$463,961	$465,976
Range of Awards	$372,634 - $555,000	$372,922 -$555,000	$376, 951 - $555,000

Nurse Education, Practice, Quality and Retention Programs

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$54,413,000	$59,413,000	$91,873,000	+$32,460,000
FTE	5	5	7	---

Authorizing Legislation: Public Health Service Act, Sections 831 and 831A, as amended by CARES Act, Section 3404, Public Law 116-136.

FY 2024 Authorizations.....$137,837,000

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

Program Description

The Nurse Education, Practice, Quality and Retention (NEPQR) Programs address national nursing needs and strengthen nursing workforce capacity in 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 several statutory purposes that support the development, distribution and retention of a diverse, culturally competent nursing workforce that can adapt to the population's changing health care needs and provide the highest quality of care for all. The Programs aim to increase the number of nursing students exposed to meaningful clinical experiences and training in medically underserved and rural communities, who will then be more likely to choose to work in these settings upon graduation.

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

Budget Request

The FY 2024 Budget Request of $91.9 million is $32.5 million above the FY 2023 Enacted Level, to expand, enhance, and modernize nursing education programs by increasing the number of faculty and students at schools of nursing. To address this critical challenge, HRSA will provide funding to schools of nursing to increase the number of faculty with an emphasis on recruiting faculty who are underrepresented in the nursing workforce. The NEPQR Programs will also target the expansion of grant-supported programs in states with the greatest shortages of nurses. The proposed expansion will lead to an increased number of faculty and entry-level nurses by funding 32 new workforce expansion grants.

Limited clinical nursing faculty is one of the most significant barriers impeding expansion of the nursing workforce. According to the American Association of Colleges of Nursing, in 2020, 80,521 qualified applications were not accepted at schools of nursing due primarily to a shortage of clinical sites, faculty, and resource constraints. The number of students enrolled in schools of nursing is highly dependent on the number of faculty available to teach them. Faculty shortages at nursing schools across the country are limiting student capacity at a time when the need for professional registered nurses continues to grow.

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

Funding History

Fiscal Year	Amount
FY 2020	$43,913,000
FY 2021	$46,757,000
FY 2022	$54,413,000
FY 2023	$59,413,000
FY 2024 President's Budget	$91,873,000

Program Accomplishments

In Academic Year (AY) 2021-2022, NEPQR Programs trained 7,560 nurses and nursing students, including 1,520 nurses and nursing students trained to provide care in medically underserved areas through NEPQR Programs. In addition, 4,230 trainees and professionals participated in interprofessional care teams through NEPQR Programs. This includes training in key areas 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;
- Increase the training of the current and future nursing workforce and strengthen their ability to provide integrated behavioral health care; and
- Strengthen nurses' capacity to address the complex health care needs of those living in rural and medically underserved areas through the use of simulation-based technology.

NEPQR's output measures reflected below were new in FY 2023, so FY 2021 is the second-year data has been reported for this measure; therefore, FY 2021 results must be weighted heavily when setting new targets until a clear trend has been established. The FY 2023 target has been maintained for FY 2024 for Measure 2160.01 because the increase from the FY 2021 actual to the FY 2023 target aligns with the projected budget increase of approximately 55 percent. The FY 2024 target for Measure 2060.02 was increased to approximately 55 percent more than the FY 2021 actual to reflect the projected budget increase.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 Target +/-FY 2023 Target
2160.01 Number of nurses and nursing students trained to provide care in medically underserved areas through Nurse Education, Practice, Quality, and Retention Programs (Output)	FY 2021: 1,520 Target: Not Defined (Historical Actual)	2,400	2,400	Maintain
2160.02 Number of Nurse Education, Practice, Quality and Retention Programs trainees and professionals contributing to interprofessional care teams at clinical training sites (Output)	FY 2021: 4,230 Target: Not Defined (Historical Actual)	5,500	6,500	+ 1,000

NEPQR Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	66	57	89
Average Award	$610,791	$708,777	$821,757
Range of Awards	$219,201 – $1,000,000	$259,126 - $1,000,000	$350,000 - $1,250,000

NEPQR: SET Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	11	22	22
Average Award	$404,460	$500,000	$500,000
Range of Awards	$480,391 - $500,000	$500,000	$500,000

Nurse Faculty Loan Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$28,500,000	$28,500,000	$28,500,000	---
FTE	4	4	4	---

Authorizing Legislation: Public Health Service Act, Section 846A, as amended by CARES Act, Section 3404, Public Law 116-136.

FY 2024 Authorization $117,135,000

Allocation Method .....Formula Grant

Program Description

The Nurse Faculty Loan Program (NFLP) seeks to increase the number of qualified nursing faculty nationwide by providing low interest loans for individuals studying to be nurse faculty and loan cancelation for those who then go on to work as faculty. A robust, geographically dispersed nurse faculty workforce is essential to producing the nursing workforce needed to meet the nation's health care needs. Successful applicants establish and operate a student loan program, including maintaining a fund, providing loans to students enrolled in advanced education nursing degree programs, and monitoring compliance with program requirements. In exchange for completion of up to four years of post-graduation full-time nurse faculty employment in an accredited school of nursing, graduates receive cancellation of up to 85 percent of the original student loan amount (plus interest thereon) as authorized by the program. The NFLP also encourages Advance Practice Registered Nurses (APRNs) to serve as full-time preceptors within an academic-practice partnership framework in an effort to expand clinical training opportunities for nursing students.

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 a 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. NFLP grantees are expected to continue conducting training activity and maintaining the loan fund account throughout the duration of the project. Currently, the NFLP has a total 208 awardees maintaining the loan fund account. Schools that do not receive a new award may continue making loans from the student loan fund accounts they have already established.

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

Budget Request

The FY 2024 Budget Request of $28.5 million is equal to the FY 2023 Enacted Level for the NFLP. In FY 2024, the NFLP will provide 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. The FY 2024 funding will be used to support 80 new awards to new and continuing NFLP applicants.

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

Funding History

Fiscal Year	Amount
FY 2020	$28,500,000
FY 2021	$28,414,000
FY 2022	$28,500,000
FY 2023	$28,500,000
FY 2024 President's Budget	$28,500,000

Program Accomplishments

In FY 2022, the NFLP supported 80 awards. In FY 2023, HRSA plans to make 80 new awards to new and continuing NFLP applicants.

In Academic Year (AY) 2021-2022, NFLP awardees provided loan repayment to 2,806 nursing students. Twenty-six percent of NFLP students were underrepresented minorities and 24 percent came from disadvantaged backgrounds. By the end of the academic year, 837 nursing students graduated from their degree programs. Seventy-four percent of NFLP graduates earned doctoral degrees and 26 percent received master's degrees. Of the 571 prior year graduates with one-year follow-up data, 65 percent currently teach in full-time faculty appointments.

BHW conducted a five-year outcome evaluation for the NFLP using data from AY 2015-2020.[39] During this time frame, 74 percent of the 3,494 NFLP graduates earned doctoral degrees and 26 percent earned master's degrees. Of the 2,541 NFLP AY 2015-2020 graduates with one-year follow-up data, 80 percent had obtained nurse faculty positions, and 91 percent of these graduates were working full-time as nurse faculty. The number of full-time nurse faculty positions in the United States increased by 3,008 positions between AY 2016-2017 and AY 2020-2021.[40] During that same period, 1,839 NFLP graduates reported full-time nurse faculty employment, potentially filling 61% of the new faculty positions. NFLP nurse faculty graduates decreased the national vacancy rate of full-time nurse faculty from nine percent to seven percent.

[39] Health Resources and Service Administration. (2022). Nurse Faculty Loan Program Outcomes: Academic Years 2015-2020. Retrieved November 22, 2022, from https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/nflp-outcomes-academic-year-2015-2020.pdf

[40] American Association of Colleges of Nursing. (2016-2020). Faculty Vacancy Survey Report. Retrieved from https://www.aacnnursing.org/News-Information/Research-Data-Center/Faculty-Vacancy-Survey-Reports.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2170.01 Number of graduate-level nursing students who received a loan in exchange for a commitment to become nurse faculty (Output)	FY 2021: 2,806 Target: 1,900 (Target Exceeded)	2,500	2,500	Maintain
2170.02 Number of graduates from advanced nursing degree programs who received a loan in exchange for a commitment to become nurse faculty (Outcome)	FY 2021: 837 Target: 400 (Target Exceeded)	700	700	Maintain

Performance Narrative

Most recent results are for activities in Academic Year (AY) 2021-2022 funded in FY 2021.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	80	80	80
Average Award	$332,250	$332,250	$332,250
Range of Awards	$49,992 - $2,637,994	$49,992 - $2,637,994	$49,992 - $2,637,994

Nurse Corps

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$88,635,000	$92,635,000	$92,635,000	---
FTE	35	39	39	---

Authorizing Legislation: Public Health Service Act, Section 846 as amended CARES Act, Section 3404, Public Law 116-136.

FY 2024 Authorization $117,135,000

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

Program Description

The Nurse Corps Program 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 behavioral health services through set-asides in scholarships and loan repayment assistance for Nurse Practitioners (NPs) specializing in psychiatric mental health; and (3) access to women's and maternal health services through set-asides in scholarships and loan repayment assistance to scholars pursuing degrees and clinicians serving in this specialty area.

In exchange for scholarship support or educational loan repayment, Nurse Corps members fulfill their service obligation by working in Critical Shortage Facilities (CSFs) located in Health Professional Shortage Areas (HPSAs) and underserved communities throughout the nation, which include rural communities and other identified geographic areas, populations, or facilities that lack access to primary care, dental health, or behavioral health services. As of September 30, 2022, over three-quarters of the Nurse Corps providers were serving in community-based settings and 21 percent were serving in rural communities.

Nurse Corps Loan Repayment Program (LRP): The Nurse Corps LRP assists in the recruitment and retention of professional RNs, including advanced practice registered nurses (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. For an optional third year of service (via a Continuation Contract), the Nurse Corps LRP will award participants an additional 25 percent of their original total qualifying educational loan balance as of the effective date of their initial two-year contract.

Nurse Corps Scholarship Program (SP): The Nurse Corps SP provides 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. 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.

Eligible Entities

Nurse Corps LRP: Participants must have a current license to practice as an RN and be employed full-time at a public or private CSF (at least 32 hours per week) or at an accredited public or private school of nursing (full-time as defined by employer for at least nine months per service year).

Nurse Corps SP: Participants must be enrolled or accepted for enrollment in an accredited diploma, associate, or collegiate (bachelors, master's, doctoral) school of nursing program.

Budget Request

The FY 2024 Budget Request of $92.6 million is equal to the FY 2023 Enacted Level. This request will fund an estimated 264 scholarship (new and continuation), and 1,207 loan repayment (new and continuation) awards. 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.

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

Funding History

Fiscal Year	Amount	Supplemental Amount
FY 2020	$88,635,000	---
FY 2021	$88,116,000	$200,000,000
FY 2022	$88,635,000	---
FY 2023	$92,635,000	---
FY 2024 President's Budget	$92,635,000	---

Program Accomplishments

The Nurse Corps performance measures gauge the program's 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 2022, 51 percent of Nurse Corps LRP participants extended their service commitment for an additional year; and in FY 2022, 90 percent of Nurse Corps participants were retained in service at a CSF for up to two years beyond the completion of their Nurse Corps service commitment. In addition, in FY 2022, 88 percent of Nurse Corps SP awardees pursued their baccalaureate degree or advanced practice degree.

In FY 2021, the American Rescue Plan (ARP) Act provided the Nurse Corps Program with $200 million in additional funding to support the nation's COVID-19 emergency response. In FY 2022, these funds allowed HRSA to bolster the nursing workforce with a total of 1,839 awards to nurses serving in CSFs, 232 awards to nurse faculty at accredited schools of nursing, and 567 awards to scholars pursuing a nursing education. In addition, Nurse Corps funded 48 Career Pathway scholarship awards to entry-level health professionals obtaining qualifying degrees to become RNs.

HRSA will continue to support Career Pathway awards in FY 2023 and FY 2024, which is a set aside to create a pathway for entry-level health professionals seeking degrees to obtain a registered nursing degree. This set-aside promotes the Nurse Corps SP's effort at improving care by to extending the pipeline of nurses to address workforce shortages. In FY 2023, with remaining ARP Act funds, the Nurse Corps Program anticipates making 1,081 total awards to clinicians serving in facilities with a shortage of nurses and nurse faculty, and 313 awards to scholars pursuing a nursing education. Approximately $845,000 of ARP Act funds support nurse faculty members who are training the next generation of nurses, including priority areas of behavioral health, women's health, and community health. The additional awards made with ARP Act funds will increase the number of continuation awards anticipated to be made in FY 2023 and FY 2024.

Furthermore, as the Administration seeks to continue to address the opioid epidemic and other substance use disorders across the nation, the Nurse Corps Program supports the behavioral health nursing workforce. In FY 2023 and FY 2024, 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 HRSA funding to address the opioid crisis and the recent impacts COVID-19 has had on the nation's mental health.

Additionally, in support of the White House's Blueprint for Addressing the Maternal Health Crisis, the Nurse Corps Program will continue to support increasing the skilled workforce of women's health nurses who are trained to provide care for women, and practice in rural and underserved communities. In FY 2023 and FY 2024, HRSA plans to continue funding for women's and maternal health services up to $5 million each for scholarship and loan repayment awards for the funding of women's health NPs, certified nurse midwifery, and certified obstetrics and gynecology RNs.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2180.01: Proportion of Nurse Corps Loan Repayment Program participants who extend their service contracts to commit to work at a critical shortage facility for an additional year. (Outcome)	FY 2022: 45% Target: 52% (Target Not Met)	52%	52%	Maintain
2180.02: Proportion of Nurse Corps Loan Repayment Program/Scholarship Program participants retained in service at a critical shortage facility for at least one year beyond the completion of their Nurse Corps Loan Repayment Program/Scholarship Program commitment. (Outcome)	FY 2022: 92% Target: 80% (Target Exceeded)	80%	80%	Maintain
2180.03: Proportion of Nurse Corps SP awardees obtaining their baccalaureate degree or advanced practice degree in nursing. (Outcome)	FY 2022: 83% Target: 85% (Target Not Met)	85%	85%	Maintain
2180.04: Default rate of Nurse Corps LRP and SP participants. (Efficiency)	FY 2021: LRP: 1.2% SP: 4.8% Target: LRP: 3% SP: 15% (Target Exceeded)	Discontinued	Discontinued	N/A

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2180.05: Default rate of Nurse Corps Loan Repayment Program participants (Efficiency)	FY 2021: 1.2% Target: 3% (Target Exceeded)	3%	3%	Maintain
2180.06: Default rate of Nurse Corps Scholarship Program participants (Efficiency)	FY 2021: 4.8% Target: 15% (Target Exceeded)	15%	15%	Maintain

Performance Narrative
Measure 2180.05, default rate of Nurse Corps Loan Repayment Program participants, and measure 2180.06, default rate of Nurse Corps Scholarship Program participants replace measure 2180.04, default rate of Nurse Corps LRP and SP participants. This allows HRSA to report the results from the two programs separately.

Nurse Corps Loans/Scholarships Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Loans	$59,090,000	$61,756,667	$61,756,667
Scholarships	$29,545,000	$30,878,333	$30,878,333

Nurse Corps Awards Table

Fiscal Year	2017	2018	2019	2020	2021[41]	2022[42]	2023	2024
Scholarships								
New Awards	198	215	220	244	529	567	286	234
Continuation Awards	14	4	6	13	15	25	27	30
Loan Repayment								
New Awards	501	544	561	465	1,246	2,071	365	17
Continuation Awards	340	279	292	291	341	208	716[43]	1,190
Total	**1,053**	**1,042**	**1,079**	**1,013**	**2,131**	**2,871**	**1,394**	**1,471**

Nurse Corps Field Strength Table

Fiscal Year	2017	2018	2019	2020	2021[44]	2022[45]	2023[46]	2024
Scholarship	496	465	450	415	400	412	770	1,047
Loan Repayment	1,093	1,129	1,279	1,293	1,907	3,171	2,811	1,410
Loan Repayment Nurse Faculty	346	271	199	135	214	349	341	161
Total	**1,935**	**1,865**	**1,928**	**1,843**	**2,521**	**3,932**	**3,922**	**2,618**

[41] FYs 2021, 2022 and 2023 awards and field strength are updated to include ARPA funding.
[42] *Ibid.*
[43] *Ibid.*
[44] *Ibid.*
[45] *Ibid.*
[46] *Ibid.*

Children's Hospitals Graduate Medical Education Payment Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$375,000,000	$385,000,000	$385,000,000	---
FTE	16	16	16	---

Authorizing Legislation: Public Health Service Act, Section 340E as amended by Dr. Benjy Frances Brooks Children's Hospital GME Support Reauthorization Act of 2018, Section 2, Public Law 115-241.

FY 2024 Authorization... Expired: Direct GME: $105,000,000; Indirect Medical Education: $220,000,000

Allocation Method .....Formula-Based Payment

Program Description

The Children's Hospitals Graduate Medical Education (CHGME) Payment Program was first established in 1999 and supports graduate medical education in freestanding children's teaching hospitals. The 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. Assessment conducted annually to verify the number of FTE resident counts reported by eligible awardees.

Eligible Entities: Freestanding children's teaching hospitals.

Budget Request

The FY 2024 Budget Request of $385 million is equal to the FY 2023 Enacted Level. This request will fund 59 awards to current eligible children's hospitals. The Budget Request will enable HRSA to continue to support approximately 8,000 physician FTEs for direct and indirect medical expenses for graduate medical education and implementing the Quality Bonus System (QBS). 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 2024 Budget 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, review of application data, and analysis of QBS data needed to determine payments.

Funding History

Fiscal Year	Amount
FY 2020	$340,000,000
FY 2021	$349,297,000
FY 2022	$375,000,000
FY 2023	$385,000,000
FY 2024 President's Budget	$385,000,000

Program Accomplishments

In FY 2022, the CHGME Payment Program awarded more than $356 million to 59 eligible awardees including a QBS payment for those who meet the QBS eligibility criteria. The QBS, allows the Secretary of HHS to distribute bonus payments to participating CHGME hospitals. In order to qualify for the QBS payment, awardees were required to complete individual-level documentation for all residents supported by the CHGME Payment Program in the FY 2022 Annual Performance Report (AY 2021-2022). In FY 2023, the CHGME Payment Program plans to award to the current eligible awardees and will continue to implement the QBS.

During Academic Year (AY) 2021-2022, the most recent year for which performance data is available, 59 children's hospitals received CHGME funding. Ninety percent of CHGME hospitals had FTE residents counts and caps. Furthermore, 100 percent of CHGME payments were made on time. The CHGME hospitals trained 8,224 resident FTEs:[47] 41 percent were pediatric residents, 30 percent were pediatric subspecialty residents, and 30 percent were residents training in other primary disciplines, such as family medicine.

CHGME-funded hospitals served as sponsoring institutions for 43 residency programs and 265 fellowship programs, and they served as major participating rotation sites for 659 other residency and fellowship programs. The CHGME program supported the training of 6,124 pediatric residents, which included general pediatrics residents and residents from eight types of combined pediatrics programs (e.g., internal medicine/ pediatrics). CHGME also supported the training of 3,201 pediatric medical subspecialty residents, 317 pediatric surgical subspecialty residents, and 516 adult and pediatric dentistry residents. In addition, CHGME funding was responsible for the training of 5,357 adult medical and surgical specialty residents, such as family medicine

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

residents, who rotate through children's hospitals for pediatrics training. In total, the CHGME program funded 15,515 residents and fellows during AY 2021-2022; 4,880 residents and fellows completed their programs. Over the course of the academic year, CHGME residents provided care through nearly 1.5 million patient encounters in primary care settings and over 5.1 million patient contact hours in medically underserved communities.
Of the full-time residents and fellows who completed their training during AY 2021-2022, 60 percent of these CHGME-funded physicians chose to remain and practice in the state where they completed their residency training. Among the 336 health care delivery sites utilized for residency training, 45 percent provided telehealth services, 40 percent integrated behavioral health into primary care settings, and 24 percent offered substance use treatment services. Residents received training on topics such as opioid use treatment (23 percent), telehealth (23 percent), integrating behavioral health into primary care settings (22 percent), and health equity (22 percent).

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2190.01 Number of full-time equivalent medical and dental residents training in eligible children's teaching hospitals (Output)	FY 2021: 8,224 Target: 7,140 (Target Exceeded)	7,700	8,000	+ 300
2190.02 Percentage of hospitals with full-time equivalent residents counts and caps (Output)	FY 2021: 90% Target: 90% (Target Met)	90%	90%	Maintain
2190.03 Percentage of payments made on time. (Efficiency)	FY 2021: 100% Target: 100% (Target Met)	100%	100%	Maintain

Performance Narrative
Most recent results are for activities in Academic Year (AY) 2021-2022 funded in FY 2021.

Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	59	59	59
Average Award	$5,999,698	$6,139,588	$6,139,588
Range of Awards	$29,298 - $25,255,074	$33,537 - $24,093,733	$33,537 - $24,093,733

Teaching Health Center Graduate Medical Education Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Mandatory	$119,290,000	$119,290,000	---	-$119,290,000
Mandatory Proposed	---	---	$157,000,000	+$157,000,000
TOTAL	**$119,290,000**	**$119,290,000**	**$157,000,000**	**+$37,711,000**
FTE	11	16	16	---

Authorizing Legislation: Public Health Service Act, Section 340H, as amended by Consolidated Appropriations Act, 2021, Title III, Subtitle A, Section 301, Public Law 116-260.

FY 2024 Authorization ....Expires end of FY 2023

Allocation Method .....Formula-Based Payment

Program Description:

The Teaching Health Center Graduate Medical Education (THCGME) Program, established in 2010, increases the number of primary care physician and dental residents trained in community-based settings where most people receive their health care. Unlike most federal funding for graduate medical education (GME) which goes to hospitals, THCGME payments are made to community-based ambulatory care sites that provide primary care training.

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 also used to foster innovation and support curriculum enhancements aimed at improving the quality of patient care, such as the Patient-Centered Medical Home model, Electronic Health Record utilization, population health, telemedicine, and health care leadership. These activities ensure residents receive high quality training and are well-prepared to practice in community-based outpatient care settings after graduation.

There are many benefits to training physicians and dental residents in community-based settings. 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.[48] Evidence demonstrates that physicians who trained in cost-efficient geographic areas

[48] 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.

continue to provide lower-cost care in their post-residency practice.[49] In addition, THCs specifically have been shown to attract residents from rural and/or disadvantaged backgrounds.[50]

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

Budget Request

The FY 2024 Budget Request of $157 million is $37.7 million above the FY 2023 Enacted Level. This request will fund up to 1,469 resident full-time equivalents (FTEs) slots in Academic Year (AY) July 1, 2024- June 30, 2025 to coincide with national residency training dates. At the start of FY 2024 the number of resident FTEs supported through this program will be 1,105. This allows the program to grow to 1,469 FTEs by the beginning of FY 2025. This cohort of resident FTEs will be comprised of current THCGME-supported resident FTEs and new FTEs as a result of the Teaching Health Center Planning and Development (THCPD) Program. As the THCPD supported residency programs achieve accreditation, they are able to support new FTE residents through THCGME Program funds.

The Budget also proposes to extend mandatory funding through FY 2026 for a total investment of $841.0 million over three years. This request would provide resources to support a total of 2,094 resident FTEs in existing, expanded, and new THCGME residency programs at current per-resident payment levels. Continued mandatory THCGME base funding will provide THCs with the confidence to launch full recruitment efforts to fill and expand their available resident slots. The Budget also proposes to remove the cap on total THCGME payments to enable the re-obligation of unobligated balances and funds recouped through statutorily required annual reconciliation process.

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

Activity	FY 2024	FY 2025	FY 2026	Total Funding
Proposed Mandatory Funding	$157 million	$320 million	$364 million	$ 841 million
FTEs	1,469	1,842	2,094	

[49] Chen C, Ku L, Regenstein M, Mullan F. Policy Issue Brief 58: Examining the Cost Effectiveness of Teaching Health Centers. March 2019. https://www.rchnfoundation.org/wp-content/uploads/2019/03/GG-IB-58-THC_3.18_Final.pdf.

[50] 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.

Funding History

Fiscal Year	Amount	Supplemental Amount
FY 2020	$126,500,000	---
FY 2021	$126,500,000	$330,000,000
FY 2022 Final	$119,290,000[51]	---
FY 2023 Enacted	$119,290,000[52]	---
FY 2024 President's Budget	$157,000,000	---

Program Accomplishments

In FY 2022, HRSA funded 46 planning and development awards with resources from the ARP Act under the Teaching Health Center Planning and Development Program (PHS Act Sec. 749A) to support the start-up of new community-based primary care residency programs. In FY 2023, HRSA plans to fund an additional 45 grants to support the start-up of new primary care, community-based residency programs beginning in April 2023 using remaining ARP Act resources.

In AY 2021-2022, the most recent year for which performance data is available, HRSA provided awards to 59 THCs that supported 792 resident FTE slots. These resident FTE slots provided funding to 932 individual primary care medical and dental residents, as an FTE slot may provide partial funding to more than one person. By the end of the academic year, 296 physicians and dentists completed their THCGME residency programs.

During their training, THCGME residents provided more than 1.1 million hours of patient care to more than 800,000 patients in medically underserved and/or rural communities. Most THCGME residents also received training on opioid use disorder treatment, telehealth, and integrating behavioral health into primary care.

Of the 251 graduates who completed their THCGME residencies in AY 2021-2022 and reported employment data, 58 percent were already working in primary care settings, and 45 percent were already working in medically underserved and/or rural communities, including Federally Qualified Health Centers or Look-alikes, Critical Access Hospitals, Rural Health Clinics, and Indian Health Service/Tribal/Urban Indian Health Centers. The number of residents 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.

The THCGME Program exceeded the target for Measure 2200.02 by 16 percentage points due to additional emphasis on training in rural and/or medically underserved areas. Measure 2200.01 captures the number of FTE resident slots awarded and not the maximum possible nor the number of individuals receiving direct financial support through the program.

[51] FY 2022 reflects the post-sequestration amount.
[52] FY 2023 reflects the post-sequestration amount.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target[53]	FY 2024 Target +/-FY 2023 Target
2200.01 Number of primary care medical and dental resident positions supported by Teaching Health Centers (Cumulative) (Outcome)	FY 2021: 792 Target: 740 (Target Exceeded)	740	1,105	+ 365
2200.02 Percentage of Teaching Health Centers Graduate Medical Education-supported medical and dental residents training in rural and/or medically underserved communities (Outcome)	FY 2021: 96% Target: 80% (Target Exceeded)	80%	85%	+ 5 percentage points

THCGME Program Outputs	Year and Most Recent Result
Number of primary care residents funded by THCGME residencies	FY 2021: 932
Number of primary care residents completing training	FY 2021: 296
Percent of residents who are from a disadvantaged and/or rural background	FY 2021: 32%
Percent of primary care resident program completers who intend to practice in primary care settings	FY 2021: 62%

Grants Awards Table:

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	72	83	83
Average Award	$2,172,203	$2,152,956	$2,280,000
Range of Awards	$320,000 - $8,720,000	$160,000 - $10,240,000	$320,000 - $10,560,000

[53] Reflects the number of resident FTEs supported at the start of the fiscal year.

National Practitioner Data Bank

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$18,814,00	$18,814,00	$18,814,00	---
FTE	48	48	48	---

Authorizing Legislation: Title IV of the Health Care Quality Improvement Act of 1986, Public Law 99-660 as amended by Patient Protection and Affordable Care Act, Section 6403, Public Law 111-148.

FY 2024 Authorization ..... Indefinite

Allocation Method ..... User Fee Program

Program Description

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 1.7 million reports since its inception in 1990, 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 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.

Budget Request

The FY 2024 Request for the National Practitioner Data Bank of $18.8 million in user fees is equal to the FY 2023 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 appropriations 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.

Funding History

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

Fiscal Year	Amount
FY 2020	$11,256,402[54]
FY 2021	$18,814,000
FY 2022	$18,814,000
FY 2023	$18,814,000
FY 2024 President's Budget	$18,814,000

Program Accomplishments:

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

- In FY 2022, the NPDB responded to more than 11.5 million queries, an increase of more than 1.0 million queries over FY 2021, from authorized health care entities, practitioners, providers, and suppliers.
- The HRSA Division of Practitioner Data Bank (DPDB) continues to operate its 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.
- The NPDB has improved services to health care practitioners by enabling digitally certified self-query responses, providing a paperless process with faster response times and assurances that the responses are unaltered. Fifty-three percent of self-queriers in FY 2022 opted for paperless responses.
- Practitioners can now view all of their reports through a single account.
- Sustained efforts to enhance user self-service has resulted in the NPDB's transaction to case ratio increasing by 27 percent, from 172 transactions per case in FY 2019 to 218 transactions per case in FY 2022.
- In an FY 2021 survey, the NPDB had a satisfaction rate of over 90 percent among entity users, and over 94 percent agreed that the information from the NPDB makes their organization confident about the decisions they make concerning practitioners.

[54] The decline in revenue collected in FY 2020 was due to the NPDB temporarily waiving query fees between March 1, 2020, and September 30, 2020 in response to the COVID-19 pandemic.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2210.01: Increase the number of practitioners enrolled by health care entities in the National Practitioner Data Bank's Continuous Query subscription service	FY 2021: 5,045,897 Target: 4,200,000 (Target Exceeded)	6,000,000	6,900,000	+ 900,000
2210.02: Increase annually the number of disclosures of National Practitioner Data Bank reports to health care organizations	FY 2021: 2,002,218 Target: 2,020,000 (Target Not Met)	2,130,000	2,150,000	+20,000

Supporting the Mental Health of the Health Professions Workforce

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	---	---	$25,000,000	+$25,000,000
FTE	---	---	2	---

Authorizing Legislation: Public Health Service Act, Section 764, as amended by P.L. 117-105

FY 2024 Authorization $35,000,000

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

Program Description

The Supporting the Mental Health of the Health Professions Workforce program will provide funding to support the implementation of evidence-informed strategies to help the health care workforce respond to workplace stressors, better endure hardships, reduce burnout, and foster healthy workplace environments that promote mental health and resilience.

Health and Public Safety Workforce Resiliency Training Program (HPSWRTP): This program supports the planning, developing, operating, or participation of health professions and nursing training activities, using evidence-based or evidence-informed strategies, to reduce and address burnout, suicide, mental health conditions, and substance use disorders and to promote resiliency among public safety officers and health care professionals, health care students, residents, trainees, and paraprofessionals in rural and medically underserved communities. Award recipients use grants funds to: (1) provide short-term training to promote resiliency; (2) create and advance training interventions, protocols, and system-wide approaches to reduce and address burnout, suicide, mental health conditions, and substance use disorders; and (3) develop innovative sustainability practices/models to promote provider resiliency and prevent or reduce health care professional burnout.

Promoting Resilience and Mental Health Among Health Professional Workforce (PRMHW): This program supports entities providing health care, health care providers associations, and Federally Qualified Health Centers (FQHCs), taking into consideration the needs of rural and medically underserved communities, to establish, enhance, or expand evidence-informed or evidenced-based programs or protocols to promote resilience, mental health, and wellness among their providers, other personnel, and members. The goal of the PRMHW Program is to help health care organizations adopt, promote, implement, and demonstrate an organizational culture of wellness that includes resilience and mental health for their health professional workforce.

Supporting the Mental Health of the Health Professions Workforce: The program authorized under Section. 764A of the Public Health Service (PHS) Act, and will support health care providers, including medical professional associations, to establish or expand evidence-informed

programs dedicated to promoting mental and behavioral health among their employees or members who are working on the front lines of the COVID-19 pandemic. The goal of the Promote Mental Health Among the Health Professions Workforce Program is to implement new programs or protocols or to expand existing programs or protocols to promote mental and behavioral health among health professional employees or members who are currently providing or who have provided services to patients diagnosed with COVID-19.

In FY 2024, HRSA is planning a new $25 million competition to support health care entities that provide health care services, such as hospitals, community health centers, and rural health clinics, or to medical professional associations, to transform organizational cultures that promote wellness, resilience, and mental health of the health care professional workforce using established or enhanced evidence-based or evidence-informed programs. HRSA anticipates making 23 awards with a period of performance of three years.

Eligible Entities: Health care entities, including entities that provide health care services, such as hospitals, community health centers, and rural health clinics, or to medical professional associations.

Budget Request

The FY 2024 Budget Request of $25 million is $25 million above the FY 2023 Enacted Level. This request will fund 23 awards to support health care organizations to adopt, promote, implement, and demonstrate an organizational culture of wellness and mental health for their health professional wellness.

Promoting the mental health and well-being of our nation’s frontline health workers is a priority for the Administration and supports HRSA’s goal to foster a health workforce and health infrastructure able to address current and emerging needs. COVID-19 has compounded rates of depression and anxiety among health care workers. The relentless physical and emotional demands of treating patients during a pandemic have exacerbated longstanding barriers to workplace well-being.

The program will support health care entities, including entities that provide health care services, such as hospitals, community health centers, and rural health clinics, or to medical professional associations, to establish or enhance evidence-based or evidence informed programs dedicated to improving mental health for health care professionals. Funds may be used to disseminate best practices and conduct a review on improving health care professional mental health and the outcomes of programs authorized under the Dr. Lorna Breen Health Care Provider Protection Act, P.L 117-105.

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

Funding History

Fiscal Year	Amount
FY 2020	---
FY 2021	---
FY 2022	---
FY 2023	---
FY 2024 President's Budget	$25,000,000

Program Accomplishments: In Academic Year (AY) 2021-2022, the first year of the HPSWRTP and PRMHW Programs and the most recent year for which performance data is available, 52,727 health professionals, health support staff, public safety officers, medical residents, and students participated in burnout prevention and provider resiliency programs through the HPSWRTP and PRMHW Programs.

Health and Public Safety Workforce Resiliency Training Program:
In Academic Year (AY) 2021-2022, the first year of HPSWRTP and the most recent year for which performance data is available, the HPSWRTP trained 14,782 health and public safety employees and students. Twenty-six percent of health and public safety employees and students completed their resiliency program during the academic year, while 74 percent participated in resiliency programs that continued into AY 2022-2023. As the HPSWRTP began in January 2022, awardees only had six months' worth of activities to report, but during that short time frame they still developed 72 new resiliency programs and enhanced 39 existing resiliency programs, which covered topics such as provider wellness/wellbeing (66 percent) and suicide, depression, anxiety, and substance use (eight percent). Awardees offered 87 unique resiliency-focused continuing education courses to health professionals, health support staff, and public safety officers. These courses were tailored to reach different levels of staff and management: front line workers and program staff (75 percent), program managers and mid-level supervisors (18 percent), and senior managers/executive leadership (seven percent). Seventy-four percent of the continuing education courses were online, but courses with in-person components were held at locations convenient to the health and public safety workforce, such as hospitals, emergency rooms, and specialty clinics (47 percent); academic institutions (32 percent); Federally Qualified Health Centers, Look-alikes, or Certified Community Behavioral Health Centers (seven percent); public safety facilities (e.g., fire departments) (five percent); and community-based organizations (five percent).

Promoting Resilience and Mental Health Among Health Professional Workforce:
In Academic Year 2021-2022, the first year of the PRMHW program and the most recent year for which performance data is available, the PRMHW program trained 37,945 health care providers and staff through employee resiliency programs that will continue throughout the three-year grant period. Participating employees included 6,850 nurses, 3,091 physicians, 875 behavioral health providers, 591 physician assistants, 7,064 other medical staff, and 19,474 non-medical staff. As the PRMHW program began in January 2022, awardees only had six months'

worth of program activities and retention data to report, but even during that short time frame, participation in a PRMHW employee resiliency program was associated with increased retention, particularly among behavioral health providers and nurses. Overall, 93 percent of PRMHW-enrolled employees remained in their organization at the end of the academic year. For behavioral health providers, 89 percent of enrollees in PRMHW employee resiliency programs remained at their organization at the end of the academic year, compared to 85 percent of non-participating behavioral health providers. Likewise, 95 percent of nurses enrolled in PRMHW employee resiliency programs remained at their organization at the end of the academic year, compared to 90 percent of non-participating nurses. Eighty-nine percent of PRMHW employee resiliency programs occurred at hospitals; 68 percent of the programs were at health care delivery sites located in medically underserved communities.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2220.01 Number of health professionals, health support staff, public safety officers, medical residents, and students who participated in burnout prevention and provider resiliency programs (Output)	FY 2021: 52,727 Target: N/A (Baseline)	Target Not Defined	25,000	N/A
2220.02 Percent of health professionals, health support staff, and medical residents who participated in provider resiliency programs and remained in a health professions field at the end of the academic year (Outcome)	FY 2021: 93% Target: N/A (Baseline)	Target Not Defined	75%	N/A

Performance Narrative

Most recent results are for activities in Academic Year (AY) 2021-2022 funded in FY 2021.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	---	---	23
Average Award	---	---	$1,000,000
Range of Awards	---	---	$1,000,000

Pediatric Subspecialty Loan Repayment Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$5,000,000	$10,000,000	$10,000,000	---
FTE	---	1	1	---

Authorizing Legislation: Public Health Service Act, Section 775(e) as amended by CARES Act, Section 3401, Public Law 116-136.

FY 2024 Authorization (discretionary): Authorized for FY 2024 (and each subsequent year), based on previous year's funding, subject to adjustment formula

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

Program Description

The Pediatric Subspecialty Loan Repayment Program (LRP) allows HRSA to provide loan repayment to pay off educational loans for individuals working in an area with a shortage of specified pediatric subspecialties, and/or physicians participating in pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental health subspecialty that involves work in a Health Professional Shortage Area (HPSA) or medically underserved area (MUA), or to serve a medically underserved population (MUP).

Eligible Entities

Pediatric Specialist, Child and Adolescent Mental and Behavioral Health Professions.

Budget Request

The FY 2024 Budget Request of $10 million is equal to the FY 2023 Enacted Level. This request will support 100 new awards to bolster the pediatric health care workforce by providing loan repayment to pediatric medical specialists, pediatric surgical specialists, and child and adolescent mental and behavioral health care. The Pediatric Subspecialty LRP will expand the eligible pool of pediatric subspecialties and add to the list of eligible facilities to serve the population located in either a health professional shortage area or medically underserved areas.

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

Funding History

Fiscal Year	Amount
FY 2020	---
FY 2021	---
FY 2022	$5,000,000
FY 2023	$10,000,000
FY 2024 President's Budget	$10,000,000

Program Accomplishments

In FY 2023, HRSA will launch the Pediatric Subspecialty LRP, to support the pediatric health care workforce and will fund approximately 100 new awards in FY 2023. In FY 2022, HRSA developed an Application and Program Guidance (APG).

Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	---	100	100
Award Amount	---	$100,000	$100,000
Range of Awards	---	$100,000	$100,000

Health Care Workforce Innovation

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	---	---	$27,540,000	+$27,540,000
FTE	---	---	3	---

Authorizing Legislation: Public Health Service Act, Sections: 741, 807

Allocation Method .....Competitive Grant

Program Description

The Health Care Workforce Innovation Program will help grow the health care workforce by funding new, leading edge health profession education and training models that will expand the supply of health care professionals in underserved and rural areas.

New approaches funded through this competitive initiative will aim to combat systemic barriers to educational opportunity, while also advancing innovative solutions to increase matriculation in and graduation from health professionals training programs, as well as the number of individuals who chose to provide clinical care upon graduation. Training should better align with the type of health care that Americans hope to receive – high quality, comprehensive, convenient, and compassionate. Examples of innovative models may include approaches such as:

- Developing new health professions admission models to better reflect and meet community health needs;
- Revamping health professions pre-admission readiness programs to better serve students from rural, underserved, or disadvantaged backgrounds;
- Building training and employment models that better integrate clinical practitioners into faculty development programs;
- Building a training-to-practice model for behavioral health professionals; and
- Expanding career pathways by creating career ladders for paraprofessionals.

Innovative, community-driven approaches to health professions education are needed today more than ever. The National Center for Health Workforce Analysis has identified current projected shortages through 2035 in a wide range of health care occupations. The Surgeon General has identified health worker burnout as a majority concern that will require multi-faceted solutions, including how workers are prepared and trained to practice. Many training curricula and models for training health professionals, particularly in medicine, remain unchanged from decades ago; they do not fully leverage the technology available today.

Budget Request

The FY 2024 Budget Request of $27.5 million is $27.5 above the FY 2023 Enacted Level. This request will support 13 new awards. The Health Care Workforce Innovation Program seeks to

seed innovative approaches and jumpstart new strategies to grow the health care workforce at a time of significant concern about workforce shortages across physicians, nursing, behavioral health. Confronting the breadth and urgency of current workforce challenges – and delivering on the promise of the Administration's significant policy steps in support of behavioral health, health care coverage, and care in home and community settings – will require innovative new approaches to accelerate the transformation of health care workforce training into a more modern, robust, and diverse workforce pipeline.

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

Funding History

Fiscal Year	Amount
FY 2020	---
FY 2021	---
FY 2022	---
FY 2023	---
FY 2024 President's Budget	$27,540,000

Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	---	---	13
Average Award	---	---	$2,000,000
Range of Awards	---	---	$2,000,000

Health Workforce Cross-Cutting Performance Measures

The Bureau of Health Workforce (BHW) tracked six cross-cutting measures for nearly 40 programs that reported performance data during Academic Year (AY) 2021-2022, the most recent year performance data is available. This includes two new measures that assess how BHW is expanding access to quality health services in community settings and underserved areas (Measures 2000.05 and 2000.06). [55]

Looking across the BHW's programs that collect individual-level data, 50 percent of graduates and program completers were underrepresented minorities and/or from disadvantaged backgrounds, which exceeded the FY 2021 target of 46 percent for Measure 2000.01. Fifty-one percent of students and health care professionals in BHW programs trained in underserved communities, which did not meet the FY 2021 target of 55 percent for Measure 2000.02. BHW did not meet the target because at different times during the COVID-19 pandemic, programs conducted training virtually rather than in underserved communities. When looking at graduates and alumni of BHW programs, 59 percent were employed in underserved areas at program completion, which set an FY 2021 baseline for Measure 2000.06. BHW met the FY 2021 target for Measure 2000.03: the percentage of individuals supported by BHW who completed a primary care training program and are currently employed in underserved areas (40 percent). This calculation is based on service location data for students who graduated from or completed their BHW program in AY 2020-2021 and reported follow-up employment data one year later in AY 2021-2022.

Two of BHW's cross-cutting measures focus on the health care delivery sites where BHW awardees provide training (Measures 2000.04 and 2000.05). Seventy-seven percent of BHW clinical training sites provided interprofessional training, which exceeded the FY 2021 target of 50 percent for Measure 2000.04. BHW exceeded the target because the Bureau has been focusing on increasing the amount of interprofessional training in its programs. In addition, 25 percent of clinical training sites were in community-based settings, which set an FY 2021 baseline for Measure 2000.05. Health care delivery sites in community-based settings (e.g., Federally Qualified Health Centers (FQHCs), Rural Health Clinics) are vital sources of primary care in underserved areas.

[55] BHW health professions training and loan programs have varying types of data reporting requirements based on the program's authorizing legislation. Using only those programs that are required to report individual-level data in the calculation ensures a higher level of accuracy and data quality, as well as consistency in the types of programs that are included in the calculation. 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.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
2000.01 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. (Outcome)	FY 2021: 50% Target: 46% (Target Exceeded)	47%	48%	+1 percentage point
2000.02 Percentage of trainees in Bureau of Health Workforce-supported health professions training programs who receive training in medically underserved communities. (Outcome)	FY 2021: 51% Target: 55% (Target Not Met)	52%	52%	Maintain
2000.03 Percentage of individuals supported by the Bureau of Health Workforce who completed a primary care training program and are currently employed in underserved areas	FY 2021: 40% Target: 40% (Target Met)	40%	40%	Maintain
2000.04 Percentage of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program. (Outcome)	FY 2021: 77% Target: 50% (Target Exceeded)	65%	68%	+ 3 percentage points
2000.05 Percentage of clinical training sites utilized in health workforce training programs that are located in community-based settings. (Outcome)	FY 2021: 25% Target: Not Defined (Baseline)	Target Not Defined	25%	N/A
2000.06 Percentage of graduates and alumni of Bureau of Health Workforce programs employed in underserved areas at graduation. (Outcome)	FY 2021: 59% Target: Not Defined (Baseline)	Target Not Defined	59%	N/A

Maternal and Child Health

TAB

MATERNAL AND CHILD HEALTH

Maternal and Child Health Block Grant

Activity	FY 2022 Final[56]	FY 2023 Enacted[57]	FY 2024 President's Budget[58]	FY 2024 +/- FY 2023
BA	$733,003,000	$815,700,000	$937,300,000	+$121,600,000
FTE	59	66	71	+5

Authorizing Legislation: Social Security Act, Title V, as amended by Public Law 106-554, Section 921

FY 2024 Authorization $850,000,000

Allocation Methods:

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

Program Description

The Maternal and Child Health (MCH) Block Grant program, authorized under Title V of the Social Security Act, seeks to improve the health of mothers, children, and their families. The activities authorized as part of the MCH Block Grant program include the State MCH Block Grant program, Special Projects of Regional and National Significance (SPRANS), and Community Integrated Service Systems (CISS) grants.

The MCH Block Grant program funding, combined with state investments, improves access to quality health care services 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 to mothers and children, especially those with low incomes or limited availability of care;
- Reduce infant mortality;
- Provide access to prenatal, delivery, and postnatal care to women, especially pregnant women who are low income and at-risk for adverse maternal health outcomes;

[56] Retroactively adjusted to reflect shift in funding from SPRANS for Innovation for Maternal Health, Integrated Services for Pregnant and Postpartum Women, and Implicit Bias Training for Health Care Providers to their own budget lines as new authorities enacted in the Consolidated Appropriations Act, 2022 (PL 117-103). Adjustments also reflect shift in funding for The Maternal Mental Health Hotline from SPRANS to its own budget line as a new authority enacted in the Consolidated Appropriations Act of 2023 (PL 117-328).
[57] Reflects funds shifted out SPRANS for four new authorities noted above.
[58] Reflects funds shifted out SPRANS for four new authorities noted above.

- Increase regular screenings and follow-up diagnostic and treatment services for children who are low income;
- Provide access to preventive and primary care services for children who are low income and rehabilitative services for children with special health needs;
- Implement family-centered, coordinated health and social services and supports for children with special health care needs; and
- Set up toll-free hotlines and assistance with applying for services to pregnant women with infants and children eligible for Medicaid.

State MCH Block Grant Program

The Title V State MCH Block Grant Program, a partnership between the federal government and states, 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. Nearly 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 2021. Nationwide, the 59 State MCH Block Grant programs reached approximately 92 percent of pregnant women, 98 percent of infants, and 58 percent of children. The MCH Block Grant Program gives states flexibility in meeting their unique health needs, while HRSA assures accountability and impact through performance measurement and technical assistance. Additionally, HRSA continues to implement efforts to reduce administrative burden, and improve accountability.

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. Federal funds, combined with required state matching investments, support activities that address an individual state's MCH needs. The program reports progress annually, and HRSA provides technical assistance on request to assist states in improving performance. A comprehensive needs assessment is required by law every five years to determine each state's highest MCH priorities.

The State MCH Block Grant program continues to play an important role as a payer of last resort to address gaps in coverage and services not covered by Medicaid/ Children's Health Insurance Program (CHIP) and other third-party payers. In addition to gap-filling direct and enabling services, state MCH programs promote access and quality of care through quality improvement initiatives, workforce training, outreach, and disease prevention and health promotion.

HRSA also provides technical assistance to states in addressing their MCH priority needs, as well as performance and programmatic requirements of the MCH Block Grant program. HRSA makes state-reported financial, program, performance, and health indicator data available to the public through the Title V Information System.[59]

Special Projects of Regional and National Significance (SPRANS)

SPRANS grants address national or regional needs, priorities, or emerging issues and demonstrate methods for improving care and outcomes for mothers and children.

[59] Title V Information System (TVIS). https://mchb.tvisdata.hrsa.gov/

Of the $212.1 million for SPRANS in FY 2023, Congress set aside approximately 8 percent to address four specific priorities: oral health, epilepsy, sickle cell disease, and fetal alcohol syndrome. Congress has also directed approximately 62 percent of funds to address priority issues, such as maternal mortality and morbidity initiatives, early childhood development initiatives, and regional pediatric pandemic preparedness efforts, among other priorities. The remainder supports additional activities authorized by statute.

SPRANS awards drive innovation, help improve systems of care for MCH populations, and enable efforts to address emerging issues. Funding complements MCH Block Grant activities by building capacity through pilot programs, research, data collection, quality improvement, and workforce development.

Critical and Emerging Issues in Maternal and Child Health

- *Maternal mortality* – HRSA supports investments with SPRANS funding that are integral to HRSA's efforts to promote maternal health and reduce maternal mortality and morbidity. In FY 2023, HRSA continued support for the State Maternal Health Innovation Program, which supports state-specific actions that address disparities in maternal health and improve maternal health outcomes, including the prevention and reduction of maternal mortality and severe maternal morbidity.
- *Reducing health disparities* – SPRANS funding has been vital to support efforts to reduce health disparities in communities across the country. The National MCH Workforce Development Center launched a new effort to help states implement, evaluate, sustain, and advance practices designed to reduce health disparities within their state/jurisdiction. SPRANS also supports a new investment to establish a research network that is comprised of and supports minority-serving institutions to study health disparities in maternal health outcomes.
- *COVID-19*— SPRANS funding has been instrumental in addressing emerging public health issues that impact the MCH population, including COVID-19. The SPRANS-funded National Survey of Children's Health (NSCH) is an annual, cross-sectional, address-based survey that collects information on the health and well-being of approximately 30,000 children ages 0-17 and related health care, family, and community-level factors. The 2021 NSCH produced actionable data, which is publicly available, on COVID-related issues, such as missed preventive care visits due to the coronavirus pandemic and reasons for missed care (past 12 months) and interruptions in childcare arrangements (past 12 months).

Community Integrated Service Systems (CISS)

CISS grants help states and communities build a comprehensive, integrated system of care to improve access and outcomes for all children, including children with special health care needs. For example, CISS funding supports the Early Childhood Comprehensive Systems (ECCS) program, which helps states improve access to and quality of preventive health and support services for people who are pregnant or have young children. As a result of the program, 20 states are engaging more family representatives as leaders in designing better health systems, connecting services across health, social services, and other sectors, and planning specific improvements to state, local and/or program policies and practices that advance health equity and ensure children are thriving at age three and school-ready by age five.

Budget Request

The FY 2024 Budget Request for the Maternal and Child Health Block Grant program of $937.3 million is $121.6 million above the FY 2023 Enacted level. The request includes $593.3 million 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 request includes $333.7 million in SPRANS funding, an increase of $121.6 million.

The SPRANS funding includes $145 million to support HRSA's efforts to improve maternal health, with a specific focus on areas with high rates of adverse maternal health outcomes or with racial and ethnic disparities in maternal health outcomes. This funding includes:

- *Addressing Emerging Issues and Social Determinants of Maternal Health*: $55.0 million for community-based organizations to reduce maternal mortality and adverse maternal health outcomes, particularly in areas with high rates of adverse maternal health outcomes and/or significant racial and ethnic disparities in maternal health outcomes. Projects could include investments in maternal mental health equity, addressing social determinants of maternal health, promoting equity in maternal health outcomes through digital tools, and expanding the use of technology-enabled collaborative learning and capacity-building models for pregnant and postpartum individuals.
- *Growing and Diversifying the Doula Workforce*: $25.0 million to provide grants to community-based organizations to develop and/or expand programs to recruit doula candidates (health workers who provide support before, during and after childbirth), support their training/certification, and then employ them as doulas to support improved birth outcomes in the community. HRSA will also use $5 million requested in FY 2024 to coordinate with the Centers for Medicare & Medicaid Services (CMS) to support states in offering coverage for doulas.
- *Funding for Minority-Serving Institutions:* $10.0 million for awarding funds through a research network to support minority-serving institutions to study health disparities in maternal health outcomes; and to develop curricula for training health professionals on identifying and addressing the risks associated with climate change for vulnerable individuals and individuals who intend to become pregnant.
- *State Maternal Health Innovation Awards*: $55.0 million to continue to support state-specific actions that address disparities in maternal health and improve maternal health outcomes, including the prevention and reduction of maternal mortality and severe maternal morbidity.

The request also provides $40 million in SPRANS funding to support a pilot initiative to integrate behavioral health supports in community settings to promote the healthy social and emotional development and mental health needs of mothers, children, and their families. Grants will support traditionally underserved communities, including those within Mental Health Professional Shortage Areas, to engage and train community-based organizations (CBOs) to identify and address the mental and behavioral health needs of mothers and children, support children's social and emotional development, and build community trust and expertise to help reduce disparities in access to behavioral health care. If more intensive care is needed, navigators and community health workers will facilitate linkages to local resources, such as medical homes, school-based and other community health centers, community-based organizations, and local

community social supports and services. Partnerships between CBOs and mental and behavioral health providers can enhance local mental health service delivery as CBOs help integrate clinicians into the community setting.

Additional SPRANS funding supports programs that will drive innovation, improve systems of care, and address emerging issues related to disparities for MCH populations.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, collection and reporting of performance and outcome measure data to include the National Survey on Children's Health, and information technology and other program support costs.

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

MCH Activities	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
State MCH Block Grant Awards	$570,389	$593,308	$593,308
SPRANS	$152,338	$212,116	$333,716
CISS	$10,276	$10,276	$10,276
Total	**$733,003**	**$815,700**	**$937,300**

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

MCH SPRANS Set-Aside Programs	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
SPRANS – Other	$136,609	$195,224	$316,824
SPRANS - Oral Health	$5,220	$5,250	$5,250
SPRANS – Epilepsy	$3,642	$3,642	$3,642
SPRANS - Sickle Cell	$5,885	$7,000	$7,000
SPRANS - Fetal Alcohol Syndrome Demo	$982	$1,000	$1,000
Total SPRANS	**$152,338**	**$212,116**	**$333,716**

Funding History

Fiscal Year	Amount
FY 2015	$637,000,000
FY 2016	$637,429,000
FY 2017	$640,163,000
FY 2018	$650,194,000
FY 2019	$671,723,000
FY 2020	$682,700,000
FY 2021	$698,545,000
FY 2022	$733,003,000[60]
FY 2023	$815,700,000[61]
FY 2024 President's Budget	$937,300,000[62]

Program Accomplishments

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:

- Nearly 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 2021. Nationwide, the 59 State MCH Block Grant programs reached approximately 92 percent of pregnant women, 98 percent of infants, and 58 percent of children.
- Access to health services for mothers has improved with the support of the State MCH Block Grant program. Women receiving early prenatal care in the first trimester of pregnancy increased from 71.0 percent in 2007 to 78.3 percent in 2021. Recognizing the importance of 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 25 percent decline in U.S. infant mortality from 7.2 infant deaths per 1,000 live births in 1997 to 5.4 infant deaths per 1,000 live births in 2021.
- States are also working to reduce maternal mortality, which has risen over the past two decades. Fifty State MCH Block Grant programs provided funding to support comprehensive maternal mortality reviews to identify contributing factors to maternal death, monitor trends, and/or initiate steps to reduce such events in the future.[63] States use MCH Block Grant funds for activities such as promoting well-woman visits,

[60] Retroactively adjusted to reflect shift in funding from SPRANS for Innovation for Maternal Health, Integrated Services for Pregnant and Postpartum Women, and Implicit Bias Training for Health Care Providers to their own budget lines as new authorities enacted in the Consolidated Appropriations Act, 2022 (PL 117-103)
[61] Reflects funds shifted out SPRANS for three new authorities noted above.
[62] Reflects funds shifted out SPRANS for three new authorities noted above.
[63] Based on reporting in the FY 2021/FY 2019 Title V Application/Annual Reports.

increasing access to prenatal care, and enhancing systems of care for maternal mental health.

- States are reducing disparities. For example, Rhode Island recently implemented a collaborative, community-led, and data-driven process to address the unique social, economic, and environmental factors that are preventing people from reaching their optimal health, with a goal of advancing equity in those communities. One community implemented a program to prevent childhood obesity and promote physical activity and healthier eating that reached over 19,000 children and adolescents.[64]

Select National Outcome and National Performance Measures in effect from 1997 to 2021 illustrate the program's successes:

National Outcome or Performance Measures	Percent Change (1997 – 2021 unless otherwise noted)	Data Source
Infant mortality rate per 1,000 live births	25% decrease	National Vital Statistics System (NVSS)
Neonatal mortality rate per 1,000 live births	27% decrease	NVSS
Postneonatal mortality rate per 1,000 live births	24% decrease	NVSS
Perinatal mortality rate per 1,000 live births plus fetal deaths	22% decrease (1997-2019)	NVSS
Child mortality rate, ages 1 through 9 per 100,000 children	32% decrease	NVSS
Percent of children who have completed the combined 7-vaccine (includes Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B) series by age 24 months[65]	5% increase (2011-2018)	National Immunization Survey (NIS)
Percentage of children without health insurance	71% decrease	National Health Interview Survey (NHIS)
Percent of infants breastfed exclusively through 6 months of age	80% increase (2007-2019)	NIS
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	10% increase (2007-2021)	NVSS

[64] The 5-2-1-0 program promotes eating 5 fruits and vegetables, engaging in no more than 2 hours of recreational screen time, getting 1 hour of exercise, and drinking 0 sugary drinks per day.
[65] Childhood vaccination measure definition has been updated to align with CDC reporting of vaccination rates by birth year cohort.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3010.01**:** The percentage of children served by the Maternal and Child Health Block Grant *(Outcome)*	FY 2021: 60% Target: 58% (Target Exceeded)	63%	63%	Maintain
3010.02**:** The percentage of pregnant women served by the Maternal and Child Health Block Grant *(Outcome)*	FY 2021: 92% Target: 87% (Target Exceeded)	93%	93%	Maintain
3010.03**:** Decrease the ratio of the Black infant mortality rate to the White infant mortality rate *(Output)*	FY 2021: 2.4 to 1 Target: 2 to 1 (Target Not Met)	2 to 1	2 to 1	Maintain
3010.04: Reduce the infant mortality rate *(Outcome)*	FY 2021: 5.4 per 1,000 Target: 5.5 per 1,000 (Target Met)	5.4 per 1,000	5.3 per 1,000	-0.1 per 1,000
3010.05: Reduce the incidence of low birth weight births *(Outcome)*	FY 2021: 8.5% Target: 7.8% (Target Not Met)	8%	8%	Maintain
3010.06**:** Increase percentage of pregnant women who received prenatal care in the first trimester. *(Outcome)*	FY 2021: 78.3% Target: 80% (Target Not Met but Improved)	80%	80%	Maintain

Performance Narrative

- For measure 3010.01, the term "children" includes both infants and children (0-21) years of age.
- For measure 3010.03, numerator data for infant deaths by race was taken from the Centers for Disease Control and Prevention, National Center for Health Statistics' CDC WONDER Online Database for Underlying Cause of Death by Single-Race Categories from 2018-2021 (https://wonder.cdc.gov/controller/saved/D158/D319F451).
- For measure 3010.03, denominator data for live births by race was taken from the Centers for Disease Control and Prevention, National Center for Health Statistics' CDC WONDER Online Database for Natality public-use data 2007-2021 (https://wonder.cdc.gov/controller/saved/D66/D268F641).

Grant Awards Table – Maternal and Child Health Block Grant

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	59	59	59
Average Award	$9,437,409	$9,747,288	$9,747,288
Range of Awards	$150,340-$39,637,360	$155,275-$41,715,138	$155,275-$41,220,240

Grant Awards Table – SPRANS

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	282	312	438
Average Award	$475,092	$594,142	$661,747
Range of Awards	$11,698-$9,696,361	$27,562-$9,700,000	$16,667-$9,700,000

Grant Awards Table – CISS

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	26	26	26
Average Award	$316,511	$300,462	$300,462
Range of Awards	$240,524-$700,000	$249,208-$700,000	$252,959-$700,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration
FY 2024 Discretionary State/Formula Grants

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
STATE/TERRITORY	FY 2022 Final[66]	FY 2023 Enacted[67]	FY 2024 President's Budget[68]	FY 2024 +/- FY 2023
Alabama	11,684,723	12,028,610	12,034,919	6,309
Alaska	1,132,163	1,166,664	1,155,348	-11,316
Arizona	7,573,250	8,016,675	7,900,685	-115,990
Arkansas	7,136,666	7,356,520	7,403,849	47,329
California	39,637,360	41,715,138	41,220,240	-494,898
Colorado	7,403,131	7,602,449	7,635,701	33,252
Connecticut	4,821,333	4,957,248	4,987,926	30,678
Delaware	2,073,458	2,122,291	2,125,700	3,409
District of Columbia	6,971,679	7,010,537	7,010,887	350
Florida	20,489,157	21,590,094	21,519,450	-70,644
Georgia	17,360,856	18,043,094	18,144,882	101,788
Hawaii	2,195,700	2,244,513	2,280,689	36,176
Idaho	3,312,923	3,399,364	3,394,287	-5,077
Illinois	21,425,576	22,059,194	22,043,316	-15,878
Indiana	12,410,368	12,772,540	12,728,763	-43,777
Iowa	6,611,198	6,738,574	6,780,826	42,252
Kansas	4,853,837	4,995,307	4,985,163	-10,144
Kentucky	11,391,252	11,694,751	11,757,222	62,471
Louisiana	12,879,593	13,283,094	13,307,837	24,743
Maine	3,306,213	3,352,234	3,380,975	28,741
Maryland	12,008,626	12,224,103	12,386,748	162,645
Massachusetts	11,229,305	11,459,297	11,464,626	5,329

[66] The poverty-based allocation for FY 22 uses 3-year poverty data from the American Community Survey, 2017-2019

[67] The poverty-based allocation for FY 23 uses 3-year poverty data from the American Community Survey, 2017-2019

[68] The poverty-based allocation for FY 24 uses 3-year poverty data from the American Community Survey, 2018, 2019, and 2021

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
STATE/TERRITORY	**FY 2022 Final[66]**	**FY 2023 Enacted[67]**	**FY 2024 President's Budget[68]**	**FY 2024 +/- FY 2023**
Michigan	19,132,104	19,684,748	19,653,882	-30,866
Minnesota	9,255,161	9,458,382	9,464,322	5,940
Mississippi	9,450,421	9,714,491	9,776,517	62,026
Missouri	12,469,248	12,803,907	12,755,341	-48,566
Montana	2,315,433	2,362,167	2,372,160	9,993
Nebraska	4,034,005	4,115,207	4,111,139	-4,068
Nevada	2,255,317	2,420,441	2,477,543	57,102
New Hampshire	1,985,454	2,017,766	2,014,662	-3,104
New Jersey	11,835,348	12,189,936	12,325,516	135,580
New Mexico	4,259,419	4,429,611	4,396,137	-33,474
New York	38,783,014	39,820,119	39,855,208	35,089
North Carolina	17,916,623	18,549,435	18,426,434	-123,001
North Dakota	1,759,550	1,784,118	1,791,693	7,575
Ohio	22,694,535	23,372,052	23,389,497	17,445
Oklahoma	7,435,504	7,707,354	7,760,326	52,972
Oregon	6,218,999	6,396,234	6,329,824	-66,410
Pennsylvania	24,281,167	24,884,780	25,039,442	154,662
Rhode Island	1,657,027	1,702,042	1,699,637	-2,405
South Carolina	11,771,069	12,095,177	12,080,002	-15,175
South Dakota	2,229,569	2,275,533	2,275,007	-526
Tennessee	12,194,313	12,624,516	12,563,019	-61,497
Texas	36,711,955	38,765,601	38,947,187	181,586
Utah	6,174,456	6,301,556	6,247,227	-54,329
Vermont	1,653,893	1,672,715	1,661,763	-10,952
Virginia	12,682,968	13,030,018	13,055,322	25,304
Washington	8,973,317	9,264,274	9,201,043	-63,231
West Virginia	6,241,696	6,356,733	6,303,329	-53,404
Wisconsin	10,977,006	11,218,004	11,222,840	4,836
Wyoming	1,232,303	1,255,769	1,258,919	3,150
Subtotal	**536,489,241**	**554,104,977**	**554,104,977**	**---**

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
STATE/TERRITORY	**FY 2022 Final[66]**	**FY 2023 Enacted[67]**	**FY 2024 President's Budget[68]**	**FY 2024 +/- FY 2023**
American Samoa	501,126	517,581	517,581	---
Guam	773,963	799,376	799,376	---
Marshall Islands	233,858	241,536	241,536	---
Micronesia	528,967	546,336	546,336	---
Northern Mariana Islands	473,287	488,827	488,827	---
Palau	150,340	155,275	155,275	---
Puerto Rico	16,136,271	16,666,109	16,666,109	---
Virgin Islands	1,520,084	1,569,996	1,569,996	---
Subtotal	**20,317,896**	**20,985,036**	**20,985,036**	**---**
TOTAL RESOURCES	**556,807,137**	**575,090,013**	**575,090,013**	**---**

Innovation for Maternal Health

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$11,775,000	$15,300,000	$15,300,000	---
FTE	---	5	5	---

Authorizing Legislation: Section 330O of the Public Health Service Act, as added by Public Law 117-103

FY 2024 Authorization $9,000,000

Allocation Methods:

- Contract
- Competitive grant/co-operative agreement

Program Description

The Consolidated Appropriations Act of 2022 (PL 117-103), Division P, Subtitle D, Section 131 established a new legislative authority, Innovation for Maternal Health, under Section 330O of the Public Health Service Act which authorizes HRSA's Alliance for Innovation on Maternal Health (AIM) program. In FY 2023, funding was appropriated under this new authority for AIM, which had previously been funded under the Social Security Act, Title V Section 501(a)(2) in the Maternal and Child Health Block Grants - Special Projects of Regional and National Significance (SPRANS) program. The Innovation for Maternal Health program authorizes the establishment or continuation of a program to identify, develop, or disseminate best practices to improve maternal health care quality and outcomes, improve maternal and infant health, and eliminate preventable maternal mortality and severe maternal morbidity, among other activities. In FY 2024, HRSA will continue the AIM program under this new legislative authority.

HRSA supports investments to promote maternal health and reduce maternal mortality and morbidity. The AIM program promotes safety and quality of care during and immediately after childbirth and works to reduce disparities in health outcomes based on race and ethnicity. AIM improves maternity care across the country by developing and implementing patient safety bundles, which are sets of small, straightforward, evidence-based practices. When these practices are implemented collectively and reliably in the delivery setting, they improve patient outcomes and reduce maternal mortality and severe maternal morbidity in hospitals, other birthing facilities, community-based organizations, and outpatient clinical settings. The bundles do not introduce new guidelines but bring together the existing evidence-based recommendations and resources to facilitate rapid implementation within birthing facilities. As of November 2022, there are seven patient safety bundles. AIM state enrollees can choose which bundle(s) to implement, according to their needs and priorities. These bundles address the following topics:

- Obstetric Hemorrhage
- Severe Hypertension in Pregnancy

- Safe Reduction of Primary Cesarean Birth
- Cardiac Conditions in Obstetrical Care
- Care for Pregnant and Postpartum People with Substance Use Disorder
- Postpartum Discharge Transition
- Sepsis in Obstetrical Care

HRSA continues to support expanded implementation of the AIM program's patient safety bundles within additional birthing facilities in new and enrolled U.S. States, the District of Columbia, U.S. territories, and tribal entities, and disseminate tested bundles to a broader array of providers, health care settings, and organizations within communities across the U.S. As of October 2022, 48 states and the District of Columbia are enrolled in AIM, with participation from 1,841 birthing facilities.

Budget Request

The FY 2024 Budget Request for the Alliance for Innovation on Maternal Health (AIM) program of $15.3 million is equal to the FY 2023 Enacted level for this program. This request will provide targeted support through grants to states, jurisdictions, U.S. territories, and tribal communities to expand the reach, depth, and quality of AIM throughout the country. These grants aim to improve the quality and safety of maternal health care nationwide and reduce maternal health disparities through the increase in the number of birthing facilities implementing and sustaining bundles as well as the continued delivery of bundles and data collection/reporting.

This request additionally supports technical assistance to expand implementation and reach of AIM program activities to all birthing facilities within the 50 states, the District of Columbia, U.S. territories, and tribal communities. The technical assistance will also support AIM data collection.

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

Funding History

Fiscal Year	Amount
FY 2020	$5,000,000
FY 2021	$9,000,000
FY 2022	$11,775,000
FY 2023	$15,300,000
FY 2024 President's Budget	$15,300,000

Program Accomplishments

Sample accomplishments from states showing improvements from implementation of the AIM safety bundles include:

- **Michigan:** In Michigan, hemorrhage is among the three leading causes of pregnancy-related death. Between November 2016 to December 2020, 56 of the state's 80 birthing facilities participated in implementation of AIM's Obstetric Hemorrhage patient safety bundle with Michigan AIM. As part of this effort, participating facilities received technical assistance, site visits, education, and data support. From 2011-2015 to 2016-2020, the statewide severe maternal morbidity (SMM) rate among birthing patients who experienced a hemorrhage, excluding those who only received blood transfusions, declined from 11% to 5%, an overall reduction of 55%.
- **Iowa:** Due to Iowa's nulliparous, term, singleton, vertex (NTSV) cesarean birth rate exceeding the Healthy People 2030 target rate of 23.6%, the Iowa Maternal Quality Care Collaborative (IMQCC) began implementation of AIM's Safe Reduction of Primary Cesarean Birth patient safety bundle in 43 of the state's 56 birthing facilities. Since the start of implementation in May 2021, participating facilities have received monthly education on evidence-based practices, quality improvement, and family-centered care. Provisional data show a 16% reduction in the statewide rate of NTSV cesarean births from 25.0% in Q1 2021 to 21.1% in Q1 2022. During the same time, non-participating facilities experienced an increased rate of low-risk (NTSV) cesarean births.
- **Alaska:** Hypertensive disorders in pregnancy are increasing in Alaska, and hypertensive disorders contributed to one third of the pregnancy-related deaths in Alaska between 2012 and 2016. Based on these data and feedback from key stakeholders, the Alaska Perinatal Quality Collaborative (AKPQC) engaged six hospitals, representing 63% of Alaska births, in implementation of the AIM Severe Hypertension in Pregnancy patient safety bundle. As a result of this initiative and efforts of participating hospitals, the statewide percent of severe maternal morbidity (SMM) among people with preeclampsia, excluding blood transfusions alone, decreased from 7.7% in 2018 to 4.1% in 2020, the lowest percentage in the most recent five years. During this period, statewide SMM among people with preeclampsia, excluding blood transfusions alone, decreased from 10.8% to 3.9% for Non-Hispanic White people and from 5.5% to 3.4% for American Indian and Alaska Native people.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	6	30	30
Average Award	$1,698,716	$447,653	$447,653
Range of Awards	$1,829,587-$4,421,210	$1,829,587-$2,000,000	$1,829,587-$2,000,000

Training for Health Care Providers

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	---	---	$5,000,000	+$5,000,000
FTE	---	---	1	+1

Authorizing Legislation: Section 763 of the Public Health Service Act, as added by Public Law 117-103

FY 2024 Authorization $5,000,000

Allocation Methods:

- Competitive Grants

Program Description

The Consolidated Appropriations Act of 2022 (PL 117-103), Division P, Subtitle D, Section 132 established a new legislative authority for the Training for Health Care Providers program under Section 763 within Title VII of the Public Health Service Act for grants to improve the provision of maternal health care for historically marginalized populations, with respect to perceptions and biases that may affect the approach to, and provision of, care.

The Training for Health Care Providers program addresses perceptions and biases among maternal health care providers that may affect the approach to, and provision of, care to reduce health disparities and improve maternal health outcomes.

Disparities persist in the rates of maternal mortality in the United States, with maternal deaths affecting a higher proportion of Black women compared to White women.[69] Research shows that provider bias can play a role in higher rates of morbidity and mortality among Black women.[70] The Listening to Mothers III survey found that approximately one in five Black and Hispanic women indicated concerns with treatment from hospital-based care providers because of their race, ethnicity, cultural background, and/or language.[71] Health care quality, starting at preconception and continuing through postpartum care, is a critical lever to improve outcomes for women, including those from racial and ethnic minority groups.[72] There is growing

[69] Hoyert DL. Maternal mortality rates in the United States, 2019. NCHS Health E-stats, 2021.
[70] Minehart RD, Bryant AS, Jackson J, Daly JL. Racial/Ethnic Inequities in Pregnancy-Related Morbidity and Mortality, Obstet Gynecol Clin N Am 48(2021) 31051.
[71] National Academies of Science, Engineering, and Medicine. Birth settings in America: Outcomes, quality, access, and choice. National Academies Press, 2020.
[72] Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017. MMWR Morb Mortal Wkly Rep 2019;68:423-429.

evidence[73,74] that training for medical providers, who are optimally positioned to identify disparities in care to best support women, can be effective in helping clinicians address bias and improve health care quality.

The Training for Health Care Providers program has three overarching objectives:

- Develop and provide evidence-informed training and curricula to support maternal health providers in addressing bias through both experiential and instructor-led learning.
- Engage faculty and trainees in research to expand the evidence base on strategies to address bias among maternal health providers.
- Engage community-based organizations and individuals with lived experience in the development, implementation and evaluation of training and research activities to address bias in maternal health care.

The program advances key goals of the White House Blueprint for Addressing the Maternal Health Crisis.[75]

Budget Request

The FY 2024 Budget Request for the Training for Health Care Providers program of $5 million is $5 million above the FY 2023 Enacted level. This request funds up to 10 training grants to institutions of higher learning to:

- Develop and deliver curricula and training content;
- Enroll, manage, and track maternal health trainees;
- Support research related to bias in maternal health care to build the evidence base around effective training and practice;
- Engage community-based organizations and individuals with lived experience in the development, implementation and evaluation of training and research activities; and
- Disseminate project curricula, products, research results, and training approaches.

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.

Funding History

Fiscal Year	Amount
FY 2020	---
FY 2021	---
FY 2022	---
FY 2023	---
FY 2024 President's Budget	$5,000,000

[73] Zestcott CA, Blair IV, Stone J. Examining the Presence, Consequences, and Reduction of Implicit Bias in Health Care: A Narrative Review. Group Process Intergroup Relat. 2016 Jul:19(4):528-542.
[74] Hagiwara N, Kron FW, Scerbo MC, Watson GS. A call for grounding implicit bias training in clinical and translational frameworks. Lancet, 2020, 395: 1457-60.
[75] https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	---	---	10
Average Award	---	---	$450,000
Range of Awards	---	---	$450,000

Integrated Services for Pregnant and Postpartum Women

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	---	$10,000,000	$25,000,000	+$15,000,000
FTE	---	1	2	+1

Authorizing Legislation: Section 330P of the Public Health Service Act, as added by Public Law 117-103

FY 2024 Authorization $10,000,000

Allocation Methods:

- Contract
- Competitive grant/co-operative Agreement

Program Description

The Consolidated Appropriations Act of 2022 (PL 117-103), Division P, Subtitle D, Section 134 established a new legislative authority for the Integrated Services for Pregnant and Postpartum Women program under Section 330P within Title III of the Public Health Service Act.

The Integrated Services for Pregnant and Postpartum Women program helps states, Indian Tribes, and tribal organizations establish or operate innovative programs to effectively deliver care for pregnant and postpartum people while considering their social, behavioral, and health care needs. These programs coordinate appropriate services and supports across care providers to improve outcomes. The program aims to reduce negative maternal health outcomes, pregnancy-related deaths, and maternal health disparities, including racial and ethnic disparities by taking a whole-person approach to care.

Approximately four million births occur in the United States each year.[76] Despite advances in medical care and investments in improving access to care, rates of maternal mortality and severe maternal morbidity (SMM)[77] have not improved.[78] In 2020, there were 861 maternal deaths in the United States, representing a maternal mortality rate of 23.8 per 100,000 live births.[79] In addition, as many as 60,000 women in the United States experience unexpected outcomes during

[76] https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-01.pdf
[77] Severe maternal morbidity includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a women's health.
[78] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html
[79] https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm

labor or delivery that have serious short- or long-term effects on their health and well-being.[80] Significant maternal health disparities exist with outcomes varying by race, ethnicity, geography, and select indicators of socio-economic status.[81]

HRSA is committed to reducing these maternal health disparities by addressing the social determinants of health and improving the quality of maternal health care. To address the high rates of adverse maternal health outcomes, additional demonstrations and programs need to test innovative strategies, identify the most effective approaches, and accelerate progress toward achieving equitable maternal health outcomes. One such strategy is the Pregnancy Medical Home (PMH) model. Some areas of the United States are testing and demonstrating the benefits of the PMH model, which organizes and coordinates the often-fragmented network of social, behavioral, and health care services and focuses on promoting evidence-based care management to improve outcomes for people with Medicaid benefits. Early evaluations of PMH models show some evidence of positive impact on birth outcomes.[82] More evidence is needed to demonstrate and determine the impact of the PMH model on maternal health, including the reduction of health disparities. HRSA seeks to build the evidence for integrated models of care, like PMH, through this program.

First funded in FY 2023, this program advances the goals of the White House Blueprint for Addressing the Maternal Health Crisis.[83]

The program funds projects that either test an existing model like PMH that integrate care and services, or develop, implement, and test new models in collaboration with relevant stakeholders, including:

- State, Tribal, and local agencies responsible for Medicaid, public health, social services, mental health, and substance use disorder treatment and services;
- Health care providers that serve pregnant and postpartum individuals;
- Community-based health organizations and health workers, including providers of home visiting services and individuals representing communities with disproportionately high rates of maternal mortality and severe maternal morbidity.

Core program components include:

- Systematically assessing pregnant individuals' risks for adverse maternal health outcomes;
- Implementing pregnancy care management and care coordination for individuals at greater risk for adverse maternal health outcomes, including referral and linkages to specialized care and support services to address unmet clinical, behavioral, and social needs;
- Improving quality of care delivered during pregnancy and the postpartum period, up to 12 months after delivery;

[80] https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/severe-maternal-morbidity-united-states-primer
[81] Ibid.
[82] https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity
[83] https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf

- Establishing a diverse workforce, to support pregnancy care management, care coordination, and quality improvement in health care practices;
- Enhancing data systems to establish baseline data, guide quality improvement, and track performance measures and outcomes; and
- Ensuring activities focus on equal treatment, inclusion, and accessibility.

Budget Request

The FY 2024 Budget Request for the Integrated Services for Pregnant and Postpartum Women program of $25 million is $15 million above the FY 2023 Enacted level. This request will continue and expand support for projects to foster the development and demonstration of innovative models that integrate care and services, such as the Pregnancy Medical Home model, to reduce negative maternal health outcomes, pregnancy-related deaths, and maternal health disparities, including racial and ethnic disparities. At this funding level, HRSA anticipates support for existing and new projects for a total of up to 12 awards.

The funding request also includes costs associated with the cooperative agreement review and award process, follow-up performance reviews, evaluation and technical assistance activities, information technology, and other program support costs.

Funding History

Fiscal Year	Amount
FY 2020	---
FY 2021	---
FY 2022	---
FY 2023	$10,000,000
FY 2024 President's Budget	$25,000,000

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	---	5	12
Average Award	---	$1,800,000	$1,800,000
Range of Awards	---	$1,800,000	$1,800,000

Maternal Mental Health Hotline

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$4,000,000	$7,000,000	$7,000,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 399V-7 of the Public Health Service Act, as added by Public Law 117-328

FY 2024 Authorization $10,000,000

Allocation Method:

- Contract
- Grants

Program Description

The Consolidated Appropriations Act of 2023 (PL 117-328), established a new legislative authority for the Maternal Mental Health Hotline. The hotline was previously implemented and funded under the Social Security Act, Title V Section 501(a)(2) in the Maternal and Child Health Block Grants - Special Projects of Regional and National Significance (SPRANS) program. The Consolidated Appropriations Act of 2023 (PL 117-328) added Section 399V-7 to Title III of the Public Health Service Act to maintain a national maternal mental health hotline to provide emotional support, information, brief intervention, and mental health and substance use disorder resources to pregnant and postpartum women at risk of, or affected by, maternal mental health and substance use disorders, and to their families or household members.

HRSA launched the National Maternal Mental Health Hotline on Mother's Day, May 8, 2022. It provides 24/7 free, confidential emotional support, information, and referrals for those who are pregnant or postpartum and their loved ones. Professional counselors, including licensed mental health clinicians; licensed health care providers such as nurses or doctors; certified doulas or childbirth educators; and certified peer support specialists, staff the hotline and provide culturally sensitive and trauma informed support in English and Spanish via telephone and text, so people can get the help they need, when they need it. Interpreter services are available in 60 additional languages, and a relay service is available for people who are deaf or hard-of-hearing.

Budget Request

The FY 2024 Budget Request for the Maternal Mental Health Hotline program is $7.0 million, which is the same as the FY 2023 Enacted level. Requested funding will support continued operation of the hotline, maintain staffing capacity, and help promote widespread national awareness and use of the hotline through a communications campaign and partner outreach.

Funding History

Fiscal Year	Amount
FY 2020	---
FY 2021	$3,000,000
FY 2022	$4,000,000
FY 2023	$7,000,000
FY 2024 President's Budget	$7,000,000

Program Accomplishments

From the launch of the National Maternal Mental Health Hotline in May 2022 through the end of calendar year 2022, hotline counselors have had more than 7,500 conversations of which approximately 70% were by phone and 30% were by text. The average speed of answer for phone and text has been under one minute.

HRSA launched the hotline in a phased manner during its first year of implementation, which included initial outreach to relevant provider associations, national organizations, community groups, and federal partners. HRSA also developed and disseminated downloadable promotional materials in English and Spanish and continues to promote the hotline to target audiences on social media and through other channels. In FY 2024, HRSA will continue and expand this outreach, including to pregnant women, new parents and their support networks, and the health and social service providers who care for them.

Autism and Other Developmental Disabilities

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$54,344,000	$56,344,000	$57,344,000	+$1,000,000
FTE	9	9	9	---

Authorizing Legislation: Section 399BB of the Public Health Service Act, as amended by Public Law 116-60

FY 2024 Authorization $50,599,000

Allocation Methods:

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

Program Description

The Autism and Other Developmental Disabilities program improves care and outcomes for children, adolescents, and young adults with autism and other developmental disabilities (DD). The program does this primarily by:

- **Training** healthcare professionals to screen, refer and provide services for children with Autism/DD;
- Supporting autism **research** networks and programs; and
- Ensuring state health agencies **implement best practices**.

Through these efforts, the program also aims to increase access to early screening, diagnosis, and treatment for children and youth with autism/DD, and to increase public awareness of the issues affecting these children and families. Finally, the program aims to promote health equity by engaging diverse families and self-advocates in program design and implementation, and targeting populations affected by discrimination primarily due to disability status.

The Combating Autism Act of 2006 authorized this program, which began operating in 2008. The Autism Collaboration, Accountability, Research, Education and Support (Autism CARES) Act reauthorized the program in 2019.

Training Program
The Autism and Other Developmental Disabilities training programs are Leadership Education in Neurodevelopmental and Other Related Disabilities (LEND) and Developmental-Behavioral Pediatrics (DBP).

The LEND program supports interdisciplinary training for health care and related students and professionals on addressing the needs of children with autism/DD. LEND training opportunities are academic, clinical, leadership, and community oriented.

The DBP program helps prepare fellows in developmental-behavioral pediatrics for leadership roles as teachers, researchers, and clinicians. It also provides pediatric practitioners, residents, and medical students with the clinical expertise necessary to support children and youth with autism/DD.

Both 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. Both training programs include self-advocates and family members in a variety of ways, including 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 Program
The research components of the Autism and Other Developmental Disabilities program include:

- Research networks
- Single investigator-led autism innovation projects
- Field-initiated research
- Secondary data analysis projects

Areas of research include:

- Research and development of reliable screening tools and guidelines for autism/DD
- Implementation of interventions to improve the physical and behavioral health of individuals with autism/DD across the life course
- How to address barriers to diagnosis and access to care, and social determinants of health and health disparities, with an explicit focus on recruiting participants from underserved populations

Collectively, these research investments respond to questions raised in the HHS Interagency Autism Coordinating Committee (IACC) Strategic Plan. Specific areas include improving early identification and advancing effectiveness of interventions and services for children with autism and other DD.

State Systems Grants
Through FY 2023, the Autism and Other Developmental Disabilities program supported organizations that improve access to comprehensive, coordinated health care and related services for children and youth with autism/DD and their families in medically underserved areas. This was accomplished by implementing family navigation and provider training. These grants ended in FY 2023.

Demonstration Program
In FY 2024, MCHB will implement a new demonstration program as part of the Autism and Other Developmental Disabilities program to better address a growing challenge of supporting youth with autism as they transition into adulthood. This new program will focus on implementing innovative strategies to improve health outcomes for youth with autism/DD and providing support for youth with autism/DD and their families in transitioning from child to adult serving systems. The overall goal of the demonstration program is for youth with autism/DD to thrive as adults in their schools, communities, and workplaces.

Budget Request

The FY 2024 Budget Request for the Autism and Other Developmental Disabilities program of $57.3 million is $1 million above the FY 2023 Enacted level. This request will continue support for training programs and research with a focus on improving access, quality, and systems of care for underserved children, adolescents, and young adults with autism or other DD.

This requested funding will allow the program to serve approximately 125,000 children. This funding will also support the LEND and DBP programs to address unmet needs and disparities in evaluation, diagnosis, and treatment. The funding increase will continue support for the DBP program including increased fellowship opportunities for existing awardees

Funding also supports a new demonstration program that will focus on family and youth engagement. The National Transition Center for Autism and Epilepsy will support grantees. This center provides national leadership to grantees and other stakeholders including technical assistance, training, and resources to autism demonstration grantees on family engagement, strategic partnership building, implementation science, policy analysis, assessment, and quality improvement.

The Budget Request does not include funding for the state systems grants, as the program shifts to focus on helping youth with autism/DD transition to adulthood.

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.

Funding History

Fiscal Year	Amount
FY 2020	$52,344,000
FY 2021	$53,184,000
FY 2022	$54,344,000
FY 2023	$56,344,000
FY 2024 President’s Budget	$57,344,000

Program Accomplishments

Recent Training Accomplishments
Data from FY 2020 showed that the LEND and DBP programs collectively provided:

- Diagnostic services to confirm or rule out autism/DD to over 115,000 children
- Training to nearly 17,500 trainees in pediatrics, developmental-behavioral pediatrics, other health professions, and people with lived experience
- Over 3,300 continuing education events on early screening, diagnosis, and services that reached over 270,000 pediatricians and other health professionals

In FY 2020, long-term trainees in the program included:

- 24% from underrepresented racial groups
- 13% who identified as Hispanic or Latino

Recent Research Accomplishments
Accomplishments from the Autism Research Networks and Autism Single Investigator Innovation Programs in FY 2021 include:

- Completed 95 studies on physical and behavioral health issues related to autism/DD, screening and diagnostic measures, early intervention, and transition to adulthood
- Enrolled 17,857 participants in primary research studies through 52 research sites across the country and included 1,049,578 participants in secondary data analyses
- Developed 65 peer-reviewed publications in leading scholarly journals
- Research findings contributed to the evidence that supports clinical and public health recommendations. For example, research findings from the Autism Longitudinal Data Project contributed to the evidence that support the following clinical and public health recommendations: (1) updated CDC guidelines on lowering lead exposure levels of health concern; and (2) consensus statement on acetaminophen use during pregnancy published in Nature Review of Endocrinology.

State Systems Accomplishments
During 2020-2021, state awardees:

- Partnered with 6 primary care practices to implement family navigation services and participate in provider trainings.
- Employed 28 family navigators.
- Served 1074 families by providing children with autism/DD or with increased likelihood of being diagnosed with autism/DD with screening, diagnosis, referral to early intervention or related services, and enrollment in community-based services before 36 months of age.
- Promoted and facilitated developmental screening services and follow-up.
- Increased awareness of autism/DD through stakeholder meetings, online learning communities, or one-time trainings that covered autism generally, intervention services, and assistance programs to families, primary care providers and community-based providers.
- Engaged family members and family advocates through trainings or training institutes, steering committees, and family support organizations through:
    - 34 webinars for primary care physicians reaching 563 attendees;

- Community and family trainings, reaching approximately 6000 participants; and
- Hosting six community and family learning communities on developmental screenings, reaching over 600 participants.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3020.02**:** Percentage of Leadership Education Neurodevelopmental and Other Related Disabilities (LEND) Training Program long-term trainees who at 5 years post-training have worked in an interdisciplinary manner to serve the MCH population (Outcome)	FY 2020 Result: 95% Target: Maintain prior year result of 94% (Target Exceeded)	90%	92%	+2 percentage points
3020.04: Percentage of Developmental-Behavioral Pediatrics (DBP) Training Program long-term trainees working with underserved populations, 5 years post-training (Outcome)	FY 2020 Result: 100% Target: Maintain prior year result of 91% (Target Met)	87%	90%	+3 percentage points
3020.05: Percentage of Developmental-Behavioral Pediatrics (DBP) Training Program long-term trainees who at 5 years post-training have worked in an interdisciplinary manner to serve the MCH population (Outcome)	FY 2020 Result: 93% Target: 100% (Target Not Met)	90%	92%	+2 percentage points

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3020.06: Percentage of Leadership Education in Neurodevelopmental and Other Related Disabilities (LEND) Training Program long-term trainees working with underserved populations 5 years post-training (Outcome)	FY 2020 Result: 82% Target: Maintain prior year result of 82% (Target Met)	82%	84%	+2 percentage points
3020.01**:** Percentage of long-term trainees (LEND, DBP) working with underserved populations, 5 years post-training (Outcome)	**LEND** FY 2020: 82% (5 years) Target: Maintain prior year result of 82% (5 years) (Target Met) **DBP** FY 2020: 100% (5 years) Target: Maintain prior year result of 91% (5 years) (Target Met)	**LEND** 82% **DBP** 87%	Discontinued	N/A
3020.03**:** Percentage of MCHB Autism research programs with at least two scientific publications in the past year (Outcome)	FY 2021: 100% Target: Not Defined (Target Not in Place)	Not Defined	Discontinued	N/A

Performance Narrative

- Measure 3020.01 has been discontinued and disaggregated into two new measures, 3020.04 and 3020.06.
- Measure 3020.02 has been modified to disaggregate the LEND and DBP data. Measure 3020.02 now reflects LEND results whereas 3020.05 is a new measure reflecting DBP results. For measures 3020.02, HRSA has established modest target increases for FY 2024 that are lower than the most recent results. This is because the LEND program recompeted in FY 2021 which included a new cohort of awardees that typically impacts

program results in the first few years with incremental increases over the award cycle. Furthermore, the impacts of COVID-19 may influence trainee results. Since these measures track trainees 5-years post training, impacts from COVID-19 on LEND trainees and their career paths will not be reflected in the recent FY2020 results. The modest increase reflects these considerations.

- For measures 3020.04 and 3020.05, HRSA has established modest target increases for FY 2024 that are lower than the most recent results. This is because the DBP program recompetes in FY 2023 which will include a new cohort of awardees that is expected to impact program results. Furthermore, the impacts of COVID-19 may influence trainee results. Since these measures track trainees 5-years post training, impacts from COVID-19 on DBP trainees and their career paths will not be reflected in the recent FY 2020 results.
- For measure 3020.03, the following grants are included in the FY 2021 data calculation: Autism Intervention Research Network on Behavioral Health, Autism Intervention Research Network on Behavioral Health, Developmental-Behavioral Pediatrics Research Network, Healthy Weight Research Network for Children with Autism Spectrum Disorders and other Developmental Disabilities, Autism Transitions Research Project, Autism Longitudinal Data Project, Autism Single Investigator Innovation Program, and Autism Field-Initiated Innovative Research Studies Program; Autism Secondary Data Analysis Research Program grants are excluded, as they are one-year grants.

Grant Awards Table

Awards	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
LEND	$36,899,604	$37,767,743	$37,767,743
DBP	$2,286,935	$3,238,380	$4,087,380
Research	$7,422,793	$7,396,353	$7,523,688
State Systems	$1,855,270	$1,800,000	$1,745,000
Resource Centers	$926,000	$975,000	$1,030,000
Number of Awards	90	90	94
Average Award	$548,784	$568,639	$554,828

Sickle Cell Disease Treatment Demonstration Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$7,010,000	$8,205,000	$8,205,000	---
FTE	2	2	2	---

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

FY 2024 Authorization .....Expired

Allocation Methods:

- Competitive grant/co-operative agreement
- Contract

Program Description

The purpose of the Sickle Cell Disease Treatment Demonstration Program (SCDTDP) is to increase access to quality, coordinated, comprehensive care for individuals with sickle cell disease (SCD) by:

- Increasing the number of clinicians or health professionals knowledgeable on evidence-based treatment of SCD and improving quality of care; and
- Improving care coordination with other providers.

First established in 2004, the SCDTDP was reauthorized in 2018 by the Sickle Cell Disease and Other Heritable Disorders Research, Surveillance, Prevention and Treatment Act (P.L. 115-327).

Sickle Cell Disease is a genetic condition where abnormal red blood cells can block blood flow to organs and tissues, causing anemia, periodic pain episodes, tissue and organ damage, and increased risk of infections and early death. SCD affects over 100,000 individuals in the U.S., and disproportionately affects Black (1 of every 365 births) and Hispanic Americans (1 of every 16,300 births).[84] While advances in science and medicine mean individuals living with SCD have an increased life expectancy, not everyone who needs therapy and treatment has been able to benefit equally. Individuals with SCD have unequal access to comprehensive, quality health care and treatment because the distribution of specialized providers across the U.S. and the jurisdictions is uneven; some primary care providers have less comfort treating and caring for individuals with SCD; primary care providers lack training; and social factors, such as racism, income, and stigma also play a substantial role. The program uses a regional model to address these barriers and help prevent and treat SCD complications.

[84] https://www.cdc.gov/ncbddd/sicklecell/data.html

Five regional SCDTDPs work collectively to improve health equity by increasing access to evidence-based care in the communities in which SCD patients live, and continuing telehealth support for access to services. The program supports partnerships between clinicians and community organizations to improve the quality of care provided to patients with SCD, and educates providers, families, and patients to improve knowledge and capacities, particularly as patients transition to adult health care settings.

The Hemoglobinopathies National Coordinating Center (HNCC) provides technical assistance to the SCDTDP by leading quality improvement activities and supporting topic-specific workgroups to address priorities and emerging needs identified by grantees. The HNCC is responsible for collecting data on SCDTDP activities that informs a report to Congress, which is planned for delivery in FY 2026. In addition to developing a report to Congress, the HNCC collects information from the SCDTDP that provides clinicians, nurses, allied health professionals, community-based organizations and public health agencies with best practices and strategies to improve sickle cell disease care.

Budget Request

The FY 2024 Budget request for the Sickle Cell Disease Treatment Demonstration program of $8.2 million is equal to the FY 2023 Enacted level. This request will continue support for the regional SCD infrastructure so that individuals with SCD can lead full and productive lives regardless of where they live. SCDTDP partners with states to develop and support knowledgeable SCD care teams to improve and increase access to appropriate care; 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.

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

Funding History

Fiscal Year	Amount
FY 2020	$5,205,000
FY 2021	$7,183,000
FY 2022	$7,010,000
FY 2023	$8,205,000
FY 2024 President’s Budget	$8,205,000

Program Accomplishments

According to data from the last funding cycle of August 1, 2017—July 31, 2021, the program successfully reached individuals with SCD, health care providers, and the community. The following accomplishments were reported:

- Served over 30,000 individuals in 51 sites annually;

- Partnered with 49 community organizations, leveraging their community expertise to link individuals and local families to knowledgeable providers and provide resources on treatment options and social services. This strategy ultimately improves access and quality of care for individuals with SCD.
- Collaborated with 200,000 health care providers through telehealth, tele-mentoring, junior faculty coaching, grand rounds, and specialized COVID-19 seminars to build capacity among local provider networks and increase the number of providers administering evidence-based SCD care.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3030.01: Number of sickle cell patients served by Sickle Cell Disease Treatment Demonstration Program network providers in the past year (Output)	FY 2021: 30,545 Target: Not Defined (Historical Actual)	31,000	32,000	+1,000
3030.02: Percentage of individuals with sickle cell disease receiving disease modifying therapies within a Sickle Cell Disease Treatment Demonstration Program (Outcome)	FY 2021: 38% Target: Not Defined (Historical Actual)	39%	40%	+1 percentage point

Performance Narrative

- The data for measure 3030.01 was reported by each SCDTDP in March 2022 as their baseline data requirement for the new funding cycle.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	5	5	5
Average Award	$1,000,000	$1,191,215	$1,191,215
Range of Awards	$900,000-$1,150,000	$900,000-1,150,000	$900,000-1,150,000

Early Hearing Detection and Intervention

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$17,818,000	$18,818,000	$18,818,000	---
FTE	5	5	5	---

Authorizing Legislation ..... Public Health Service Act, Title III, Section 399M, as amended by Public Law 117-241

FY 2024 Authorization $17,818,000

Allocation Methods:

- Competitive grant/co-operative agreement

Program Description

The Early Hearing Detection and Intervention (EHDI) program helps states, territories, families, and providers ensure that newborns, infants, and young children up to three years of age who are deaf or hard of hearing get the care they need when they need it. Early involvement can help these children meet age-appropriate language, social, and developmental milestones. This program:

- Recruits, educates, and trains staff and health care providers on current evidence-based practices and national EHDI system goals;
- Improves access to early intervention services and language acquisition; and
- Improves family engagement, education, partnership, and leadership to strengthen family support.

First established in 2000, the Early Hearing Detection and Intervention Act of 2022 (P.L. 117-241) most recently reauthorized the program.

The program funds 59 competitive grants to states and jurisdictions to develop coordinated statewide EHDI systems of care and two technical resource centers to support these efforts. The program also empowers families to serve as leaders through activities that train families to increase their engagement and support in EHDI systems of care.

Funding also supports supplemental awards to 12 Leadership Education in Neurodevelopmental and Related Disabilities (LEND) training programs supported by the Autism and Other Developmental Disabilities program to train future leaders in pediatric audiology.

Budget Request

The FY 2024 Budget Request for the Early Hearing Detection and Intervention Program of $18.8 million is equal to the FY 2023 Enacted level. The Budget Request will continue to support 59 competitive grants to states and jurisdictions, technical assistance, 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, information technology, and other program support costs.

Funding History

Fiscal Year	Amount
FY 2020	$17,818,000
FY 2021	$17,765,000
FY 2022	$17,818,000
FY 2023	$18,818,000
FY 2024 President's Budget	$18,818,000

Program Accomplishments

Before 1993, fewer than 1 in 10 newborns in the U.S. were screened for hearing loss, but now nearly all are screened. Since the EHDI program started, states and territories have had significant success identifying and getting services for newborns and infants with hearing loss. The EHDI Program continues to work with states to meet the Healthy People 2030 objectives of screening no later than one month of age, conducting audiologic evaluations no later than three months of age, and enrolling in early intervention services no later than six months of age (1-3-6 objectives). In 2020, 97.2% of infants were screened before one month of age, 60.6% were diagnosed before three months of age, and 72.4% were enrolled in early intervention before six months of age.[85] Despite the progress, 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.

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 are undocumented as they have not been reported to the EHDI Program). In addition, the EHDI Program encourages awardees to develop an integrated EHDI health information system that allows communication and protected data sharing among health care providers. This ensures that newborns, infants, and young children up to three years of age receive pertinent screenings and follow-up services.

[85] 2020 CDC EHDI Hearing Screening & Follow-up Survey (HSFS) data. https://www.cdc.gov/ncbddd/hearingloss/ehdi-data2020.html

Additionally, awardees were 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. States identified priority areas to increase access to services, supports, and education in rural areas for non-English speaking families and increased opportunities for family engagement and leadership for diverse families. Since the program's inception, states and jurisdictions have had significant success in identifying newborns and infants who are deaf or hard of hearing.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2024
3040.01**:** Percentage of infants screened for hearing loss prior to one month of age (Output)	FY 2020: 97.2% Target: 98% (Target Not Met)	98%	98%	Maintain
3040.02**:** Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by three months of age (Output)	FY 2020: 60.6% Target: 77% (Target Not Met)	79%	79%	Maintain
3040.03**:** Increase the percentage of infants with hearing loss enrolled in early intervention before six months of age (Output)	FY 2020: 72.4% Target: 72% (Target Exceeded)	73%	73%	Maintain

Performance Narrative

- For measure 3040.02, the percent decrease in FY 2020 is due to several factors associated with the pandemic, including staffing shortages, facility closures, limited hours for outpatient procedures, families sick or quarantining, and parental hesitancy to return for follow-up services. HRSA is not lowering targets for FY 2023 and FY 2024 at this time based on the FY 2020 results since it is anticipated numbers will rebound to pre-COVID-19 pandemic levels in future years. For comparison, the FY 2019 result for this measure was 79.1%.
- "Confirmed" diagnosis refers to a documented diagnosis, which is consistent with terminology used in newborn hearing screening programs.
- Measure 3040.03 is 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.

Grant Awards Table[86]

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	59	59	59
Average Award	$218,660	$243,931	$243,931
Range of Awards	$103,445 -$235,000	$243,931	$243,931

[86] Does not include EHDI National Technical Resource Center cooperative agreement ($0.85M), 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 ($154,000 in FY 2022; $0 in FY 2023 and $0 in FY 2024), Cares National Interdisciplinary Training Resources Center ($100,000), and Bright Futures Pediatric Implementation ($200,000 in FY 2023).

Emergency Medical Services for Children

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$22,276,000	$24,334,000	$28,134,000	+$3,800,000
FTE	6	6	6	---

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

FY 2024 Authorization $22,334,000

Allocation Method

- Competitive grant/co-operative agreement
- Contract

Program Description

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.

Children have unique emergency care needs, especially during serious or life-threatening emergencies. 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 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 providers must be knowledgeable and skilled in carrying out pediatric emergency triage, procedures, and treatments while using protocols that consider the pediatric patient's developmental needs including the importance of their relationship with family. It is critical that EMS systems are optimally prepared to provide high-quality pediatric care at the site of an injury and during transportation to a hospital, also referred to as prehospital EMS, and in emergency departments, also referred to as hospital EMS.

In recent years, the EMSC Program has invested in programs that interact to expand and improve pediatric emergency care across the U.S.:

- The EMSC State Partnership Program forms a national network across the U.S. to increase uptake and adoption of evidence-based system improvements and pediatric readiness guidelines in prehospital and hospital settings.
- The National Pediatric Readiness in EDs project is a collaborative national initiative that assesses pediatric readiness in more than 5,000 of our nation's EDs and develops resources to expand pediatric readiness in EDs.
- The National Pediatric Readiness in EMS agencies project is a collaborative national initiative that aims to assess pediatric readiness in more than 16,000 EMS agencies and develops resources to expand pediatric readiness in EMS agencies.
- The EMSC Innovation and Improvement Center supports quality improvement initiatives to increase implementation of evidence-based clinical guidelines, and drive expansion of pediatric readiness in EMS agencies and EDs in each state and jurisdiction.
- The Pediatric Emergency Care Applied Research Network (PECARN) provides infrastructure support for research that improves pediatric emergency clinical care.
- The Targeted Issues program studies how expansion of pediatric emergency readiness across the nation impacts pediatric health outcomes.
- The EMSC Data Center tracks performance improvement efforts across all funded states and jurisdictions and serves as a central data coordinating entity for PECARN research.

Budget Request

The FY 2024 Budget Request for the Emergency Medical Services for Children program of $28.1 million is $3.8 million above the FY 2023 Enacted level. This request will provide support to states to address critical gaps that remain for expanding access to pediatric readiness in EMS agencies and EDs to ensure that EDs have the essential guidelines and resources in place to provide effective emergency care to children.

Pediatric readiness in prehospital EMS agencies is critically important for severely ill and injured children. Currently, only 25 percent of EMS agencies require EMS practitioners to demonstrate the effective use of pediatric equipment and only 36 percent have a dedicated pediatric emergency care coordinator.[87] The funding request will continue to support the EMSC State Partnership Program in helping states increase pediatric readiness in their state's EMS agencies through support for quality improvement efforts and policy initiatives. Funding will also support states in establishing Pediatric Recognition Programs for EMS agencies and EDs.

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

[87] Data reported by EMSC State Partnership performance reports.

Funding History

Fiscal Year	Amount
FY 2020	$22,334,000
FY 2021	$22,267,000
FY 2022	$22,276,000
FY 2023	$24,334,000
FY 2024 President's Budget	$28,134,000

Program Accomplishments

Notable accomplishments of the EMSC Program include:

- **Nationally Assessed the Pediatric Readiness of EDs:** In 2021, HRSA collaborated with national organizations in a multi-phase survey and quality improvement initiative involving 5,150 hospitals. This survey, which had a response rate of 71%, found that the average pediatric readiness of EDs increased from 69 in 2013 to 71 in 2021, out of a total possible score of 100, which indicates that many EDs are still struggling to be optimally prepared to care for children. Pediatric readiness ensures that all U.S. EDs have access to recommended pediatric readiness guidelines and resources to provide optimal emergency care to children.
- **Increased our Understanding of the Importance of Pediatric Readiness:** In 2021, a HRSA-funded Targeted Issues study found that children with trauma who were cared for in a trauma center ED with lower pediatric readiness were more likely to die than children cared for in a trauma center ED with higher pediatric readiness.[88] Another Targeted Issues study found that EMS transports of critically ill children to EDs with lower pediatric readiness, who could have been transported to EDs with higher pediatric readiness, were more likely to die.[89] These findings highlight the need for hospital EDs to raise their level of pediatric readiness.
- **Supported the Expansion of Evidence Based Guidelines:** In 2022, to improve the emergency care of children in pain, HRSA jointly funded the development of Evidence-Based Guidelines for Prehospital Pain Management.[90,91] These recommendations help EMS providers learn how to safely treat pain in children as they are transported to an ED.

[88] Newgard CD, Lin A, Olson LM, Cook JN, Gausche-Hill M, Kuppermann N, Goldhaber-Fiebert JD, Malveau S, Smith M, Dai M, Nathens AB. Evaluation of emergency department pediatric readiness and outcomes among US trauma centers. JAMA Pediatrics. 2021 Sep 1;175(9):947-56.
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[90] Lindbeck G, Shah MI, Braithwaite S, Powell JR, Panchal AR, Browne LR, Lang ES, Burton B, Coughenour J, Crowe RP, Degn H. Evidence-based guidelines for prehospital pain management: Recommendations. Prehospital Emergency Care. 2021 Dec 23:1-10.
[91] Powell JR, Browne LR, Guild K, Shah MI, Crowe RP, Lindbeck G, Braithwaite S, Lang ES, Panchal AR. Evidence-based guidelines for prehospital pain management: Literature and methods. Prehospital Emergency Care. 2021 Dec 23:1-8.

- **Advanced EMSC Science and Clinical Practice:** In 2021**,** PECARN identified new, more effective approaches to treating children in a diabetic crisis that reduce risk of poor neurological outcomes.[92,93]
- **Advanced EMSC Health Equity Research and Care**: EMSC State Partners are addressing health inequities that have previously been documented by PECARN-supported research, through virtual trainings focusing on the needs of children in rural and tribal areas, increasing diverse representation on EMSC advisory councils, and increasing EMS relationship-building with the families of children with special health care needs.[94,95]
- **Expanded Pediatric Education Program in Native American Communities**: In 2021, in partnership with the Indian Health Service, HRSA expanded a simulation-based pediatric education program across seven Indian Health Service and tribal EDs. These simulations trained ED staff in critical pediatric emergency care skills that will improve care delivery for American Indian/Alaska Native children.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3050.01**:** Percentage of responding Emergency Medical Services agencies nationwide that have a pediatric emergency care coordinator (Outcome)	FY 2021: 36% Target: Not Defined (Historical Actual)	39%	40%	+1 percentage point

[92] Rewers A, Kuppermann N, Stoner MJ, Garro A, Bennett JE, Quayle KS, Schunk JE, Myers SR, McManemy JK, Nigrovic LE, Trainor JL, Tzimenatos L, Kwok MY, Brown KM, Olsen CS, Casper TC, Ghetti S, Glaser NS. Effects of fluid rehydration strategy on correction of acidosis and electrolyte abnormalities in children with diabetic ketoacidosis. Diabetes Care. 2021;44(9):2061–8.

[93] Glaser NS, Stoner MJ, Garro A, Baird S, Myers SR, Rewers A, Brown KM, Trainor JL, Quayle KS, McManemy JK, DePiero AD. Serum sodium concentration and mental status in children with diabetic ketoacidosis. Pediatrics. 2021 Sep 1;148(3):e2021050243.

[94] Goyal MK, Chamberlain JM, Webb M, Grundmeier RW, Johnson TJ, Lorch SA, Zorc JJ, Alessandrini E, Bajaj L, Cook L, Alpern ER; Pediatric Emergency Care Applied Research Network (PECARN). Racial and ethnic disparities in the delayed diagnosis of appendicitis among children. Acad Emerg Med. 2021 Sep;28(9):949-56.

[95] Drendel AL, Brousseau DC, Casper TC, Bajaj L, Alessandrini EA, Grundmeier RW, Chamberlain JM, Goyal MK, Olsen CS, Alpern ER. Opioid prescription patterns at emergency department discharge for children with fractures. Pain Medicine. 2020 Sep;21(9):1947-54.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3050.02: Percentage of states and jurisdictions that have an established Pediatric Readiness Recognition program for hospital emergency departments capable of managing and stabilizing pediatric emergencies (Outcome)	FY 2021: 29% Target: Not Defined (Baseline)	31%	35%	+4 percentage points
3050.03**:** Number of children enrolled in Pediatric Emergency Care Applied Research Network (PECARN) studies (Outcome)	FY 2022: 158,249 Target: 135,000 (Target exceeded)	144,000	168,000	+24,000
14.4**:** Percentage of responding hospitals nationwide that have written interfacility transfer guidelines that cover pediatric patients and that include specific components of transfer (Outcome)	FY 2021: 62% Target: Not Defined (Historical Actual)	65%	Discontinued	N/A

Performance Narrative

- For all FY 2021 targets noted in the table, targets were not defined because the FY 2021 Congressional Justification zeroed out the program. Targets are not set when no funding is proposed for a program.
- Data source for the pediatric emergency care coordinator measure (3050.01) is the EMSC Data Center annual survey.
- The Pediatric Recognition Readiness measure (3050.02) is a new measure in the FY 2024 Congressional Justification. The data source for the measure is the EMSC performance reports submitted by grantees.
- Data for the PECARN measure (3050.03) is gathered through grantee reporting to the EMSC Data Center.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget[96]
Number of Awards	72	73	69
Average Award	$270,465	$289,217	$349,163
Range of Awards	$130,000-$3,200,000	$130,000-$3,200,000	$130,000-$3,200,000

[96]A revising of the EMSC portfolio will result in the five Targeted Issues grants becoming one cooperative agreement that will improve the EMSC program.

Healthy Start

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$131,340,000	$145,000,000	$185,000,000	+$40,000,000
FTE	18	22	25	+3

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

FY 2024 Authorization $125,500,000

Allocation Method:

- Competitive grant/co-operative agreement

Program Description

The purpose of the Healthy Start Program is to improve infant and maternal health outcomes before, during, and after pregnancy, and to reduce persistent racial and ethnic disparities in infant deaths and adverse perinatal (immediately before and after birth) health outcomes.

The Healthy Start Program began in 1991 under the Public Health Service Act, Title III, Part D, Section 330H (42 U.S.C 254c-8) and was reauthorized in March 2020 by the Coronavirus Aid, Relief, and Economic Security Act, or CARES Act (P.L. 116-136). Healthy Start serves 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 2022, Healthy Start funded 101 competitive grants to higher-risk communities in 35 States, the District of Columbia, and Puerto Rico.

Healthy Start projects tailor their services to their community's needs to maximize the program's impact on the enrolled individuals as well as the overall community. Healthy Start services start with community health workers reaching out to women who are at an increased risk of adverse maternal health outcomes. Each enrolled family receives a standardized, comprehensive assessment that facilitates discussion about individual and household characteristics, physical and behavioral health, access to and utilization of health care, health and parenting behaviors, the need for referrals to additional services, and more. Case managers provide and/or link women and families to appropriate services, including:

- **Health care services**
    - Prenatal, postpartum, well-baby, youth care, reproductive life planning, and women's health

    - Screening and referral to services for depression, substance use, and interpersonal violence
- **Services that increase access to health care and improve health outcomes**
    - Screening and referrals for health care; insurance; and social services such as WIC, home visiting, and doula (health workers who provide support before, during, and after birth) services
    - Parenting skill building, self-esteem building, childcare, and supports for fathers/partners
    - Transportation, language translation, housing assistance, job training, and prison/jail-based services
- **Public Health Services**
    - Immunization and health education (for example, smoking cessation, youth pregnancy prevention, childbirth education, breastfeeding and nutrition)
- **Provider and Community training**
    - Continuing education and training on best practices for Healthy Start staff and community partners

After a plateau between 2000 and 2005, the U.S. infant mortality rate declined approximately 21 percent overall between 2005[97]and 2021[98] to a record low of 5.44 infant deaths per 1,000 live births. However, the non-Hispanic Black infant mortality rate is more than double that for non-Hispanic Whites.[99,100] In 2021, the five leading causes of infant mortality in the U.S. included birth defects, preterm birth and low birthweight, sudden infant death syndrome, unintentional injuries, and maternal complications.[101] Healthy Start works with women who are at higher risk for adverse perinatal health outcomes and with their families, to reduce disparities by providing and/or facilitating access to needed services to improve the health of mothers and children before, during, and after pregnancy, and through the first 18 months after birth. With the ongoing emphasis on including the partners of enrolled women, the program also actively recruits fathers and partners in education, activities, services, and events.

Healthy Start grantees collaborate within local communities to build upon a community's existing resources to improve the quality of, and access to, health care and other supports. Every Healthy Start project has a Community Action Network (CAN) composed of neighborhood

[97] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html on Aug 11, 2021 1:58:19 PM
[98] NCHS Data Brief No. 456, December 2022; Mortality in the United States, 2021 (cdc.gov). Accessed at https://www.cdc.gov/nchs/data/databriefs/db456.pdf on Jan 19, 2023.
[99] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 2018-2021 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on Jan 20, 2023 11:08:15 AM
[100] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2007-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/natality- current.html on Dec 3, 2022 12:33:45 AM.
[101] NCHS Data Brief No. 456, December 2022; Mortality in the United States, 2021 (cdc.gov). Accessed at https://www.cdc.gov/nchs/data/databriefs/db456.pdf on Jan 19, 2023.

residents, community leaders, consumers, medical and social service providers, faith-based leaders, and business representatives. The CAN addresses fragmented service delivery and supports culturally and linguistically appropriate services. Grantees also collaborate with other local programs and at the federal and state levels. Some collaborations include:

- Maternal, Infant, and Early Childhood Home Visiting Program
- Title V State Maternal and Child Health Block Grant
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Early Head Start
- Medicaid
- Children's Health Insurance Program (CHIP)
- Local community health centers that provide maternity care services

These collaborations strengthen the services provided to Healthy Start families 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.

With the increase in funding provided in FY 2023, HRSA launched a new competition to support the Enhanced Healthy Start pilot program model in 10 new communities with the highest rates of perinatal health disparity in the country to reduce racial disparities in poor maternal and infant health outcomes. These recipients will continue to support individual physical, and behavioral client interventions while also addressing the unique structural, environmental, and systemic factors that contribute to disparities in poor outcomes for mothers and their babies. Grant recipients will engage a broader set of partners—from sectors such as education, labor, public safety, and housing—in order to address social determinants of maternal and infant health.

HRSA supports the Healthy Start Technical Assistance (TA) Center to support program implementation through technical assistance, training, and education for grantees, including the FY 2023 Enhanced Healthy Start pilot grantees. Healthy Start TA Center services strengthen staff skills to implement evidence-based practices in maternal and child health; facilitate grantee-to-grantee sharing of expertise and lessons learned from the field; and facilitate resource sharing for effective program delivery. The Healthy Start TA Center provided instrumental COVID-19-related training to Healthy Start grantees impacted by the COVID-19 pandemic.

Budget Request

The FY 2024 Budget Request for the Healthy Start Program of $185.0 million is $40 million higher than the FY 2023 Enacted level. The FY 2024 funding request will also support a recompetition of the program to serve women and families across the Nation through approximately 101 new grants.

Recognizing that improving birth outcomes begins with improving women's health before, during, and after pregnancy, funding will continue to improve access to quality health care and support services for women and children throughout the prenatal, postpartum, and inter-conception periods. Within this total, $15.0 million will continue to support grantees to hire clinical service providers at Healthy Start sites to provide direct access to well woman care and maternity care services. This will reduce barriers to care and better address health disparities

among high-risk and underserved women. This funding will also continue a $13.1 million Enhanced Healthy Start pilot funded in FY 2023 that supports up to 10 awards in new communities with the highest rates of perinatal health disparity in the country to address the unique structural, environmental, and systemic factors that contribute to disparities in poor outcomes for mothers and their babies.

The Budget Request also includes $40 million within the Healthy Start Program to expand the scope of Healthy Start grants by investing in promising practices learned from the "Benefits Bundle" pilots initiated in FY 2023. This pilot is focused on most effectively and efficiently utilizing government resources by developing innovative, family-centered approaches to making enrollment in existing public benefits easier for eligible low-income families, addressing social determinants of health (food insecurity, unstable housing, lack of transportation), and delivering culturally competent care. Healthy Start grantees will leverage this additional funding to implement these innovative Benefit Bundle pilot approaches for the clients and communities they serve. Healthy Start grantees will demonstrate improvement on defined Benefits Bundle measures, such as increased enrollment of underserved communities in existing safety net supports, increased multi-program enrollment, and improved mental health of parents. HRSA will collaborate with evaluation staff within the agency and at HHS, including HHS' Evaluation Officer in ASPE, to ensure evaluation and evidence building are incorporated in this effort.

This initiative follows the White House's commitment to improve the Federal Customer Experience by making service delivery of available benefits more efficient for women and families and ultimately improving infant and early childhood development outcomes.

The funding request also includes costs associated with the Healthy Start Monitoring and Evaluation Data (HSMED) system as well as the grant review and award process, follow-up performance reviews, information technology, and other program support costs.

Funding History

Fiscal Year	Amount
FY 2020	$125,500,000
FY 2021	$128,000,000
FY 2022	$131,340,000
FY 2023	$145,000,000
FY 2024 President's Budget	$185,000,000

Program Accomplishments

In FY 2019, Healthy Start funded a new initiative to reduce maternal mortality by hiring clinical service providers (e.g., nurse practitioners, certified nurse midwives, physician assistants, behavioral health providers, and other maternal-child advanced practice health professionals) to provide clinical support, such as well-woman care and maternity care services, within program sites nationwide. In FYs 2019 through 2023, HRSA used $15 million per year to support these activities within existing Healthy Start awards. Available data show that by the end of 2021, nearly 200 clinicians were providing care at 92 grant sites through this funding.

In 2021, HRSA funded supplemental grants to help train, certify, and pay for community-based doulas in Healthy Start service areas. This funding increased the pool of available doulas in communities with higher rates of infant deaths and racial and ethnic differences in the health outcomes of infants and pregnant people. In FY 2021, the first opportunity supported 25 Healthy Start projects in 19 states. In 2022, HRSA announced the second funding opportunity for current Healthy Start sites to further grow, diversify, and sustain the community-based doula workforce. This funding will increase the total number of Healthy Start doula programs from 25 to approximately 38 nationwide.

Key program accomplishments highlighted below reflect FY 2021 outcomes among Healthy Start Program participants. This is the third year of data reporting for the cohort of grantees initially funded in FY 2019. In FY 2021, the program exceeded two of the three performance measure targets: timely prenatal care utilization and number of participants served. The program did not meet the target for low birthweight infants, possibly reflecting the national increase in preterm birth rate in 2021 (the highest reported since 2007)[102], as well as the program's focus on reaching the highest risk populations in communities with elevated rates of infant mortality and adverse perinatal outcomes.

The Healthy Start Program served approximately 72,000 women and children in FY 2021, in addition to nearly 4,800 men. During the same period, Healthy Start projects screened 99 percent of women participants for depression, with 85 percent of those who screened positive receiving referral for services (of the remainder, some have already been receiving services or declined a referral) In addition, with the funding made available starting in FY 2019 to hire more clinical service providers as part of the initiative to reduce maternal mortality, 92 Healthy Start grantees have hired 198 new clinical providers. Between November 2019 and October 2021, these clinicians provided 29,644 in-person visits and nearly 15,000 telehealth visits, including well-woman care, prenatal care, postpartum care, and behavioral health counseling.

The 2019-2021 (three-year average) infant mortality rate (IMR) in the U.S. was 5.48 per 1,000 live births, and 7.17 per 1,000 live births for Healthy Start participants.[103] The higher rates for Healthy Start participants likely reflects the high-risk populations that are targeted by the program. The current Healthy Start grantee cohort began in 2019, as new grantees entered the program and some current grantees changed service areas to address areas of greater need. As

[102] Hamilton BE, Martin JA, Osterman MJK. Births: Provisional data for 2021. Vital Statistics Rapid Release; no 20. Hyattsville, MD: National Center for Health Statistics. May 2022. https://www.cdc.gov/nchs/data/vsrr/vsrr020.pdf

[103] A multi-year infant mortality rate (IMR) is reported for 2019-2021. This allows the Healthy Start Program to track infant mortality while taking into consideration that infant death is a rare event. 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 2019 to 2021 are as follows:
2019: Healthy Start 8.05 per 1,000 live births, United States 5.58 per 1,000 live births
2020: Healthy Start 7.04 per 1,000 live births, United States 5.42 per 1,000 live births
2021: Healthy Start 6.67 per 1,000 live births, United States 5.44 per 1,000 live births
Healthy Start Data Source: Healthy Start Aggregate Reporting Spreadsheet/Birth-Death
U.S. IMR Data Sources:
2019, 2020: https://www.cdc.gov/nchs/products/databriefs/db427.htm
2021: https://www.cdc.gov/nchs/data/databriefs/db456.pdf

noted in the table below, Healthy Start single-year IMRs have decreased with each successive year as grantees are able to better serve their participants.

Table 1.0 Single Year Infant Mortality Rates in the U.S. and among Healthy Start Participants

Year	U.S. Single Year Infant Mortality Rates (per 1,000 live births)	Healthy Start Single Year Infant Mortality Rates (per 1,000 live births)
2019	5.58	8.05
2020	5.42	7.04
2021	5.44	6.67

Healthy Start is committed to data-driven and evidence-based decision-making. In FY 2021, HRSA invested in a four-year contract to conduct a national evaluation of the Healthy Start program to determine the effectiveness of the program. The evaluation concludes in FY 2025, and results will be used to inform decision-making and develop recommendations to improve implementation of the Healthy Start program.

These efforts continue to build from evaluation work that began in 2017 when Healthy Start initiated a national evaluation that showed positive outcomes related to program goals.[104] These include earlier and more frequent prenatal care visits, greater engagement in infant safe sleep practices, and lower rates of low birthweight deliveries. Healthy Start participants also met or exceeded targets with respect to usual source of care and depression screening.

To address the impact of COVID-19 in Healthy Start communities, the Healthy Start Technical Assistance Center provided Beyond COVID-19- Webinar Series information sessions to grantees impacted by the COVID-19 pandemic. Topics covered include breastfeeding, reconnecting and reengaging clients, and mental health.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3060.01: Increase the percentage of pregnant women enrolled in Healthy Start who have a prenatal care visit in the first trimester (Outcome)	FY 2021: 85% Target: 80% (Target Exceeded)	84%	84%	Maintain

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

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3060.02: Decrease the percentage of singleton births weighing less than 2,500 grams (low birthweight) born to women enrolled in Healthy Start (Outcome)	FY 2021: 12.2% Target: 9.6% (Target Not Met)	9.6%	9.6%	Maintain
3060.03: The number of persons case managed in the Healthy Start Program (Outcome)	FY 2021: 77,019 Target: 75,000 (Target Exceeded)	82,000	82,000	Maintain

Performance Narrative

- Fiscal year targets reflect calendar year data. Awards are made annually in April, thus the bulk of the data coincides with two fiscal years.

Grant Awards Table[105]

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	101	111	111
Average Award	$1,053,787[106]	$1,115,520[107]	$1,462,079
Range of Awards	$980,000-$1,144,121	$980,000-$1,200,000	$980,000-$1,497,929

[105] FY 2023 reflect before -offset awards.
[106] FY 2022 does not include executed $2.996M for Community-Based Doulas.
[107] FY 2023 does not include executed $4.4M for Catalyst for Infant Health Equity

Heritable Disorders in Newborns and Children

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$19,558,000	$20,883,000	$20,883,000	---
FTE	5	5	5	---

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

FY 2024 Authorization……Expired

Allocation Methods:

- Contract
- Competitive grant/co-operative agreement

Program Description

The Heritable Disorders in Newborns and Children program focuses on reducing the morbidity and mortality caused by heritable disorders in newborns and children. The program achieves this by supporting state and local public health agencies to provide screening, counseling, and health care services. Approximately, four million newborns each year are screened for at least 31 of the 36 core conditions on the Recommended Uniform Screening Panel (RUSP). This is a list of conditions recommended by the Secretary of Health and Human Services (HHS) for state newborn screening (NBS) programs. Identifying and diagnosing babies with one of these conditions enables them to 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 nearly 13,000 babies in the United States each year.

The Heritable Disorders in Newborns and Children program began in 2000 and was reauthorized by the NBS Saves Lives Reauthorization Act of 2014. The authorization expired in 2019.

The Heritable Disorders portfolio was recently redesigned based on results from a FY 2022-2023 evaluation of the portfolio, and input from a variety of stakeholders, experts, and families. The intention of the redesign is to better address current needs and increase efficiencies so that newborns with a heritable disorder get the services they need to thrive and become healthy adults. The updated portfolio includes funding for state newborn screening programs so that states can directly improve processes and ensure that infants and their families receive timely information and services.

The Heritable Disorders portfolio is composed of the following programs:

- The **Newborn Screening Priorities Program (NBS Propel)** which began in FY 2023 supports state NBS programs to address state-specific challenges; and enhances, improves, and expands state NBS systems through two focus areas. Focus area 1 includes

activities related to improving timely collection and reporting of NBS specimens and implementing screening for newly added RUSP conditions so that NBS-identified individuals with a heritable disorder may be diagnosed and treated early. Focus area 2 includes activities related to improving follow-up across the lifespan and helping families understand and navigate the process from confirmation of a diagnosis to treatment. Focus area 2 also supports activities to strengthen communication with families of infants diagnosed with **Severe Combined Immune Deficiency (SCID) and other NBS disorders,** to ensure infants have access to specialty care and treatment, particularly in underserved populations, and that families are actively engaged at all levels of the newborn screening system. In FY 2024 this program also includes NBS Co-Propel, which supports organizations that directly work with states to improve state NBS systems.

- The **National Center for Newborn Screening System Excellence (NBS Excel),** awarded in FY 2023, supports a national organization to strengthen state public health agencies and NBS system partners to provide screening, counseling, or health care services to newborns and children with, or at risk for, heritable disorders. NBS Excel provides leadership, technical assistance, and quality improvement expertise; collects data to identify barriers to achieving health equity and equitable access to NBS services for all infants and families; enhances state performance in NBS; and provides subject matter expertise, technical assistance, and training, education, and other resources to families and/or individuals with heritable disorders to promote engagement and partnership at all levels of the newborn screening system.
- The **Newborn Screening Information Center (NBSIC)** is a clearinghouse of NBS information and serves as a central hub of educational resources, research, and data on NBS, as well as family support information. The NBSIC provides clear and up-to-date information, materials, and resources about NBS in the United States. These resources help increase awareness, knowledge, and understanding of NBS and genetic conditions.

In FY 2020, after the authorization expired, the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children was re-established as a discretionary committee. The charter was renewed in FY 2023. The Committee provides national NBS guidance and standards by making systematic evidence-informed and peer-reviewed recommendations regarding conditions for inclusion on the RUSP. It also advises the Secretary on reducing mortality or morbidity from heritable disorders and considers ways to ensure state and jurisdiction capacity to screen for RUSP conditions.

Budget Request

The FY 2024 Budget Request for the Heritable Disorders in Newborns and Children program of $20.9 million is equal to the FY 2023 Enacted level. This request will continue support of the 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 NBS 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.

Funding History

Fiscal Year	Amount
FY 2020	$17,883,000
FY 2021	$18,826,000
FY 2022	$19,558,000
FY 2023	$20,883,000
FY 2024 President's Budget	$20,883,000

Program Accomplishments

In FY 2022, program accomplishments include supporting multiple states with implementing screening for the latest conditions added to the RUSP, a key program goal. Currently, 78% of state newborn screening programs are screening for Spinal Muscular Atrophy, which was added to the RUSP in 2018. Approximately, 60% of states and territories are screening for Pompe disease (added in 2015), X-linked Adrenoleukodystrophy (added in 2016), and Mucopolysaccharidosis Type 1 (added in 2016).

The program has also supported many quality improvement activities. Nearly all participating states improved their time of collecting specimens from birthing facilities within 48 hours after birth and reporting results out within seven days of life. These benchmarks were set by the Advisory Committee on Heritable Disorders in Newborns and Children as a critical measure of the success of state NBS programs. In addition, the program funded dozens of toolkits, webinars, model practices, videos, policy statements, publications, educational tools, reports, data visualizations, and presentations. These are available for state NBS programs and the public. The NBSIC continues to serve as an important resource, with over 319,000 page views from September 2021 through October 2022.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3070.01: Percentage of states that reported collecting 95% or more of specimens within 48 hours of birth (Output)	FY 2020: 78% Target: Not Defined (Historical Actual)	79%	80%	+1 percentage point
3070.02: Percentage of states that reported 95% or more of all newborn screening results (normal and out-of-range) within seven days of birth (Output)	FY 2020: 29% Target: Not Defined (Historical Actual)	29%	30%	+1 percentage point

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	24	35	40
Average Award	$615,118	$448,725	$393,052
Range of Awards	$199,758 -$3,300,000	$345,000-$2,300,000	$345,000-$2,300,000

Pediatric Mental Health Care Access

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$11,000,000	$13,000,000	$13,000,000	---
FTE[108]	4	4	5	---

Authorizing Legislation.…….Public Health Service Act, Section 330M, as amended by Public Law 117-159, Section 11005

FY 2024 Authorization.……..$31,000,000

Allocation Method

- Competitive grant/ co-operative agreement

Program Description

The Pediatric Mental Health Care Access (PMHCA) Program promotes behavioral health integration in pediatric primary care by developing new, or expanding existing, statewide or regional pediatric mental health care telehealth access programs. These programs use telehealth to help pediatric primary care providers diagnose, treat, and refer children with behavioral health conditions. PMHCA works to address the shortages of psychiatrists, developmental-behavioral pediatricians, and other behavioral health clinicians who can support children and adolescents with behavioral concerns.

PMHCA is authorized through the Public Health Service Act, Section 330M, which was first established in 2018 through the 21st Century Cures Act (P.L. 114-255). The program was recently reauthorized through the Bipartisan Safer Communities Act (P.L. 117-159).

The *National Survey of Children's Health* found significant increases in the number of children diagnosed with mental health conditions between 2016 and 2020. During the study timeframe, the number of children ages 3-17 years old diagnosed with anxiety grew by 29 percent and those with depression grew by 27 percent.[109] Significant disparities exist in access to behavioral health care. Studies have generally found lower behavioral health service use among Black/African American and Hispanic/Latino children, compared with White children.[110] Black/African American children residing in urban areas and Hispanic/Latino children residing in both rural and urban areas are less likely to be connected to mental health care than White children. White

[108] FTEs in this table include FTEs provided by supplementary funds.
[109] Lebrun-Harris, L. A., Ghandour, R. M., Kogan, M. D., & Warren, M. D. (2022). Five-Year Trends in US Children's Health and Well-being, 2016-2020. *JAMA Pediatrics*, *176*(7), e220056. https://doi.org/10.1001/jamapediatrics.2022.0056
[110] Hodgkinson,S., Godoy,L., Beers,L.S., Lewin, A.(2017) Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. *Pediatrics, 139* (1): e20151175. 10.1542/peds.2015-1175

children in rural areas are significantly less likely to receive mental health services than their counterparts in urban areas.[111] Evidence suggests that practical barriers, bias, and discrimination play a central role in creating these disparities. Often, pediatric primary care providers are the first responders in behavioral disorder identification and service provision. However, they may not have the knowledge, training, or resources to screen, diagnose, and treat behavioral disorders. Telehealth strategies, like the ones the PMHCA program supports, connect primary care providers with specialty mental and behavioral health care providers. This approach increases access to behavioral health services including for those living in rural and other underserved areas.

Budget Request

The FY 2024 President's Budget Request for the Pediatric Mental Health Care Access Program of $13 million is equal to the FY 2023 Enacted level. The request will continue to support at least 21 statewide or regional pediatric mental health care telehealth access programs funded through the FY 2023 competition. These programs will continue to provide tele-consultation, training, technical assistance, and care coordination support 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.

Funding History

Fiscal Year	Amount
FY 2020	$10,000,000
FY 2021	$9,970,000
FY 2022	$11,000,000
FY 2023	$13,000,000
FY 2024 President's Budget	$13,000,000

Program Accomplishments

PMHCA program award recipients addressed increases in behavioral health issues among children and adolescents related to the COVID-19 pandemic, including increased reports of anxiety, depression, and suicidal ideation and attempts. Award recipients also supported resilience strategies among families and clinicians. Across 21 states in FY 2021,[112] the program achieved the following:

- Over 6,700 primary care providers enrolled in a statewide or regional PMHCA program.
- Over 2,000 providers used consultation and care coordination support services and over 6,400 providers were trained.

[111] Hodgkinson,S., Godoy,L., Beers,L.S., Lewin, A.(2017) Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. *Pediatrics*, *139* (1): e20151175. 10.1542/peds.2015-1175
[112] FY 2021 data covers a 12-month period of work from 7/1/2020-6/30/2021 and 9/30/2020-9/29/2021

- Pediatric primary care providers who contacted the pediatric mental health team served over 8,200 children and adolescents.

The Bipartisan Safer Communities Act (BSCA) (P.L. 117-159) reauthorized HRSA's PMHCA Program from FY 2023 to FY 2027 and includes new activities to extend PMHCA reach to schools and emergency departments, expand PMHCA nationwide, including to Tribes and Tribal organizations, and provide technical assistance to PMHCA awardees.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3080.01**:** Number of providers using the Pediatric Mental Health Care Access Program consultation (teleconsultation and in-person) and care coordination services for treatment and referral of children with behavioral health conditions (Output)	FY 2021: 2,049 Target: Not Defined (Historical Actual)	4,500	5,000	+500
3080.04: Number of providers trained through the Pediatric Mental Health Care Access Program to better screen, diagnose, treat, or refer children with behavioral health conditions (Output)	FY 2021: 6,428 Target: Not Defined (Baseline)	7,500	8,000	+500
3080.05: Number of children and adolescents for whom a provider contacted the Pediatric Mental Health Care Access Program for consultation or referral (Output)	FY 2021: 8,274 Target- Not Defined (Baseline)	10,000	11,500	+1,500
3080.02: Percentage of providers using the teleconsultation line (Output)	FY 2021: 34% Target: Not Defined (Historical Actual)	47%	Discontinued	N/A

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3080.03: Number of children served through teleconsultation who were recommended for referral/treatment (Outcome)	FY 2021: 4,852 Target: Not Defined (Historical Actual)	Not Defined	Discontinued	N/A

Performance Narrative

- HRSA is replacing measure 3080.03 with two measures that better reflect the purpose of the program. Targets have been established for these measures (3080.04 and 3080.05).
- The results and targets have been updated to reflect annual discretionary funding.

Grant Awards Table[113]

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	21	13	13
Average Award	$422,926	$700,000	$700,000
Range of Awards	$204,496 – $445,000	$700,000	$700,000

[113] Does not include ARP and BSCA awards.

Screening and Treatment for Maternal Mental Health and Substance Use Disorders

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$6,500,000	$10,000,000	$10,000,000	---
FTE	1	2	2	---

Authorizing Legislation: Section 317L-1 of the Public Health Service Act, amended by Public Law 117-328, section 1111

FY 2024 Authorization……$24,000,000

Allocation Method

- Competitive co-operative agreement

Program Description

The Screening and Treatment for Maternal Mental Health and Substance Use Disorders program aims to improve the mental health and well-being of women who are pregnant, postpartum or have given birth within the preceding 12 months by expanding health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for maternal mental health and substance use disorders. This is accomplished by establishing, improving, and/or maintaining statewide, tribal, or regional[114] networks that provide real-time psychiatric consultation, care coordination support services, and culturally and linguistically appropriate training to maternity care providers and clinical practices. This program is also intended to help reduce maternal health inequities.

Maternal mental health conditions, such as depression, anxiety, and substance use disorder, are common complications during pregnancy and the postpartum period. Across the country, there is a significant shortage of psychiatrists and mental health providers. Thus, it is important to train front-line providers to identify and treat behavioral health conditions as part of routine primary care so that pregnant and postpartum people affected by these conditions receive timely, appropriate care.

The Screening and Treatment for Maternal Mental Health and Substance Use Disorders program began in 2018 under the Public Health Service Act, Section 317L-1, as added by the 21st Century Cures Act, Section 10005 (P.L. 114-255). In 2022, the program was reauthorized by the Consolidated Appropriations Act of 2023 (P.L. 117-328) and the program title was changed from "Screening and Treatment for Maternal Depression and Related Behavioral Disorders."

[114] Regional MMHSUD teams are defined as MMHSUD care teams within regions of a state, jurisdiction, or Tribal area

In FY 2023, the program was recompeted and expanded to support up to 17 awardees. The FY 2023 competition includes program modifications to reflect changes outlined in the recent reauthorization. The program will:

- Require grant recipients to provide a 10 percent match to support program activities.
- Expand eligible entities to include Indian Tribes and Tribal Organizations, in addition to States.
- Give priority, as appropriate, to entities that: 1) focus on enhancing screening, prevention and treatment; 2) partner with community-based organizations that address maternal mental health and substance use disorders; 3) are located in, or provide services to, areas with disproportionately high rates of maternal mental health or substance use disorders, or other related disparities; and 4) operate in a health professional shortage area.

The program's long-term goals are to:

- Increase routine mental and behavioral health screening for pregnant and postpartum persons;
- Increase routine detection, assessment, treatment, and referral of maternal mental health conditions using evidence-based practices; and,
- Increase access to treatment and recovery support services for pregnant and postpartum persons that are affordable, culturally and linguistically appropriate, community-based, and provided via telehealth and traditional in-person services.

Budget Request

The FY 2024 Budget Request for the Screening and Treatment for Maternal Mental Health and Substance Use Disorders program of $10 million is equal to the FY 2023 Enacted level. This request continues previous investments as part of the Improving Maternal Health Initiative to expand support for the Screening and Treatment for Maternal Mental Health and Substance Use Disorders program to increase access for perinatal women to behavioral health care. This effort supports use of consultation (teleconsultation or in-person) and care coordination support, and training to expand front-line health care provider capacity to screen, assess, treat, and refer women who are pregnant, postpartum, or have given birth within the past 12 months for maternal mental health and substance use disorders. This funding will support efforts to address ongoing and growing maternal mental health needs.

Funding will also be used to support a joint MCH Tele-behavioral Health Programs Technical Assistance Innovation Center with the Pediatric Mental Health Care Access program, as well as Evaluation Support for State Behavioral Health Telehealth 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.

Funding History

Fiscal Year	Amount
FY 2020	$5,000,000
FY 2021	$5,000,000
FY 2022	$6,500,000
FY 2023	$10,000,000
FY 2024 President's Budget	$10,000,000

Program Accomplishments

Training
Awardees trained 782 providers in FY 2021, a decrease from 1,085 providers trained in FY 2020.[115] Trainings covered a variety of evidence-based practices such as: Screening, Brief Intervention, and Referral to Treatment (SBIRT); Medication Assisted Treatment; how to use standardized validated screening tools for perinatal depression and anxiety; ways to integrate behavioral health in primary care settings; and training on perinatal mood and anxiety disorders. Providers trained include obstetricians/gynecologists, psychiatrists, licensed clinical social workers, licensed professional counselors, nurses/nurse practitioners, certified nurse midwives, physician assistants, care coordinators/patient navigators, family medicine physicians, and other health professionals.

Consultation[116]
Providers sought/received expert consultation for 18,066[117] pregnant and postpartum women in FY 2021, of whom 77% lived in rural/underserved areas. This was an increase from 7,448 pregnant and postpartum women in FY 2020, of whom 47% lived in rural/underserved areas.

Screening[118]

- The number of pregnant and postpartum women screened for *depression* by participating providers increased from 24,518 in FY 2020 to 37,764 in FY 2021
- The number of pregnant and postpartum women screened for *anxiety* by participating providers increased from 14,978 in FY 2020 to 31,096 in FY 2021
- The number of pregnant and postpartum women screened for *substance use* by participating providers increased from 12,928 in FY 2020 to 21,485 in FY 2021

[115] The decrease in the number of providers attending training is due to: 1) the toll of the COVID pandemic on provider capacity and time to attend trainings, and; 2) changes in the way states offered training resources (i.e. recorded trainings available online that do not require registration or track participants versus interactive, in-person trainings with registered participants).
[116] "Consultation" refers to psychiatric consultation and/or care coordination support provided either via telehealth or in-person by the program.
[117] The FY21 result is likely an overestimate, as some awardees report the total caseloads of enrolled providers instead of the number of pregnant and postpartum women for whom a provider sought consultation. The program is moving towards a more consistent approach to reporting for this information.
[118] The increases in the numbers screened are due to more complete reporting and increased engagement with providers to report screening within their practices.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3090.01: Number of pregnant or postpartum women about whom a provider contacted the Maternal Depression and Related Behavioral Disorders Program for consultation or referral (Output)	FY 2021: 18,066 Target: Not Defined (Historical Actual)	Not Defined	7,500	N/A
3090.03: Number of providers utilizing the Maternal Depression and Related Behavioral Disorders Program for consultation (teleconsultation or in-person) and care coordination support services for treatment and referral of pregnant and postpartum women with behavioral health conditions (Output)	FY 2021: 584 Target: Not Defined (Historical Actual)	Not Defined	600	N/A
3090.04: Number of providers trained through the Maternal Depression and Related Behavioral Disorders Program to better screen, diagnose, treat, and refer pregnant and postpartum women with behavioral health conditions (Output)	FY 2021: 782 Target: Not Defined (Historical Actual)	Not Defined	800	N/A

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3090.02 Number and percent of pregnant or postpartum women (PPW) screened for: • **Depression** number (percent); • **Anxiety** number (percent); • **Substance use** number (percent) by participating providers (Output)	**Depression:** FY 2021: 37,764 (55%) Target: Not Defined (Historical Actual) **Anxiety:** FY 2021: 31,096 (44%) Target: Not Defined (Historical Actual) **Substance use:** FY 2021: 21,485 (32%) Target: Not Defined (Historical Actual)	Discontinued	Discontinued	N/A

Performance Narrative

- Measure 3090.01 reflects use of provider consultation as a major component of the Screening and Treatment for Maternal Mental Health and Substance Use Disorders program. Previous targets not established. The FY 2021 result is likely an overestimate, as some awardees report the total caseloads of enrolled providers instead of the number of pregnant and postpartum women for whom a provider sought consultation. The program is moving towards a more consistent approach to reporting for this information. Given these factors, we have set a target for FY 2024 that is more in line with prior results.
- Measures 3090.03 and 3090.04 are new measures in the FY 2024 Congressional Justification. Previous targets not established. HRSA identified trends over a three-year period using data from awardee reports to set appropriate targets for the FY 2024 Congressional Justification.
- Measure 3090.03 represents the unduplicated count of providers who contacted the program for consultation & care coordination support, which is a better indication of program reach.
- The program was reauthorized by the Consolidated Appropriations Act of 2023 (P.L. 117-328) and the program title was changed to “Screening and Treatment for Maternal Mental Health and Substance Use Disorders.” Program measure titles will reflect this new program name in the next Congressional Justification.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	7	17	17
Average Award	$772,556	$514,706	$514,706
Range of Awards	$488,748-$909,447	$500,000-$750,000	$500,000-$750,000

Poison Control Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$25,846,000	$26,846,000	$26,846,000	---
FTE	3	3	3	---

Authorizing Legislation: Sections 1271-1274 of the Public Health Service Act, as amended by Public Law 116-94, Division N, Title I, Subtitle D, Section 403

FY 2024 Authorization $30,100,000

Allocation Method:

- Contracts
- Competitive grants/co-operative agreements

Program Description

The Poison Control Program (PCP) is legislatively mandated to establish and maintain a national toll-free number to ensure access to poison control services; implement a national media campaign to educate and support outreach to the public and health care providers; and support poison control centers (PCCs) to help prevent poisonings, provide recommendations for managing poisonings, and comply with accreditation requirements.

The PCP was established in 2000 by the Poison Control Center Enhancement and Awareness Act (P.L. 106-174) and has since been reauthorized as part of the Public Health Service Act, Title XII, Section 1271-1274, most recently by the Further Consolidated Appropriations Act of 2020 (P.L. 116-94).

The program helps ensure that individuals can call a national toll-free Poison Help line from anywhere in the United States and the territories and connect to the PCC that serves their respective areas. The PCP maintains the toll-free Poison Help Line (800-222-1222), provides interpretation services in over 161 languages, and offers services for the hearing impaired.

Through the PCCs, individuals have access to health care providers and other specially trained toxicology experts twenty-four hours a day, seven days a week who provide assessments, triage, and treatment recommendations at no cost to callers 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. PCCs are consulted for a range of exposures including, for example, when a child swallows a household product; an adolescent intentionally ingests an over-the-counter medication; a worker is exposed to harmful substances; or a senior takes an additional dose of a prescribed medication. Emergency 911 operators refer poison-related calls to PCCs, and

emergency and in-patient health care professionals regularly consult PCCs for expert consultation in managing poisonings. The PCCs also conduct follow-up calls to monitor case progress and document medical outcomes. PCCs are also critically important partners in emergency and disaster preparedness.

Additionally, the PCP supports a national Poison Help media campaign to educate the public and health care providers about poison and toxic exposure prevention, share the availability of poison control resources in local communities, and to advertise the nationwide toll-free number. Activities include partnering with health departments, education departments, and other state agencies; promoting safe prescription medication use and storage; messaging in local news sources and at community events; and collaborating to develop media campaigns focused on preventing poisonings. PCCs are actively engaged in National Poison Prevention Week, which is dedicated to raising awareness about poisoning risks, PCCs, and the Poison Help line. PCCs also participate in National Prescription Drug Take-Back events to provide a safe, convenient, and responsible means of prescription drug disposal.

Budget Request

The FY 2024 Budget Request for the Poison Control program of $26.8 million is equal to the FY 2023 Enacted level. This request will provide grants to the 52 PCCs. These grants provide a small base of support to each PCC, contributing on average 13 percent to each PCC's overall budget that is needed to maintain infrastructure and core triage and treatment services. While PCCs have innovatively secured funding from a variety of local sources, including philanthropic organizations, their financial stability is tenuous.

The FY 2024 Budget Request will also continue to support interpretation services for non-English speaking callers and maintenance of the national toll-free Poison Help line, which is currently based on a 2010 model with legacy infrastructure that does not allow for updates such as geolocation and texting. The nationwide media campaign will continue to educate the public and health care providers about poisoning and toxic exposure prevention, the availability of the national toll-free number, and local PCC services.

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.

Funding History

Fiscal Year	Amount
FY 2020	$22,846,000
FY 2021	$24,846,000
FY 2022	$25,846,000
FY 2023	$26,846,000
FY 2024 President's Budget	$26,846,000

Program Accomplishments

In 2021, PCCs managed 2.85 million encounters.[119] The number of human exposure poisonings remained essentially level at 2.1 million. Despite significant decreases in overall information requests (down 37 percent), medication identification requests (down 21 percent), and medical information requests (down 61 percent) compared to 2020, the first year of the COVID-19 pandemic, these requests were still 13-fold higher than before the pandemic. In 2021, drug information requests increased 146 percent compared with 2020, related in part to COVID-19 vaccines. Calls from health care facilities increased 7 percent compared to 2020, accounting for 24 percent of all human exposure cases in 2021. The majority of calls, 69 percent, originated from residences and were managed by the PCC without requiring emergency medical attention. Access to around-the-clock professional guidance from PCCs decreases unnecessary visits to emergency departments and underscores the PCCs' role as easily accessible and trusted sources of public health information.

In FY 2021, the national Poison Help media campaign helped educate the public about poisoning risks, the accessibility of the toll-free number, and PCC services by supporting public service announcements that garnered over 76 million impressions through more than 12,000 airings on nearly 250 television and radio stations in over 100 markets.

Outputs and Outcomes

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
5030.02: Number of calls received each fiscal year via the national, toll-free, Poison Help line (Output)	FY 2021: 2,851,166 Target: Not Defined (Baseline)	2,900,000	2,900,000	Maintain
5030.03: Number of human cases of poison exposure managed by the Nation's Poison Control Centers (Output)	FY 2021: 2,080,917 Target: Not Defined (Baseline)	2,150,000	2,150,000	Maintain

[119] Gummin DD, Mowry JB, Beuhler MC, Spyker DA, Rivers LJ, Feldman R, Brown K, Nathaniel PTP, Bronstein AC, & Weber JA. (2022). 2021 Annual Report of the National Poison Data System (NPDS) from America's Poison Centers: 39th Annual Report. Clinical Toxicology, 60;12:1381-1643.

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
25.III.D.6: Percent of human exposure calls made to Poison Control Centers that came from health care facilities (Output)	FY 2021: 24% Target: 24% (Target Met)	20%	Discontinued	N/A
5030.01: Percentage of inbound volume on the toll-free number. (Output)	FY 2021: 82% Target: 78% (Target Exceeded)	73%	Discontinued	N/A

Performance Narrative

- For measure 5030.02, the data source for this measure is Verizon Enterprise Information Solutions (EIS), which is different from the other measures.
- For measure 5030.03, the source for this data is the National Poison Data System (NDPS).

Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards[120]	52	52	52
Average Awards	$435,061	$450,385	$450,385
Range of Award	$88,487-$2,686,905	$83,176-$2,411,210	$83,176-$2,411,210

[120] There are 55 Poison Control Centers across the U.S. Fifty-two awards were made in FY 2022 and are anticipated in FY 2023 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.

Contracts Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Contracts	2	2	2
Average Contract	$608,434	$529,921	$529,921
Range of Contracts	$510,829-$706,039	$511,000-$548,842	$511,000-$548,842

Family-To-Family Health Information Centers

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$5,658,000	$5,658,000	$5,658,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 501(c)(1)(A) of the Social Security Act, Title V, as amended by Public Law 116-39, Section 5

FY 2024 Authorization……$6,000,000

Allocation Method:

- Competitive grant/co-operative agreement

Program Description

The Family-to-Family Health Information Centers (F2F HICs) program offers families of children and youth with special health care needs (CYSHCN) peer support and information on accessing care and coverage for their children's complex needs. Staffed by family members of CYSHCN with first-hand experience navigating health care and other needed services and supports for their children, F2F HICs also advise health care professionals on developing more effective partnerships with families. The program aims to empower families to be active participants and decision-makers in choosing and paying for their children's care.

F2F HIC support and services include:

- Guidance on building productive relationships between families and health professionals
- Training and guidance for health professionals on caring for CYSHCN
- Promoting F2F HIC services and resources to families, health professionals, schools, etc.
- Engaging families of CYSHCN and health professionals as staff and leaders for these programs

When it was initially authorized by the Deficit Reduction Act of 2005, the program funded one F2F HIC in each of the 50 states and the District of Columbia. Since then, HRSA expanded F2F HICs to all jurisdictions and to Indian tribes. Most recently, the Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39) reauthorized the program through FY 2024.

Research supports the effectiveness of the F2F HIC strategy.[121] 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.[122] 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 health; and
- Increased access to preventive health care in a medical home.

Budget Request

The F2F HIC program is funded at $6.0 million for each fiscal year through FY 2024.[123] In FY 2024, F2F HICs will be reduced by $342,000 through sequestration pursuant to the Balanced Budget and Emergency Deficit Control Act (BBEDCA). This request will support 59 F2F HIC grants. The FY 2024 funding will help ensure continued delivery of patient-centered information, education, technical assistance, and peer support to families of CYSHCN.

The F2F HICs will continue to address health equity through targeted outreach and leadership development to specific underrepresented populations, such as populations living in rural or urban areas, those with limited English proficiency, and those that reflect other demographic factors such as ethnicity, disability, gender, sexual orientation, family structure and socioeconomic status. F2F HICs also continue to develop partnerships with organizations serving diverse families.

The F2F HICs will continue to address the long-term impact of COVID-19 by providing education to families on COVID-19, accessing telehealth services, and the importance of vaccinations.

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.

[121] Marbell, P. (2017). Engaging families in improving the health care system for children with special health care needs. Lucile Packard Foundation for Children's Health

[122] Smalley et al. (2014). Family perceptions of shared decision-making with health care providers: Results of the National Survey of CYSHCN, 2009-2010. Doi 10.1007/s10995-013-1365-z

[123] Funding is subject to sequestration.

Funding History

Fiscal Year	Amount[124]
FY 2020	$6,000,000
FY 2021	$5,658,000
FY 2022	$5,658,000
FY 2023	$5,658,000
FY 2024 President's Budget	$5,658,000

Program Accomplishments

FY 2021 grantee data show F2F HICs provided services to 204,548 families, which exceeded the target of 195,000 families. FY 2022 awardee survey data reveal that ninety-six percent of families reported that the information they received from an F2F HIC met their needs and ninety-nine percent reported they would recommend F2F HIC services to another family. Eighty-eight percent of families reported that the information or services received from F2F HICs helped prepare them to work with those who serve their children.

Additionally, FY 2021 grantee data show F2F HICs trained and provided information, resources, and referrals to 103,675 health professionals who serve CYSHCN and their families within community and state public health agencies, managed care and insurance organizations, medical practices, children's hospitals, universities, Federally Qualified Health Centers, and more. FY 2022 awardee survey data show ninety-seven percent of professionals served by an F2F HIC reported they were satisfied with the information and ninety-six percent would recommend F2F HIC services to families or other professionals. Ninety-eight percent of professionals reported the information or services received from F2F HICs helped prepare them to work better with families and/or others who serve CSHCN.

To address health equity, an objective of the F2F HIC program is to increase the number of individuals from underrepresented and diverse communities trained to partner with families at all levels of decision making. F2F HICs participated in community forums and town halls led by the national family-led organization, Family Voices, to address the impact of racism on CYSHCN and their families.

[124] FY2021-FY2024 funding amounts reflect the post-sequestration amount.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3100.01**:** Number of families with children with special health care needs who have been provided information, education, and/or training from Family-to-Family Health Information Centers (Outcome)	FY 2021: 204,548 Target: 195,000 (Target Exceeded)	210,000	210,000	Maintain
3100.02**:** Number of professionals who serve children with special health care needs who have been provided information, education, and/or training from Family-to-Family Health Information Centers (Output)	FY 2021: 103,675 Target: 100,000 (Target Exceeded)	100,000	100,000	Maintain
3100.03**:** Percentage of families with children with special health care needs 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 2022: 88% Target: 90% (Target not met)	90%	Discontinued	N/A

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3100.04**:** 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 children with special health care needs and/or others who serve children with special health care needs (Outcome and Developmental)	FY 2022: 98% Target: 96% (Target Exceeded)	97%	Discontinued	N/A

Performance Narrative

- For measures 3100.01 and 3100.02, FY 2024 targets will be maintained because a new F2F HIC grant cycle started in FY 2022. These new grantees have not submitted data to date for HRSA to use to base future projections; in addition, some grantees may be implementing new methodology to ensure there are no duplicate counts.
- The data for measures 3100.03 and 3100.04 are collected from awardee surveys.
- For measure 3100.03, FY 2022 results were impacted by COVID-19 as families faced difficulties in receiving information and accessing services due to the pandemic limiting in-person interactions.

Grant Awards Table[125]

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	59	59	59
Average Award	$90,517	$89,139	$89,139
Range of Awards	$46,588-$93,175-	$49,000-$96,750	$49,000-$96,750

[125] Does not include carryover funding. FY 2022, FY 2023, and FY 2024 reflect post-sequestration funding.

Maternal, Infant, and Early Childhood Home Visiting Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Current Law Mandatory[126]	$377,200,000	$500,000,000	$518,650,000	+$18,650,000
FTE	50	55	55	---

Authorizing Legislation: Section 511 of the Social Security Act, Title V, as amended by Public Law 117-328, Section 6101

FY 2024 Authorization $550,000,000

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 pregnant people and parents with young children who live in communities that face greater risk and barriers to achieving positive maternal and child health outcomes. The MIECHV Program has been in existence since 2010, and builds upon decades of scientific research showing that home visits by a nurse, social worker, early childhood educator, or other trained professional 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.[127]

State and jurisdiction grantees conduct statewide needs assessments to identify eligible at-risk communities, determine priority populations, and choose one or more of the 22 approved evidence-based home visiting models or identify promising approaches that will best meet the

[126] FY 2022 and FY 2024 reflect the post-sequestration funding amount.

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

specific needs of their states and communities. As part of all MIECHV programs, trained home visiting professionals meet regularly with expectant parents or families with young children in their homes to build strong, positive relationships. Home visitors work with families to provide services tailored to their needs, such as:

- Teaching parenting skills and modeling effective parenting techniques.
- Creating a language-rich environment that stimulates early language development.
- Advising on topics such as breastfeeding, safe sleep, injury prevention, and nutrition.
- Screening 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.

HRSA distributes MIECHV funds through base and matching grants to states, jurisdictions, and nonprofit organizations and competitive cooperative agreements to Indian tribes, tribal organizations, and urban Indian organizations. Statute sets aside funds for other purposes, such as technical assistance, workforce supports, including the Jackie Walorski Center for Evidence-Based Case Management, and research, evaluation, and federal administration.

- **Base Grants:** In FY 2022, HRSA awarded $336 million in MIECHV formula grants to 56 states, jurisdictions, and nonprofit organizations. Grants are generally administered by the lead state agency for home visiting designated by the Governor, or they can be competitively awarded to a nonprofit organization in those states or jurisdictions that opted not to participate in the grant program. By law, state and jurisdictional 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 that undergo rigorous evaluation.
- **Tribal Awards:** Beginning in FY 2023, six percent of total MIECHV funding is reserved for grants to Indian tribes, tribal organizations, and urban Indian organizations; in earlier fiscal years, three percent of funding was reserved. As of FY 2022, 36 tribal entities have received funding through the Tribal Home Visiting Program, administered by the Administration for Children and Families. There are currently 30 grant recipients in 16 states. The program:
    - Develops and strengthens tribal capacity to support and promote the health and well-being of American Indian and Alaska Native families through home visiting programs;
    - Expands the evidence base around home visiting in tribal communities; and
    - Supports and strengthens cooperation and linkages between programs that serve Native children and their families.

The American Rescue Plan Act of 2021 (P.L. 117-2) (ARP) appropriated $150 million to enable MIECHV state, jurisdiction, and Tribal grantees to support emergency needs of children and families affected by the COVID-19 pandemic. Examples include:

- Providing emergency supplies, including groceries, diapers, and other supplies.
- Training home visitors, including to identify and address families' mental health needs.
- Funding home visitor hazard pay or other staff costs, including overtime for home visitors to reach families unable to participate in home visiting during regular work hours.

- Advancing data and technology innovations.

Budget Request

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is funded at $518.7 million[128] in FY 2024, and funding will increase incrementally up to $800 million in FY 2027. Funding will continue to support the state, jurisdictional, and tribal administration of locally-run, voluntary, evidence-based home visiting services that have been proven to help prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. This level of funding will provide:

- Awards to 54 state and territory grantees and two non-profit organizations.
- Awards to approximately 45 tribal entities.
- Technical assistance for state, jurisdictional, and tribal MIECHV grantees.
- Workforce support, retention, and case management, including workforce-related technical assistance and the establishment and operation of the Jackie Walorski Center for Evidence-Based Case Management.
- Support for research, evaluation, and federal administration.

Table 1. Mandatory Funding (FY 2023 – FY 2027)

MIECHV Program	**FY 2023**	**FY 2024[129]**	**FY 2025**	**FY 2026**	**FY 2027**	**Five-Year Total**
Mandatory Funding	$500,000,000	$550,000,000	$600,000,000	$650,000,000	$800,000,000	$3,100,000,000

The increase in funds will expand the capacity of MIECHV grantees to reach more communities and families. Currently, MIECHV-funded programs serve over 69,000 families, reaching approximately 15% of the more than 465,000 families who are likely currently eligible and in need of MIECHV services.[130] Over 5 years, funding increases will allow MIECHV-funded programs to provide comprehensive, coordinated home visiting services to additional communities and families through targeted evidence-based home visiting.

The increased appropriations may be used to maintain service expansion supported by the American Rescue Plan Act funding to ensure families are able to continue accessing services. Funds will also support the technology necessary for virtual service delivery as an option for families, as well as the recruitment and retention of the home visiting workforce, including increasing home visitor supports, and training and hiring a diverse workforce. States and jurisdictions may also begin to plan for expansion of services to additional communities and families by improving community capacity to initiate services and expanding the infrastructure to support home visiting service delivery. Additionally, up to 18 new awards will be made to tribal entities to expand services to additional tribal communities.

[128] FY 2024 current law mandatory funding is subject to sequestration.
[129] Appropriation as provided through the Consolidated Appropriations Act, 2023 (Public Law 117-328, Section 6101). However, FY24 post-sequestration amount is $518.7 million.
[130] HRSA internal analysis using 2019 Current Population Survey data.

Funds will continue to support a portfolio of research and evaluation on home visiting, technical assistance to ensure families have access to quality evidence-based and promising home visiting service delivery models, and workforce supports to ensure a well-trained and stable workforce.

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

Funding History

Fiscal Year	Amount[131]	Supplemental Funding
FY 2020	$376,400,000	---
FY 2021	$377,200,000	$150,000,000[132]
FY 2022	$377,200,000	---
FY 2023	$500,000,000	---
FY 2024	$518,650,000	---

Program Accomplishments

MIECHV state and jurisdictional grantees provided over 8.8 million visits from FY 2012 through FY 2022. In FY 2022, states reported serving more than 137,000 parents and children in over 1,000 counties across all 50 states, the District of Columbia, and 5 territories. This is more than a 300 percent increase in the number of participants served since FY 2012 (see Table 1 below). Tribal grantees provided over 161,300 home visits from FY 2012 to FY 2022 and served more than 3,500 parents and children in FY 2022.

Table 1: Number of State/Jurisdictional Participants and Home Visits (FY 2012 – FY 2022)[133]

Fiscal Year	Number of Participants	Number of Home Visits
2012	34,180	174,257
2013	75,970	489,363
2014	115,545	746,303
2015	145,561	894,347
2016	160,374	979,521
2017[134,135]	156,297	942,676
2018[136]	150,291	930,595

[131] Reflects post-sequestration amounts in FY 2020, FY 2021, FY 2022, and FY 2024.
[132] American Rescue Plan Act of 2021 (P.L. 117-2)
[133] Data in Table 1 represent the number of participants and home visits provided by state and jurisdictional grantees (does not include tribal data).
[134] 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.
[135] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.
[136] Does not include data from the Commonwealth of the Northern Mariana Islands due to reporting delays caused by Super Typhoon Yutu.

Fiscal Year	Number of Participants	Number of Home Visits
2019	154,496	1,015,217
2020[137]	140,606	928,130
2021[138]	140,674	921,706
2022[139]	137,802	841,694

The MIECHV Program helps families living in at-risk communities. In FY 2022:

- 67 percent of participating families had household incomes at or below 100 percent of the federal poverty guidelines[140] ($27,750 for a family of four), and 40 percent were at or below 50 percent of those guidelines.
- 23 percent of adult program participants had less than a high school education, and 38 percent had only a high school degree or equivalent.
- 9 percent of households included pregnant teens; 19 percent of households reported a history of child abuse and maltreatment; and 13 percent of households reported substance abuse.

In FY 2020, all state and jurisdictional grantees showed performance improvement in at least four of the six MIECHV benchmark areas outlined in statute:[141]

- 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.
- Improving service coordination and referrals for other community resources and supports.

[137] FY 2020 results were impacted by funding cuts due to sequestration, the impacts of COVID-19 on enrollment and service delivery, and a reporting error in one state.
[138] FY 2021 results were impacted by funding cuts due to sequestration and the impacts of COVID-19 on enrollment and service delivery.
[139] FY 2022 results were impacted by funding cuts due to sequestration, the impacts of COVID-19 on enrollment and service delivery, and significant issues with workforce recruitment and retention across the early childhood care and education field.
[140] The HHS Poverty Guidelines are updated annually in February and published in the Federal Register. See https://aspe.hhs.gov/poverty-guidelines
[141] Section 511 of the Social Security Act [42 U.S.C. 711] includes statutory requirements for demonstration of improvements. https://www.ssa.gov/OP_Home/ssact/title05/0511.htm.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
3110.04**:** Percentage of children enrolled in MIECHV who received daily early language and literacy support from a family member (Outcome)	FY 2022: 79.1% Target: 65.4% (Target Exceeded)	71.5%	72.3%	+0.8 percentage points
3110.05**:** Percentage of parents enrolled in MIECHV who were screened for depression after enrollment or after giving birth (Outcome)	FY 2022: 81.0% Target: 76.5% (Target Exceeded)	78.7%	78.8%	+0.1 percentage points
3110.06: Number of home visits to families receiving services under the State/Jurisdiction Maternal, Infant, and Early Childhood Home Visiting Program (Output)	FY 2022: 841,694 Target: Not Defined (Historical Actual)	1,051,345	1,202,191	+150,846
3110:07: Number of home visits to families receiving services under the Tribal Maternal, Infant, and Early Childhood Home Visiting Program. (Output)	FY 2022: 18,795 Target: Not Defined (Historical Actual)	19,271	22,036	+2,765
3110.08: Number of participants served by the State/Jurisdiction Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program (Outcome)	FY 2022: 137,802 Target: Not Defined (Historical Actual)	164,470	188,067	+23,597
3110.09: Number of participants served by the	FY 2022: 3,498	3,871	4,427	+556

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program (Outcome)	Target: Not Defined (Historical Actual)			
3110.01**:** Number of home visits to families receiving services under the MIECHV program. (Output)	FY 2022: 860,489 Target: 945,000 (Target Not Met)	1,132,000	Discontinue	N/A
3110.02**:** Number and percent of grantees that meet benchmark area data requirements for demonstrating improvement (Outcome)	**State/ Jurisdiction** FY 2020: 56 (100%) Target: 47 (84%) (Target Exceeded) **Tribal** FY 2020: 14 (74%) Target: 22 (88%) (Target Not Met)	**State/ Jurisdiction** 53 (95%) **Tribal** 22 (88%)	Discontinue	N/A
3110.03**:** Number of participants served by the MIECHV Program (Outcome)	FY 2022: 141,300 Target: 144,000 (Target Not Met)	163,000	Discontinue	N/A

Performance Narrative

- 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" in measures 3110.06 and 3110.07 demonstrate the level of effort and service utilization for all enrollees and index children participating in the MIECHV Program.
- For all measure results from 2022, the COVID-19 pandemic continued to negatively impact new enrollment of families throughout the year.
- Given the new requirement for matching grants beginning in FY 2024, as included in the Consolidated Appropriations Act, 2023 (Public Law 117-328, Section 6101), additional time is required to estimate the impact on performance measures. HRSA plans to reevaluate performance measures. in.

- The data source for measure 3110.01 through 3110.06, and 3110.08, is the Home Visiting Information System (HVIS). Results reflect the most recent data available, which include FY 2022 data for state, jurisdictional, and Tribal grants.
- The results for 3110.02 reflect the most recent data available.
- The results for 3110.03 reflect the most recent data available, including FY 2022 data for state, jurisdictional, and Tribal grants.
- The results for 3110.04 reflect the most recent data available, including state and jurisdictional grants only, and reflect a two-year average from FY 2021and FY 2022.
- The FY 2022 target for 3110.04 reflects state and jurisdictional grants only, and reflects a two-year average from FY 2017 and FY 2018.
- The results for 3110.05 reflect the most recent data available, which include state and jurisdictional grants only, and reflect a two-year average from FY 2021 and FY 2022.
- The FY 2022 target for 3110.05 reflects state and jurisdictional grants only, and reflects a two-year average from FY 2017 and FY 2018.

Grant Awards Tables[142] [143]

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	84	102	102
Average Award	$5,100,898[144]	$4,564,627	$5,054,824
Range of Awards	$300,000-$19,390,701	$250,000-$27,244,590	$250,000-$27,244,590

[142] The table does not include carryover funding. FY 2022 reflects post-sequestration funding.
[143] Award projections are based on a funding formula codified in statute (Social Security Act, Title V, as amended by Public Law 117-328, Section 6101). Projections for FY24 may be updated in the FY25 President's Budget given the impact of sequestration, and implementation of a new requirement for matching grants in FY24.
[144] Includes Supplemental funding awards through the American Rescue Plan in FY 22.

RYAN WHITE HIV/AIDS TAB

RYAN WHITE HIV/AIDS

Program Description

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 percent of RWHAP clients (patients) live at or below 100 percent of the federal poverty level and nearly three-quarters of clients are from racial and ethnic minority populations.[145] 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[146] or state programs, or private insurance. Since 1990, the 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 – more than half of all people with diagnosed HIV in the United States.[147] 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 parameters of 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.

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 further transmission of the virus,[148] which furthers the public health goal of ending the HIV epidemic in the United States.[149] An overwhelming body of clinical evidence has firmly established that a person with HIV who is on treatment and has an undetectable viral load cannot sexually transmit HIV. This is referred to as Undetectable Equals Untransmittable, or U=U.

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[145] Published December 2022.Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2021. http://hab.hrsa.gov/data/data-reports. Published December 2022. Accessed January 2023.

[146] The Indian Health Service is statutorily exempted from the payor of last resort provision.

[147] Centers for Disease Control and Prevention. *HIV Surveillance Report, 2020*; vol. 33. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2022. Accessed January 2023.

[148] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2015–2019. HIV Surveillance Supplemental Report, 2021; vol. 26. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed January 2022.

[149] 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.

MPx Public Health Emergency

On August 4, 2022, the MPx outbreak was declared a public health emergency in the U.S. Gay, bisexual, and other men who have sex with men (MSM), and transgender women, have been particularly affected by this outbreak. Due to the impact of the MPx public health emergency on the populations to which the RWHAP provides HIV care and treatment, HRSA has engaged in providing testing, treatment, and vaccines as part of the federal government response to MPx.

Ending the HIV Epidemic in the U.S.

The *Ending the HIV Epidemic in the U.S.* (EHE) initiative aims to reduce new HIV infections to less than 3,000 per year by 2030. The multi-year EHE initiative initially focuses on 48 counties, Washington, D.C., and San Juan (PR), which account for more than half of new HIV diagnoses, as well as 7 states that have a substantial rural HIV burden. The initiative will continue to bring the additional expertise, technology, and resources needed to end the HIV epidemic in the United States. EHE recipients made significant progress toward implementing their EHE initiative activities, despite challenges posed by the COVID-19 pandemic, including developing service delivery infrastructure, engaging with community members and new partners, and delivering services to clients.

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 Collaborative Efforts

In FY 2024, the RWHAP will continue to ensure effective use of resources and a coordinated and focused public health response to HIV. The RWHAP will also continue to coordinate and collaborate with other federal, state, and local entities as well as external 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 use And Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), the Administration for Community Living (ACL), 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 the HRSA-funded Health Center Program.

The RWHAP has developed a coordinated implementation response that outlines the specific actions that the agency will take to achieve the goals and objectives that are outlined in National HIV/AIDS Strategy and accelerate our efforts toward ending the HIV epidemic.[150] The Strategy builds on the targets for the Ending the HIV Epidemic in the United States initiative by 2030 and reflects the Administration's commitment to re-energize and strengthen a whole-of-society response to the epidemic while supporting people with HIV and reducing HIV-associated morbidity and mortality.

[150] The White House. 2021. National HIV/AIDS Strategy for the United States 2022-2025. Washington, DC.

The RWHAP will also coordinate with federal partners, grant recipients, and other partners to address the syndemics (epidemics that closely interact with each other) 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 through 2025, with the aim of reversing the dramatic rise in STIs in the United States.

- *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.

- *Behavioral Health:* In alignment with HHS's Strategy to advance behavioral health care in the most underserved and rural communities, HRSA will continue to work collaboratively with other federal partners to address opioid use disorder screening, treatment and support for people with HIV.

- *HHS Office of Infectious Disease Policy Syndemic Steering Committee:* This committee will identify cross-agency policy and programmatic opportunities and collaborative approaches to address challenges, including gaps at the federal and jurisdictional levels; develop cross-departmental/agency policies, programs, or initiatives that capitalize on opportunities and address challenges; and apply a syndemic approach and focus on reducing disparities. CDC and HRSA are collaborating to help encourage the delivery of status neutral services to provide comprehensive care for all people, regardless of HIV status at the jurisdictional level to most efficiently and effectively address disparities, address social determinants of health, and reduce HIV stigma.

- *CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC):* HRSA will continue to partner with CDC to convene the CHAC which advises the Secretary of HHS in accordance with the Federal Advisory Committee Act, on objectives, strategies, policies, and priorities for HIV, viral hepatitis, and STD prevention and treatment efforts for the nation

- *Federal Strategic Plan to Prevent and End Homelessness*[151]*:* HRSA, HUD, and the CDC are collaborating to examine opportunities and barriers for enhancing access to HUD-assisted housing for people with HIV and impacted communities, with particular emphasis on the priority populations identified in the National HIV/AIDS Strategy. HRSA and HUD will continue to work closely together, cross-training staff and recipients, informing RWHAP technical assistance and the RWHAP SPNS housing-related initiative.

[151] Opening Doors: Federal Strategic Plan to Prevent and End Homelessness

- *Leveraging Collaboration between the RWHAP and Aging Agencies: Enhancing Support Services for Older Adults with HIV:* Aging with HIV is an important topic for the RWHAP; approximately half of people served by the program are 50 years and older. HRSA and the Administration for Community Living have continued to collaborate and share information to improve the assessment of psychosocial needs and the delivery of health care for older adults with HIV so that they may age with dignity and independence and have access to a broad array of services. Health and other concerns change as people with HIV grow older, requiring different approaches and services from health care and social services providers. In FY 2022, HRSA launched the Emerging Strategies to Improve Health Outcomes for People Aging with HIV initiative to conduct the following activities:

    - Implement emerging strategies that comprehensively screen and manage comorbidities, geriatric conditions, behavioral health, and psychosocial needs of people 50 years and older with HIV
    - Assess the uptake and integration of emerging strategies
    - Research and assess implementation processes, including assessing specific implementation strategies
    - Research and assess broader contextual factors affecting implementation
    - Evaluate the impact of the emerging strategies
    - Document and disseminate the emerging strategies

RWHAP Part A - Emergency Relief Grants

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$670,458,000	$680,752,00	$680,752,000	---
MAI (non add)	$54,105,000	$54,105,000	$54,105,000	---
FTE	42	48	48	---

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

FY 2024 Authorization……..……..…….Expired

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

The 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. Nearly 71 percent of all people with diagnosed HIV reside in a RWHAP Part A EMA or TGA. [152,153]

The RWHAP requires EMAs and TGAs to utilize local needs assessments and planning processes to develop coordinated systems of HIV care to improve health outcomes for low-income people with HIV, thereby reducing transmission of HIV. These 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, and more broadly support the HHS goals to protect and strength equitable access to high quality and affordable healthcare.

RWHAP Part A prioritizes primary medical care, access to antiretroviral treatment, and other core medical and supportive services 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 as reported to the Centers for Disease Control and Prevention, whereas TGAs are jurisdictions with at least 1,000

[152] Centers for Disease Control and Prevention. *HIV Surveillance Report*, 2020 (Updated); vol. 33. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2022. Accessed January 2023.
[153] Centers for Disease Control and Prevention. HIV/AIDS data through December 2019 provided for the Ryan White HIV/AIDS Program, for fiscal year 2021;27(No. 1). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published January 2022. Accessed January 2023.

but fewer than 2,000 AIDS cases over the last five years as reported to the Centers for Disease Control and Prevention. Two-thirds of the funds available for EMAs and TGAs are awarded according to a formula, based on the number of people with diagnosed HIV in the EMAs and TGAs.

The remaining funds are awarded as discretionary supplemental grants based on the demonstration of additional need by the eligible EMAs and TGAs, and as Minority AIDS Initiative (MAI) grants. The MAI funds are a statutory set-aside 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.

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 Ending the HIV Epidemic (EHE) initiative activities related to Pillar Two (Treat) and Pillar Four (Respond) in FY 2022. This initiative is now in its fourth 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.

Budget Request

The FY 2024 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part A of $680.7 million is equal to the FY 2023 Enacted level. These requested funding levels will support the provision of core medical and support services for people with HIV in the 24 EMAs and 28 TGAs.

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. Approximately 65 percent of all RWHAP clients are served by one of the 52 cities funded under the RWHAP Part A[154]. Nearly 71 percent of all people with diagnosed HIV reside within these metropolitan areas. The RWHAP serves populations that have 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).

Part A funding contributes to achieving the FY 2024 targets for performance goals that relate to cross-cutting activities, such as the total clients served and percentage of clients (total and minority 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.

[154] Data as of FY 2021.

RWHAP Part A Funding History[155]

Fiscal Year	Amount
FY 2014	$649,373,000
FY 2015	$655,220,000
FY 2016	$655,876,000
FY 2017	$654,296,000
FY 2018	$655,876,000
FY 2019	$655,876,000
FY 2020	$655,876,000
FY 2021	$655,706,000
FY 2022	$670,458,000
FY 2023	$680,752,000
FY 2024 President's Budget	$680,752,000

Program Accomplishments

The RWHAP Part A has contributed to the tremendous progress the RWHAP has made toward ending the HIV epidemic in the United States. In 2021 alone, RWHAP Part A funded sites provided nearly 3.2 million core medical service visits for health-related care utilizing a combination of RWHAP Parts A, B, C, and D funding. From 2010 to 2021, HIV viral suppression among RWHAP patients has increased from 69.5 percent to 89.7 percent, and racial and ethnic, age-based, and regional disparities have decreased.[156] However, even with these positive outcomes, fully addressing the HIV epidemic domestically continues to be a challenge as the CDC estimates that 1.2 million people in the United States have HIV, and 1 in 8 are unaware of their HIV.[157] In addition, over 36,000 HIV diagnoses occur every year.[158]

Research studies demonstrate that people with HIV who take HIV medications and get and keep an undetectable viral load, will not transmit HIV to their sex partner.[159,160] Not only do improved viral suppression rates reduce the transmission of HIV, but they also result in significant cost-savings to the health care system.[161] In the RWHAP, 89.7 percent of patients receiving RWHAP

[155] EHE funding is not included in this table.
[156] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019. http://hab.hrsa.gov/data/data-reports. Published December 2020. Accessed March 2021.
[157] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2015–2019. HIV Surveillance Supplemental Report 2021;26(No. 1). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed January 2022.
[158] Centers for Disease Control and Prevention. *HIV Surveillance Report*, 2019 (Updated); vol. 32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed January 2023.
[159] National Institute of Allergy and Infectious Disease (NIAID). Preventing Sexual Transmission of HIV with Anti-HIV Drugs. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2016 Mar 29]. Available from: http://clinicaltrials.gov/show/ NCT00074581 NLM Identifier: NCT00074581.
[160] 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.
[161]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.

medical care are virally suppressed,[162] far exceeding the 70.5 percent rate of viral suppression for the general population of people with diagnosed HIV[163] - an outcome measure that demonstrates the success of the program and results in major public health benefits. These results align with a study published in *Clinical Infectious Diseases*, which found that 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.[164] Furthermore, RWHAP patients are more likely to reach viral suppression regardless of other health care coverage (e.g., uninsured, Medicaid, Medicare, or private insurance).

RWHAP Part A Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	52	52	52
Average Award	$12,435,737	$12,435,737	$12,435,737
Range of Awards	$2,832,860 - $93,314,502	$2,832,860 - $93,314,502	$2,832,860 - $93,314,502

RWHAP Part A – FY 2022 Formula, Supplemental & MAI Grants[165]

Table 1. Eligible Metropolitan Areas

EMAs	Formula	Supplemental	MAI	Total
Atlanta, GA	$18,286,677	$9,345,134	$2,809,857	$30,441,668
Baltimore, MD	$9,330,202	$5,486,376	$1,510,893	$16,327,471
Boston, MA	$9,580,392	$4,567,495	$1,060,618	$15,208,505
Chicago, IL	$16,882,605	$8,522,960	$2,415,927	$27,821,492
Dallas, TX	$12,099,417	$6,116,510	$1,662,479	$19,878,406
Detroit, MI	$6,013,374	$3,107,141	$852,393	$9,972,908
Ft. Lauderdale, FL	$9,821,238	$4,983,171	$1,306,373	$16,110,782
Houston, TX	$15,567,812	$7,630,959	$2,427,918	$25,626,689
Los Angeles, CA	$27,880,046	$14,262,184	$3,780,205	$45,922,435

[162] 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.
[163] Centers for Disease Control and Prevention. Social determinants of health among adults with diagnosed HIV infection, 2019. *HIV Surveillance Supplemental Report* 2020;27(No. 2). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published March 2022. Accessed January 2023.
[164] 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.
[165] Awards to EMAs and TGAs include prior year unobligated balances.

EMAs	Formula	Supplemental	MAI	Total
Miami, FL	$16,141,380	$8,390,714	$2,713,251	$27,245,345
Nassau-Suffolk, NY	$3,267,517	$1,945,171	$441,892	$5,654,580
New Haven, CT	$3,193,291	$1,888,360	$438,967	$5,520,618
New Orleans, LA	$4,703,771	$2,799,694	$649,628	$8,153,093
New York, NY	$53,433,121	$31,464,387	$8,416,994	$93,314,502
Newark, NJ	$7,145,456	$4,177,905	$1,202,651	$12,526,012
Orlando, FL	$6,763,423	$3,470,771	$886,903	$11,121,097
Philadelphia, PA	$13,365,417	$7,697,876	$1,971,111	$23,034,404
Phoenix, AZ	$6,510,638	$3,281,782	$662,789	$10,455,209
San Diego, CA	$7,410,698	$3,772,478	$793,221	$11,976,397
San Francisco, CA	$9,169,292	$5,249,617	$783,570	$15,202,479
San Juan, PR	$6,074,104	$3,573,610	$1,138,604	$10,786,318
Tampa-St. Petersburg, FL	$6,578,636	$3,374,510	$720,986	$10,674,132
Washington, DC-MD-VA-	$18,961,462	$10,778,395	$2,936,195	$32,676,052
West Palm Beach, FL	$4,400,118	$2,553,268	$647,581	$7,600,967
Subtotal EMAs	$147,709,427	$84,082,653	$21,249,200	$253,041,280

Table 2. Transitional Grant Areas

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$3,268,024	$1,704,533	$407,480	$5,380,037
Baton Rouge, LA	$2,727,373	$1,452,146	$451,542	$4,631,061
Bergen-Passaic, NJ	$2,305,304	$1,350,268	$343,336	$3,998,908
Charlotte-Gastonia, NC-SC	$3,979,513	$1,978,115	$610,050	$6,567,678
Cleveland, OH	$2,931,876	$1,554,886	$392,273	$4,879,035
Columbus, OH	$3,025,334	$1,545,111	$309,899	$4,880,344
Denver, CO	$4,863,347	$2,517,541	$408,845	$7,789,733
Fort Worth, TX	$3,109,748	$1,635,348	$436,140	$5,181,236
Hartford, CT	$1,783,244	$1,033,179	$249,070	$3,065,493
Indianapolis, IN	$2,875,600	$1,504,797	$329,883	$4,710,280
Jacksonville, FL	$3,688,587	$1,900,103	$524,265	$6,112,955
Jersey City, NJ	$2,824,851	$1,639,095	$455,149	$4,919,095
Kansas City, MO	$2,738,930	$1,436,811	$287,771	$4,463,512
Las Vegas, NV	$4,275,464	$2,235,276	$508,083	$7,018,823
Memphis, TN	$4,153,365	$2,106,492	$711,238	$6,971,095
Middlesex-Somerset-Hunterdon, NJ	$1,649,086	$942,600	$241,174	$2,832,860
Minneapolis-St. Paul, MN	$3,759,936	$1,965,751	$397,732	$6,123,419
Nashville, TN	$2,863,541	$1,458,786	$322,377	$4,644,704
Norfolk, VA	$3,481,069	$1,756,166	$525,630	$5,762,865
Oakland, CA	$4,423,691	$2,307,304	$594,258	$7,325,253
Orange County, CA	$4,061,917	$2,173,180	$486,344	$6,721,441
Portland, OR	$2,622,358	$1,331,410	$155,583	$4,109,351
Riverside-San Bernardino, CA	$5,352,749	$2,710,476	$624,770	$8,687,995
Sacramento, CA	$2,173,658	$1,128,128	$216,608	$3,518,394
Saint Louis, MO	$3,905,148	$1,997,810	$490,048	$6,393,006
San Antonio, TX	$3,591,611	$1,894,925	$578,661	$6,065,197
San Jose, CA	$2,037,491	$1,069,501	$264,277	$3,371,269
Seattle, WA	$4,529,711	$2,363,332	$388,666	$7,281,709
Subtotal TGAs	$93,002,526	$48,693,070	$11,711,152	$153,406,748
TOTAL EMAs/TGAs	$385,582,613	$207,133,538	$53,942,158	$646,658,309

RWHAP Part B - HIV Care Grants to States

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$1,344,240,000	$1,364,878,000	$1,364,878,000	---
MAI (non-add)	$10,145,000	$10,145,000	$10,145,000	---
ADAP (non-add)	$900,313,000	$900,313,000	$900,313,000	---
FTE	50	66	66	---

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Public Law 116-136

FY 2024 Authorization……Expired

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

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 directly support the HHS goal to protect and strengthen equitable access to high quality and affordable healthcare, including efforts to reduce costs and ensure access to medications. These 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 ADAPs, state or jurisdiction operated programs which support 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. ADAPs provide FDA-approved prescription medications for people with HIV who cannot afford HIV medications and are instrumental in efforts to end the HIV epidemic across the nation. Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral suppression are not at risk to transmit HIV to others. 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 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.

Ending the HIV Epidemic in the U.S. - States

Seven RWHAP Part B recipients with a substantial rural burden of new HIV diagnoses 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 Ending HIV Epidemic (EHE) initiative activities related to Pillar Two (Treat) and Pillar Four (Respond) in FY 2022. 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.

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, which is comprised of data reported by recipients annually in order to evaluate the national impact of ADAP through client-level data on individuals being served, services being delivered, and costs associated with these services, ADAPs continue to provide robust formularies of antiretroviral medications to treat HIV infection, prevent and treat opportunistic infections, manage side effects, and treat co-morbidities.[166]

Across the RWHAP, grant recipients are encouraged to maximize resources and leverage efficiencies. Increased demand for RWHAP ADAP services has led States to implement cost-containment strategies for their ADAPs, including by coordinating benefits with Medicare Part D and improving drug-purchasing models, which result in effective funds management, enabling ADAPs to serve more people. In 2020, ADAPs participating in cost-savings strategies on medications saved $2.5 billion. Over the last 5 years, ADAPs participating in medication cost-savings strategies saved $9.4 billion.

With no individuals on the ADAP waiting lists since 2015, states requested and HRSA distributed $75 million in Emergency Relief Funding (ERF) in FY 2022. ADAP ERF awards are intended for states/territories that demonstrate the need for additional resources to prevent,

[166] Health Resources and Services Administration. Ryan White HIV/AIDS Program AIDS Drug Assistance Program (ADAP) Annual Client-Level Data Report 2020. https://ryanwhite.hrsa.gov/data/reports. Published August 2022.

reduce, or eliminate ADAP waiting lists, including through cost-containment measures (for example, the provision of health care coverage assistance). 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 can request RWHAP Part B supplemental funds to assist in meeting shortfalls. HRSA continues to closely monitor the impact of ending the COVID-19 public health emergency and the Medicaid continuous enrollment requirement on the ADAPs.

Budget Request

The FY 2024 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part B of $1.3 billion is equal to the FY 2023 Enacted level. This request includes $900.3 million for RWHAP ADAPs to provide access to life saving HIV related medications and funding to provide direct health care services for people with HIV in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and five Associated Pacific Jurisdictions.

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 people who require assistance with insurance premiums and cost-sharing
- need for medication and/or health care coverage assistance for clients who remain uninsured

RWHAP Part B funding will also contribute to achieving the FY 2024 targets for performance goals that related to cross-cutting activities, such as the total number of clients served, and the percentage of clients (total and minority 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.

Funding History[167]

Fiscal Year	Amount	ADAP (Non-Add)
FY 2014	$1,314,446,000	($900,313,000)
FY 2015	$1,315,005,000	($900,313,000)
FY 2016	$1,315,005,000	($900,313,000)
FY 2017	$1,311,837,000	($900,313,000)
FY 2018	$1,309,251,000	($894,559,000)
FY 2019	$1,315,005,000	($900,313,000)
FY 2020	$1,315,005,000	($900,313,000)
FY 2021	$1,314,622,000	($900,313,000)
FY 2022	$1,344,240,000	($900,313,000)
FY 2023	$1,364,878,000	($900,313,000)
FY 2024 President's Budget	$1,364,878,000	($900,313,000)

Program Accomplishments

The RWHAP Part B has contributed to the tremendous progress the RWHAP has made toward ending the HIV epidemic in the United States.

From 2010 to 2021, HIV viral suppression among RWHAP patients has increased from 69.5 percent to 89.7 percent, and racial and ethnic, age-based, and regional disparities have decreased.[168] However, even with these positive outcomes, fully addressing the HIV epidemic domestically continues to be a challenge as the CDC estimates that 1.2 million people in the United States have HIV, and 1 in 8 are unaware of their HIV.[169] In addition, over 36,000 HIV diagnoses occur every year.[170]

Research studies demonstrate that people with HIV who take HIV medications and get and keep an undetectable viral load, will not transmit HIV to their sex partner.[171,172] Not only do improved viral suppression rates reduce the transmission of HIV, but they also result in significant cost-savings to the health care system.[173] In the RWHAP, 89.7 percent of patients receiving RWHAP

[167] EHE funding is not included in this table.
[168] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019. http://hab.hrsa.gov/data/data-reports. Published December 2020. Accessed March 2021.
[169] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2015–2019. HIV Surveillance Supplemental Report 2021;26(No. 1). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed January 2022.
[170] Centers for Disease Control and Prevention. *HIV Surveillance Report*, 2019 (Updated); vol. 32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed January 2023.
[171] National Institute of Allergy and Infectious Disease (NIAID). Preventing Sexual Transmission of HIV with Anti-HIV Drugs. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2016 Mar 29]. Available from: http://clinicaltrials.gov/show/ NCT00074581 NLM Identifier: NCT00074581.
[172] 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.
[173]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.

medical care are virally suppressed,[174] far exceeding the 70.5 percent rate of viral suppression for the general population of people with diagnosed HIV[175] - an outcome measure that demonstrates the success of the program and results in major public health benefits.

These results align with a study published in *Clinical Infectious Diseases*, which found that 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.[176] Furthermore, RWHAP patients are more likely to reach viral suppression regardless of other health care coverage (e.g., uninsured, Medicaid, Medicare, or private insurance).

AIDS Drug Assistance Program

According to the RWHAP ADAP data, the number of people with HIV receiving ADAP services has grown 38 percent over the last ten years from 208,809 clients in 2010, to 289,290 clients in 2021, exceeding the FY 2021 target by 4,290. In FY 2020, the RWHAP ADAP provided medication and health care coverage assistance for nearly 29 percent of people diagnosed with HIV in the United States. Of all the ADAP clients served nationwide, 72 percent had incomes at or below 200 percent of the federal poverty level, and 70 percent were racial and ethnic minorities.

The RWHAP ADAP plays a crucial role in ensuring access to HIV medications for pregnant women. 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 2021, 99 percent of HIV-positive pregnant women served by the RWHAP (Part A, Part B, Part C, and Part D) were prescribed antiretroviral therapy to prevent maternal-to-child transmission of HIV, exceeding the FY 2021 performance target by 3 percentage points.

RWHAP Part B Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	59	59	59
Average Award	$21,684,452	$22,011,076	$22,011,076
Range of Awards	$50, 000-$138,272,256	$50, 000-$140,346,400	$50, 000-$140,346,400

[174] 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.
[175] Centers for Disease Control and Prevention. Social determinants of health among adults with diagnosed HIV infection, 2019. *HIV Surveillance Supplemental Report* 2020;27(No. 2). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published March 2022. Accessed January 2023.
[176] 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.

RWHAP Part B – FY 2022 State Table[177]

State / Territory	Base	Supplemental	ADAP Total	Emerging Communities	MAI	Total
Alabama	$8,660,566	$0	$10,476,008	$320,809	$147,684	$19,605,067
Alaska	$500,000	$123,768	$558,133	$0	$0	$1,181,901
Arizona	$4,522,985	$7,930,576	$12,034,374	$0	$125,897	$24,613,832
Arkansas	$3,607,390	$0	$4,475,345	$0	$49,495	$8,132,230
California	$35,261,689	$8,101,562	$101,592,676	$184,772	$1,233,131	$146,373,830
Colorado	$3,578,151	$3,151,391	$9,387,649	$0	$76,837	$16,194,028
Connecticut	$2,646,200	$7,606,146	$7,824,142	$0	$0	$18,076,488
Delaware	$1,995,603	$557,954	$2,413,925	$181,232	$33,908	$5,182,622
District of Columbia	$3,467,443	$0	$11,072,329	$0	$178,478	$14,718,250
Florida	$31,651,120	$8,029,737	$85,093,238	$466,488	$1,200,247	$126,440,830
Georgia	$15,754,746	$8,146,210	$48,608,531	$181,006	$604,346	$73,294,839
Hawaii	$1,542,692	$0	$1,866,073	$0	$0	$3,408,765
Idaho	$591,942	$2,049,284	$716,026	$0	$0	$3,357,252
Illinois	$9,695,405	$5,020,415	$35,243,706	$0	$393,376	$50,352,902
Indiana	$3,901,135	$8,075,299	$10,765,012	$0	$0	$22,741,446
Iowa	$1,555,441	$6,861,470	$1,881,495	$0	$0	$10,298,406
Kansas	$1,195,429	$1,684,988	$2,532,895	$0	$0	$5,413,312
Kentucky	$4,552,185	$0	$5,506,422	$295,199	$46,212	$10,400,018
Louisiana	$6,860,063	$0	$16,588,298	$0	$242,549	$23,690,910
Maine	$786,220	$52,250	$951,029	$0	$0	$1,789,499
Maryland	$7,877,111	$1,817,254	$24,018,075	$0	$398,539	$34,110,979
Massachusetts	$5,347,808	$0	$15,111,449	$0	$173,428	$20,632,685
Michigan	$5,312,456	$266,296	$12,972,184	$0	$168,602	$18,719,538
Minnesota	$2,211,724	$0	$6,305,433	$0	$64,815	$8,581,972
Mississippi	$6,154,611	$0	$7,686,078	$275,238	$120,426	$14,236,353
Missouri	$3,687,725	$0	$9,876,749	$0	$0	$13,564,474
Montana	$500,000	$481,779	$370,130	$0	$0	$1,351,909
Nebraska	$1,313,200	$2,319,026	$1,588,476	$0	$0	$5,220,702
Nevada	$2,438,746	$1,322,849	$7,000,162	$0	$0	$10,761,757
New Hampshire	$500,000	$0	$918,716	$0	$0	$1,418,716
New Jersey	$9,960,421	$2,683,291	$27,411,670	$0	$425,671	$40,481,053
New Mexico	$2,007,138	$0	$2,427,878	$0	$0	$4,435,016
New York	$32,299,992	$6,320,463	$92,321,794	$547,839	$1,432,810	$132,922,898
North Carolina	$12,099,857	$7,786,600	$22,959,091	$306,724	$335,871	$43,488,143
North Dakota	$500,000	$0	$308,442	$0	$0	$808,442
Ohio	$7,653,054	$0	$17,012,038	$355,308	$0	$25,020,400
Oklahoma	$3,891,639	$0	$4,707,411	$239,232	$0	$8,838,282
Oregon	$1,853,998	$0	$4,732,380	$0	$0	$6,586,378

[177] Awards include prior year unobligated balances.

State/Territory	Base	Supplemental	ADAP Total	Emerging Communities	MAI	Total
Pennsylvania	$10,864,163	$0	$26,071,417	$272,978	$352,538	$37,561,096
Puerto Rico	$5,490,958	$5,712,953	$16,741,777	$0	$253,899	$28,199,587
Rhode Island	$1,545,120	$1,759,286	$1,869,011	$186,881	$20,020	$5,380,318
South Carolina	$10,661,088	$2,399,744	$13,147,702	$558,837	$194,401	$26,961,772
South Dakota	$500,000	$814,603	$477,351	$0	$0	$1,791,954
Tennessee	$5,447,881	$6,674,742	$13,757,242	$0	$173,975	$26,053,840
Texas	$26,330,660	$8,142,002	$87,704,783	$0	$1,037,748	$123,215,193
Utah	$1,919,106	$1,622,771	$2,919,121	$0	$0	$6,460,998
Vermont	$500,000	$321,549	$375,271	$0	$0	$1,196,820
Virginia	$7,441,937	$769,751	$17,795,627	$367,661	$245,439	$26,620,415
Washington	$3,849,873	$0	$9,817,999	$0	$81,523	$13,749,395
West Virginia	$1,107,969	$1,944,347	$1,440,130	$0	$0	$4,492,446
Wisconsin	$3,764,107	$0	$4,575,956	$259,796	$51,038	$8,650,897
Wyoming	$500,000	$0	$248,222	$0	$0	$748,222
Guam	$200,000	$62,499	$83,720	$0	$0	$346,219
Virgin Islands	$500,000	$0	$453,116	$0	$7,969	$961,085
American Samoa	$50,000	$0	$734	$0	$0	$50,734
Marshall Islands	$50,000	$0	$734	$0	$0	$50,734
Mariana Island	$50,000	$0	$11,016	$0	$182	$61,198
Republic of Palau	$50,000	$0	$6,609	$0	$0	$56,609
F. States Micronesia	$50,000	$0	$0	$0	$0	$50,000
TOTALS	$328,808,747	$120,612,855	$824,813,000	$5,000,000	$352,538	$1,289,105,656

RWHAP Part C - Early Intervention Services

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$205,054,000	$208,970,000	$208,970,000	---
MAI (non-add)	$71,012,000	$71,012,000	$71,012,000	---
FTE	51	56	56	---

Authorizing Legislation: Public Health Service Act, Section 2651-2667, as amended by Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

FY 2024 Authorization……..……..……..…...Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

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. 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.

Minority AIDS Initiative (MAI) funds are a statutory set-aside funding 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.

Budget Request

The FY 2024 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part C of $208.9 million is equal to the FY 2023 Enacted level. These requested levels will support comprehensive medical, treatment and support services necessary to achieve improved health outcomes, such as improved viral suppression rates, essential to ending the HIV epidemic.

RWHAP Part C supports direct health care services for low-income people with HIV who are uninsured or underserved. These services are considered essential to improving health outcomes and are a crucial part of the care network that links and retains people with HIV into health care. Such critical health care services include intensive case management and care coordination services, linking and retaining people with HIV into care, and getting them on antiretroviral medications as early as possible.

RWHAP Part C funding will contribute to achieving the FY 2024 targets for performance goals that relate to cross-cutting activities, such as total number of clients served, and percentage of clients (total and minority 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.

Funding History

Fiscal Year	Amount
FY 2014	$205,544,000
FY 2015	$204,179,000
FY 2016	$205,079,000
FY 2017	$200,585,000
FY 2018	$201,079,000
FY 2019	$201,079,000
FY 2020	$201,079,000
FY 2021	$201,079,000
FY 2022	$205,054,000
FY 2023	$208,970,000
FY 2024 President's Budget	$208,970,000

Program Accomplishments

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.

The RWHAP Part C has contributed to the tremendous progress the RWHAP has made toward ending the HIV epidemic in the United States

From 2010 to 2021, HIV viral suppression among RWHAP patients has increased from 69.5 percent to 89.7 percent, and racial and ethnic, age-based, and regional disparities have decreased.[178] However, even with these positive outcomes, fully addressing the HIV epidemic domestically continues to be a challenge as the CDC estimates that 1.2 million people in the United States have HIV, and 1 in 8 are unaware of their HIV.[179] In addition, over 30,000 HIV diagnoses occur every year.[180]

[178] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019. http://hab.hrsa.gov/data/data-reports. Published December 2020. Accessed March 2021.
[179] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2015–2019. HIV Surveillance Supplemental Report 2021;26(No. 1). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed January 2022.
[180] Centers for Disease Control and Prevention. *HIV Surveillance Report*, 2020; vol. 33. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2022. Accessed January 2023.

Research studies demonstrate that people with HIV who take HIV medications and get and keep an undetectable viral load, will not transmit HIV to their sex partner.[181,182] Not only do improved viral suppression rates reduce the transmission of HIV, but they also result in significant cost-savings to the health care system.[183] In the RWHAP, 89.7 percent of patients receiving RWHAP medical care are virally suppressed,[184] far exceeding the 70.5 percent rate of viral suppression for the general population of people with diagnosed HIV[185] - an outcome measure that demonstrates the success of the program and results in major public health benefits.

These results align with a study published in *Clinical Infectious Diseases*, which found that 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.[186] Furthermore, RWHAP patients are more likely to reach viral suppression regardless of other health care coverage (e.g., uninsured, Medicaid, Medicare, or private insurance).

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	355	365	365
Average Award	$510,207	$510,207	$510,207
Range of Awards	$94,486-$1,169,012	$94,486-$1,169,012	$94,486-$1,169,012

[181] National Institute of Allergy and Infectious Disease (NIAID). Preventing Sexual Transmission of HIV with Anti-HIV Drugs. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2016 Mar 29]. Available from: http://clinicaltrials.gov/show/ NCT00074581 NLM Identifier: NCT00074581.
[182] 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.
[183]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.
[184] 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.
[185] Centers for Disease Control and Prevention. Social determinants of health among adults with diagnosed HIV infection, 2019. *HIV Surveillance Supplemental Report* 2020;27(No. 2). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published March 2022. Accessed January 2023.
[186] 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.

RWHAP Part D - Women, Infants, Children and Youth

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$77,252,000	$77,935,000	$77,935,000	---
MAI (non-add)	$23,671,000	$23,671,000	$23,671,000	---
FTE	10	12	12	---

Authorizing Legislation: Public Health Service Act, Section 2671, as amended by Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

FY 2024 Authorization…….……Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

The Ryan White HIV/AIDS Program (RWHAP) Part D provides grants directly to public or private community-based organizations, hospitals, and State and local governments. Currently, there are 116 RWHAP Part D grant recipients located in 39 states 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 Part D services focus on low-income, uninsured, and underserved women, infants, children, and youth with HIV and their affected[187] 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 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.

Budget Request

The FY 2024 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part D of $77.9 million is equal to the FY 2023 Enacted level. These requested funding levels 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.

[187] 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.

RWHAP Part D supports health care services for low-income people with HIV who are uninsured or underserved, particularly women, infants, 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.

RWHAP Part D funding will contribute to achieving the FY 2024 targets for performance goals that relate to cross-cutting activities, such as the total number of clients served, and the percentage of clients (total and minority 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.

Funding History

Fiscal Year	Amount
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	$72,888,000
FY 2022	$77,252,000
FY 2023	$77,935,000
FY 2024 President's Budget	$77,935,000

Program Accomplishments

The RWHAP Part D serves women, infant, children, and youth – populations that tend to have poor health outcomes due to poverty, lack of access to health care, and other factors.

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.

The RWHAP Part D has contributed to the tremendous progress the RWHAP has made toward ending the HIV epidemic in the United States: from 2010 to 2021, HIV viral suppression among RWHAP patients has increased from 69.5 percent to 89.7 percent, and racial and ethnic, age-based, and regional disparities have decreased.[188] However, even with these positive outcomes, fully addressing the HIV epidemic domestically continues to be a challenge as the CDC

[188] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019. http://hab.hrsa.gov/data/data-reports. Published December 2020. Accessed March 2021.

estimates that 1.2 million people in the United States have HIV, and 1 in 8 are unaware of their HIV.[189] In addition, over 36,000 HIV diagnoses occur every year.[190]

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	112	112	112
Average Award	$610,062	$610,062	$610,062
Range of Awards	$119,319-$2,000,640	$119,319-$2,000,640	$119,319-$2,000,640

[189] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2015–2019. HIV Surveillance Supplemental Report 2021;26(No. 1). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed January 2022.
[190] Centers for Disease Control and Prevention. *HIV Surveillance Report*, 2019 (Updated); vol. 32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed January 2023.

RWHAP Part F - AIDS Education and Training Center Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$34,358,000	$34,886,000	$34,886,000	---
MAI (non-add)	$10,144,000	$10,144,000	$10,144,000	---
FTE	4	4	4	---

Authorizing Legislation: Public Health Service Act, Section 2692(b), as amended by Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

FY 2024 Authorization..... ……...….Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

The Ryan White HIV/AIDS Program (RWHAP) Part F AIDS Education and Training Center (AETC) Program supports a network of leading HIV experts who provide locally based, tailored education, clinical consultation, and technical assistance to health care professionals and health care organizations to integrate state-of-the-science comprehensive care for people with or affected by HIV in all states, DC, Puerto Rico, the U.S. Virgin Islands, and the Associated Jurisdictions. The network includes two national centers, eight regional centers, more than 85 regional partner (local sites), the online National HIV Curriculum, and two Integration of the National HIV Curriculum into Health Professions Training programs

The RWHAP AETC program leverages multidisciplinary education and training programs for health care providers in the prevention and treatment of HIV, bolstering the health workforce to ensure delivery of quality services and care for underserved populations.

Ending the HIV Epidemic in the U.S. - AETC Program

Eleven RWHAP AETC Program recipients received funding through the Ending HIV Epidemic (EHE) initiative to expand workforce capacity by offering training and technical assistance to health care providers and paraprofessionals in FY 2022. Jurisdictions utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States.

Budget Request

The FY 2024 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F-AETC of $34.8 million is equal to the FY 2023 Enacted level. The requested funding levels will assure access to high-quality HIV care by supporting targeted, multidisciplinary education and training

programs for new and experienced health care providers treating people with HIV. 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 HIV Curriculum e-Learning Platform 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 positive 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, with a particular focus on training health care providers on delivering high quality HIV care and treatment services in primary care 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.

Funding History[191]

Fiscal Year	Amount
FY 2014	$33,275,000
FY 2015	$33,349,000
FY 2016	$33,611,000
FY 2017	$33,530,000
FY 2018	$33,611,000
FY 2019	$33,611,000
FY 2020	$33,611,000
FY 2021	$33,510,000
FY 2022	$34,358,000
FY 2023	$34,886,000
FY 2024 President’s Budget	$34,886,000

Program Accomplishments

The RWHAP AETC Program targets training to health care providers who serve underserved populations, including rural communities, racial and ethnic minority populations, the homeless, incarcerated persons, federally qualified community and migrant health centers, and RWHAP

[191] EHE funding is not included in this table.

sites. AETC-trained health care providers are trained to offer innovative and culturally- and linguistically appropriate healthcare services that empowers clients. This directly supports the HHS goal to protect and strengthen equitable access to high quality and affordable healthcare.

The RWHAP AETC Program trains providers through a variety of training modalities, including didactics, clinical preceptorships, self-study, clinical consultation, communities of practice and distance-based technologies. A variety of educational formats are used, including skills building workshops, hands-on preceptorships and mini-residencies, on-site training, tele-education, and technical assistance. For example, the RWHAP AETC implemented an online interactive platform that hosts an HIV care and treatment curriculum targeted to health care professionals. Clinical faculty also provides timely clinical consultation in person or via the telephone or internet.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
4051.01 Percentage of health professionals trained through the RWHAP AETC who are racial and ethnic minorities. (Output)	FY 2021: 53% Target: 46% (Target Exceeded)	46%	50%	+ 4 percentage points

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	14	14	14
Average Award	$2,446,239	$2,363,992	$2,363,992
Range of Awards	$587,179 – 4,215,804	$550,000 – 4,500,000	$550,000 -$4,500,000

RWHAP Part F - Dental Programs

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$13,414,000	$13,620,000	$13,620,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 2692(b), as amended by Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

FY 2024 Authorization……..……..Expired

Allocation Method:

- Competitive Grants
- Formula Grants
- Contracts

Program Description

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.

Budget Request

The FY 2024 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F-Dental of $13.6 million is equal to the FY 2023 Enacted level. These requested levels will support oral health care for people with HIV and the reimbursement of applicant institutions through the RWHAP Dental Reimbursement Program and funding of the RWHAP Community-Based Dental Partnership Program.

The FY 2024 funding request will support the RWHAP target for training 21,000 providers through both dental programs (includes both didactic and clinical trainings).

The FY 2024 funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology, and other program support costs.

Funding History

Fiscal Year	Amount
FY 2014	$12,991,000
FY 2015	$13,020,000
FY 2016	$13,122,000
FY 2017	$13,090,000
FY 2018	$13,122,000
FY 2019	$13,122,000
FY 2020	$13,122,000
FY 2021	$13,083,000
FY 2022	$13,414,000
FY 2023	$13,620,000
FY 2024 President's Budget	$13,620,000

Program Accomplishments

In FY 2021, the RWHAP DRP awards were able to provide 39 percent of the total non-reimbursed costs requested by 48 participating institutions in support of oral health care. These institutions reported providing care to 19,142 people with HIV, a nearly seven percent increase from 2020 despite the COVID-19 related disruptions in the delivery of oral health care nationwide.

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 2021, 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.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
4052.01: Number of persons for whom a portion/ percentage of their unreimbursed oral	FY 2021: 19,142 Target: 26,000 (Target Not Met)	26,000	Discontinued	N/A

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
health costs were reimbursed. (Output)				
4052.02: Number of providers trained through the RWHAP Part F Dental Reimbursement and Community-Based Partnership Programs (Output)	FY 2021: 20,969 Target: Not Defined (Historical Actual)	N/A	21,000	N/A

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	60	61	61
Average Award	$210,518	$210,518	$210,518
Range of Awards	$315 to $1,646,613	$315 to $1,646,613	$315 to $1,646,613

RWHAP Part F - Special Projects of National Significance

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$25,000,000	$25,000,000	$25,000,000	---
FTE	3	3	3	---

Authorizing Legislation: Public Health Service Act, Section 2691, as amended by Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

FY 2024 Authorization…….…….…..Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

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 to quickly respond to emerging needs of RWHAP clients. Through demonstration and implementation projects, SPNS evaluate the design, utilization, cost, and health-related outcomes of treatment strategies while systemically promoting the dissemination and replication of successful interventions through tools kits and other modalities that allow for rapid dissemination and uptake. 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 to ensure that research investments maximize healthcare value and improve public health. 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.

Budget Request

The FY 2024 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F-SPNS of $25 million is equal to the FY 2023 Enacted level. The requested funding will support the continued development of innovative intervention strategies of HIV care and treatment for populations that have traditionally had lower rates of continuous care and viral suppression.

Through demonstration and implementation projects, SPNS evaluate the design, utilization, cost, and health-related outcomes of treatment strategies while systemically promoting the dissemination and replication of successful interventions through tools kits and other modalities

that allow for rapid dissemination and uptake. This unique program advances knowledge and skills in the delivery of health care and support services to underserved populations. In particular, 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 funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Funding History

Fiscal Year	Amount
FY 2014	$25,000,000
FY 2015	$25,000,000
FY 2016	$25,000,000
FY 2017	$24,940,000
FY 2018	$25,000,000
FY 2019	$25,000,000
FY 2020	$25,000,000
FY 2021	$25,000,000
FY 2022	$25,000,000
FY 2023	$25,000,000
FY 2024 President's Budget	$25,000,000

Program Accomplishments

Of the 47 FY 2022 RWHAP SPNS grant recipients, 21 percent are community-based/AIDS services organizations; 6 percent are state/county/local health departments; 36 percent are community health centers; 21 percent are academic-based clinics; 11 percent are public health research/training institute; and 6 percent are universities/evaluation and technical assistance providers.

Current SPNS initiatives include: Supporting replication of housing interventions in the RWHAP; supporting emerging strategies to improve health outcomes for people aging with HIV; improving collecting and reporting viral suppression data to the Medicaid adult core set; improving care and treatment coordination focusing on black women with HIV.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	47	21	20
Average Award	$455,492	$965,604	$1,011,197
Range of Awards	$205,000 - $4,825,000	$218,093-$4,825,000	$226,185 - $4,825,000

RWHAP – Ending the HIV Epidemic Initiative (EHE)

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$125,000,000	$165,000,000	$290,000,000	+$125,000,000
FTE	27	29	29	---

Authorizing Legislation: Public Health Service Act, Section 311(c) and Title XXVI, as amended by Consolidated Appropriations Act 2022, Public Law 117-103.

FY 2024 Authorization……..……..Not Specified

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

The Ending the HIV Epidemic in the U.S. (EHE) initiative is an HHS-wide effort to reduce new HIV infections to fewer than 3,000 per year by 2030. The multi-year EHE initiative currently focuses on 48 counties, Washington, D.C., San Juan (PR), as well as 7 states that have a substantial rural HIV burden (EHE jurisdictions). 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.

Funding levels for the EHE initiative were informed by modeling by the Centers for Disease Control and Prevention (CDC), that analyzed the impact of specific activities (increased engagement in care and viral suppression, and Pre-Exposure Prophylaxis (PrEP) services uptake) on priority communities, and costs related to provision of these services. At current funding levels, it is estimated that HRSA will serve 76,000 people.

Budget Request

The FY 2024 Budget Request of $290 million for Ending the HIV Epidemic in the U.S. (EHE) is $125 million above the FY 2023 Enacted level. These requested levels will support HIV care and treatment in the 48 counties, DC, San Juan (PR), and seven states that contain more than 50% of new HIV infections.

In FY 2024, HRSA will continue to direct EHE funding to the current 39 RWHAP Part A jurisdictions 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 coordinates with the respective RWHAP 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.

The FY 2024 request of $290 million will greatly increase HRSA's ability to meet the goals of the initiative[178]. The request will support HIV care and treatment needs for an estimated 76,000 clients. The request will allow HRSA to continue efforts to engage people who are newly diagnosed and maintain the HIV care and treatment for those who were reengaged and newly diagnosed in prior years of the initiative. As more people with HIV receive HIV care and treatment, an increase in EHE funding is critical for engaging those out of care and keeping an increasing number of patients on medications to prevent HIV transmissions and improve HIV health outcomes.

As part of EHE, HRSA will fund the RWHAP AETC Program 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 Bureau Reporting Systems (BRS) to provide timely monitoring of the EHE 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.

Funding History

Fiscal Year	Amount
FY 2014	---
FY 2015	---
FY 2016	---
FY 2017	---
FY 2018	---
FY 2019	---
FY 2020	$70,000,000
FY 2021	$105,000,000
FY 2022	$125,000,000
FY 2023	$165,000,000
FY 2024 President's Budget	$290,000,000

Program Accomplishments

The EHE-funded technical assistance (TA) and systems coordination cooperative agreements will continue to support strategies such as data to care efforts that leverage HIV surveillance and other data to identify persons living with HIV who are in need of HIV medical care or other services and facilitating linkage to these services; 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. HRSA and the TA entity utilize and disseminate those lessons learned nationally.

The EHE jurisdictions funded by HRSA will continue to work with their respective 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 Part F AIDS Education and Training Center (AETC) Program will continue 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.

HRSA-funded EHE jurisdictions made significant progress toward implementing the EHE workplans despite the COVID-19 pandemic, and in FY 2021, HRSA EHE-funded service providers served 22,413 clients who were new or re-engaged in HIV care.

Grants Awards Table

The table below includes the awards to jurisdictions only (47 total):

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Jurisdiction Awards	47	47	47
Average Award	$2,186,218	unavailable	unavailable
Range of Awards	$1,200,000 - $13,110,582	unavailable	unavailable

The table below includes the awards to jurisdictions (47), AIDS Education and Training Centers (11), and Technical Assistance and Coordination Providers (2):

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Jurisdiction, AETC, and Technical Assistance Awards	60	60	60
Average Award	$1,912,537	unavailable	unavailable
Range of Awards	$115,910- $13,110,582	unavailable	unavailable

Outputs and Outcomes Table for Over-Arching Performance Measures – RWHAP Part A, Part B, Part C, and Part D (includes Ending the HIV Epidemic initiative)

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
4000.04: Number of people served by the Ryan White HIV/AIDS Program. (Outcome)	FY 2021: 576,076 Target: Not Defined (Historical Actual)	Not Defined	571,000	N/A
4000.01: Percentage of racial and ethnic minorities with diagnosed HIV served by the Ryan White HIV/AIDS Program as compared with the HIV epidemic in the United States (Outcome)	FY 2021: 73.4% Target: Not lower than 3 percentage points of CDC data or 71% (Target Met)	Discontinued	Discontinued	N/A
4000.02: Percentage of women with diagnosed HIV served by the Ryan White HIV/AIDS Program as compared with the HIV epidemic in the United States. (Outcome)	FY 2021: 25.7% Target: Not lower than 3 percentage points of CDC data or 23% (Target Met)	Discontinued	Discontinued	N/A
4000.03: Percentage of Ryan White HIV/AIDS Program clients who are virally suppressed. (Outcome)	FY 2021: 89.7% Target: 83% (Target Exceeded)	84%	85%	+1 percentage point
4000.06: Percentage of Ryan White HIV/AIDS Program female clients who are virally suppressed. (Outcome)	FY 2021: 89.9% Target: Not Defined (Historical Actual)	Not Defined	85%	N/A
4000.05: Percentage of Ryan White HIV/AIDS Program racial and ethnic minority clients who are virally suppressed. (Outcome)	FY 2021: 88.8% Target: Not Defined (Historical Actual)	Not Defined	85%	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
17.I.A.2: Number of RWHAP Part A visits for health-related care. (Output)	FY 2021: 3.2 million Target: 3.6 million (Target Not Met)	3.3 million	Discontinued	N/A
18.I.A.2: Number of RWHAP Part B visits for health-related care. (Output)	FY 2021: 2.8 million Target: 3 million (Target Not Met)	Discontinued	Discontinued	N/A
4020.01: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. (Output)	FY 2021: 289,290 Target: 285,000 (Target Exceeded)	285,000	289,000	+4,000
4020.02: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. (Efficiency)	FY 2020: $2.5 billion Target: Sustain Prior Year Results (Target Not Met)	$2.5 billion	$2.5 billion	Maintain
4020.03: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive antiretroviral medications. (Output)	FY 2021: 99.6% Target: 96% (Target Exceeded)	Discontinued	Discontinued	N/A
19.II.A.3: Number of RWHAP Part C visits for health-related care. (Output)	FY 2021: 2.3 million Target: 2.2 million (Target Met)	Discontinued	Discontinued	N/A
20.II.A.2 Number of RWHAP Part D visits for health-related care and support services. (Output)	FY 2021: 1.6 million Target: 1.5 million (Target Met)	Discontinued	Discontinued	N/A
4060.01 Number of new clients served by RWHAP EHE-funded providers (Output)	FY 2021: 22,413 Target: Not Defined (Historical Actual)	22,000	24,000	+2,000
4060.02 Percentage of new clients who are virally	FY 2021: 78.6% Target: Not Defined	76.2%	76.2%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
suppressed among those clients in medical care served by RWHAP EHE-funded providers (Outcome)	(Historical Actual)			

Considerations for Target Setting

The RWHAP aims to continue to achieve high viral suppression rates for clients in medical care that far exceed the national average and to reduce the health disparity in viral suppression rates among racial and ethnic minorities. The following helped inform the methodology for establishing all four viral suppression targets (both RWHAP and EHE-specific targets):

- People with HIV who are not engaged in care tend to have more complex needs than those that remain engaged. Multiple studies indicate that patients retained in care are more likely to achieve viral suppression compared to those not engaged in regular care.
- Viral suppression can take 3 or more months to achieve based on viral dynamics if the person is routinely engaged in care and able to maintain adherence to HIV medications. .
- Due to the significant number of clients who are not in care or routinely retained in care who will be engaged/re-engaged through the EHE efforts, there is a potential negative impact that new EHE clients may have on overall viral suppression rates as people who are not in care or not retained in care routinely have lower viral suppression rates.
- Despite the improved rates of durable viral suppression in the RWHAP overall,, vulnerable populations, including clients who have been out of care and who have co-morbidities such as mental health and substance use disorders, are still at increased risk of virological failure.[192]

Baselines and targets for EHE measures have been changed due to improvements in EHE reporting and data quality. The baselines for Measure 4060.01 and Measure 4060.02 have been updated with available data from the calendar year 2021 Ryan White HIV/AIDS Services Report. The FY 2024 target for Measure 4060.01 reflects an increase in funding. Note that targets for this measure were adjusted due to a refinement of this performance measure and methodology. The targets were previously based on cumulative clients. The new targets for FY 2023 and FY 2024 are based on newly enrolled clients only. The FY 2024 target for Measure 4060.02 is to maintain enrollment as each year will represent a new cohort of patients who are new or reengaged in care and who therefore will have lower rates of viral suppression than the overall RWHAP.

[192] Durability of viral suppression with first-line antiretroviral therapy in patients with HIV in the UK: an observational cohort study. Lancet HIV. 2017 Jul;4(7):e295-e302.

Health Systems
TAB

HEALTH SYSTEMS

Organ Transplantation

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$30,049,000	$31,049,000	$67,049,000	+$36,000,000
FTE	6	10	25	+15

Authorizing Legislation: Public Health Service Act, Sections 371-378, as amended by Public Law 113-51

FY 2024 Authorization……..……..……..……...……..……..……..…….....Expired

Allocation Method:

- Contracts
- Competitive Grants/Cooperative Agreements
- Other (Interagency Support)

Program Description

The Organ Transplantation Program extends and enhances the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment. The National Organ Transplant Act requires HRSA to oversee a national system, the Organ Procurement and Transplantation Network (OPTN), to allocate and distribute donor organs to individuals waiting for transplants. Organ allocation is guided by OPTN policies informed by analytical support from the Scientific Registry of Transplant Recipients (SRTR). In addition, HRSA funds the Living Organ Donation Reimbursement Program (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 ensure living organ donors' safety.

The OPTN is a critical system that facilitates matching donor organs to transplant candidates. 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 for transplant candidates placed on the waiting list.

The SRTR provides analytical support to the OPTN in the development of organ allocation policies and performance evaluation. Additionally, the SRTR provides analytical support to HHS, including the ACOT. SRTR shares information publicly about the performance of

transplant programs and organ procurement organizations at https://www.srtr.org/. It publishes online transplant program risk-adjusted patient and graft outcomes data 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, and publications nationwide
- Educational web videos for reposting, downloading, 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 number of patients waiting for an organ and the number of donors from these groups.
- Organ donation and transplantation related articles for newspapers and journals
- 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 donor registration

In September 2020, HRSA increased the income eligibility threshold for the Living Organ Donation Reimbursement Program from 300 to 350 percent of the HHS Poverty Guidelines. The Program also expanded the qualified reimbursable expenses to include lost wages and dependent care expenses (childcare and eldercare). The changes aim to increase the number of kidney transplants from living donors and decrease recipient waiting times.

Budget Request

The FY 2024 Budget Request of $67 million is $36 million more than the FY 2023 Enacted level. HRSA plans to address priority issues to increase accessibility, transparency, and equitable distribution of organs through modernization of the OPTN. This request will invest in critical needs to advance OPTN modernization. The budget request also includes a legislative proposal to modernize the statute that governs the OPTN to improve oversight, transparency, accountability, and efficiency in the organ transplantation system.

Specifically, this budget request will support two key initiatives: 1). Program Modernization Design to focus on policy, governance, and technology to drive improvements in IT system performance, health equity, patient outcomes and patient safety; and 2). Modernization Strategy Implementation which will launch implementation of the design features needed to improve system processes, patient experience, and accountability.

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

Funding History

Fiscal Year	Amount
FY 2020	$27,549,000
FY 2021	$29,049,000
FY 2022	$30,049,000
FY 2023	$31,049,000
FY 2024 President's Budget	$67,049,000

Program Accomplishments

The Living Organ Donation Reimbursement Program processed more donor applications in 2022 compared 2021.

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 increases in the numbers of deceased donor organs procured and organ transplants performed annually since 2015. The number of deceased donor organs transplanted in 2022 was 39,861 compared to 38,093 in 2021.

HRSA continues to support efforts to remove financial barriers to living organ donation under the Living Organ Donation Reimbursement Program. In 2022, the Living Organ Donation Reimbursement Program facilitated more than 1,040 living organ transplants, with more than 44% going to R/E minorities.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
5010.01: Annual number of deceased donor organs transplanted	FY 2022: 39,861 Target: 32,652 (Target Exceeded)	33,311	33,994	+683
5010.02: Annual rate eligible deceased donors become actual donors after death.	FY 2022: 69% Target: 74% (Target not Met)	74%	74%	Maintain

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
5010.03: Annual number of people from racial/ethnic minority populations receiving living organ donor transplants facilitated via HRSA's Living Organ Donation Reimbursement Program	FY 2022: 481 Target: Not Defined (Historical actual)	244	424	+180

Performance Narrative

The budget request proposes an increase to support OPTN modernization which will not impact expected performance until after FY 2024. Accordingly, FY 2024 targets resemble the performance of recent years with lower funding.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	1	1	1
Average Award	$9,700,000	$7,000,000	$8,000,000
Range of Awards	$9,700,000-$9,700,000	$7,000,000 - $7,000,000	$8,000,000 - $8,000,000

Blood Stem Cell Transplantation Program[193]

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$50,275,000	$52,275,000	$52,275,000	---
FTE	8	8	8	---

Authorizing Legislation: Public Health Service Act, Section 379-379B, as amended by Public Law 117-15

FY 2024 Authorizations:
C.W. Bill Young Cell Transplantation…..…….....$31,009,000
National Cord Blood Inventory……..……$23,000,000

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[194] 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),.

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, however, only 30 percent of people have a fully matched relative. The other 70 percent, often search for a matched unrelated adult donor or umbilical cord blood unit.

[193] The National Cord Blood Inventory (NCBI) and the C.W. Bill Young Cell Transplantation Program (CWBYCTP) were funded separately in FY 2022 and FY 2023.
[194] Public Health Service Act, Sections 379-379B, as amended by P.L. 117-15 states that the term 'bone marrow' means the cells found in the adult bone marrow and peripheral blood.

The BSCTP operates through four major 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:

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 provides funds through competitive contracts for the collection and storage of qualified cord blood units (CBUs) by a network of public umbilical cord blood banks in the U.S. HRSA prioritizes cord blood banks that have biological license agreements (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.

Budget Request

The FY 2024 Budget Request of $52.3 million is equal to the FY 2023 Enacted level. The FY 2024 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 expects the registry will list approximately 4 million adult donors who self-identify as belonging to an underrepresented racial or ethnic population and add approximately 3,100 cord blood units in FY 2024. 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.

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

Funding History

Fiscal Year	Amount
FY 2020	$47,275,000
FY 2021	$49,275,000
FY 2022	$50,275,000
FY 2023	$52,275,000
FY 2024 President's Budget	$52,275,000

Program Accomplishments

The Blood Stem Cell Transplantation Program 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 2022, more than 24 million potential adult volunteer donors and over 111,000 HRSA-funded CBUs (see Table 1) were listed on the C.W. Bill Young Cell Transplantation Program's registry.

Table 1. Cord Blood Collections

Fiscal Year	HRSA-funded NCBI CBU	CBU Collected and Made Available[195] for Patient Searches	Cumulative CBU Made Available
2016	5,840	6,660	90,261
2017	6,369	7,719	97,980
2018	7,774	4,889	102,869
2019	3,958	4,594	107,463
2020	4,567	4,049	111,512
2021	4,117	5,418	116,930
2022	3,937	3,556	111,002

The FY 2022 goal of 4 million adult donors who self-identified as belonging to an underrepresented racial or ethnic population was met. HRSA expects the registry will list 4.02 million adult donors who self-identify as belonging to an underrepresented racial or ethnic population and add 3,127 cord blood units in FY 2024. The number of cord blood units collected varies yearly based on funding levels and the contractors' ability to collect and store units from diverse populations.

[195] 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.

As shown in Table 2, the number of cord blood units released for transplants increased in FY 2022 from FY 2021, at 342 and 313 cord blood units, respectively. The total number of cord blood units released for transplantation has been decreasing since FY 2017 due to the increasing use of alternative therapies. Despite this recent trend, cord blood remains key in servicing a diverse population.

Table 2. Cord Blood Units Released for Transplantation

Fiscal Year	HRSA-funded CBUs Released for Transplantation	Total CBUs (HRSA-funded and Non-HRSA funded) released for Transplantation through the BSCTP
2017	494	1,050
2018	493	949
2019	459	848
2020	344	702
2021	313	589
2022	342	576

Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
5020.01: The cumulative number of cord blood units from underrepresented racial and ethnic populations available through the C.W. Bill Young Cell Transplantation Program[196] (Outcome)	FY 2022: 168,777 Target: 148,721 (Target Exceeded)	149,721	166,643	+16,922
5020.02: The number of HRSA-funded cord blood units banked and available through the C.W. Bill Young Cell Transplantation Program (Outcome)	FY 2022: 111,002 Target:113,000 (Target Not Met)	117,000	120,310	+3,310

[196]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 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
5020.03: The annual number of cord blood units released for transplant.[197] (Outcome)	FY 2022: 342 Target: 350 (Target Not Met)	350	Discontinued	N/A
5020.04: The number of blood stem cell transplants facilitated by the Program. (Outcome)	FY 2022: 6,425 Target: Not Defined (Historical Actual)	Not Defined	Not Defined	Maintain
5020.05: The number of blood stem cell transplants facilitated for minority patients by the Program.[198] (Outcome)	FY 2022: 649 Target: Not Defined (Historical Actual)	Not Defined	Not Defined	Maintain
5020.06: The rate of patient survival at one-year, post-transplant. (Outcome)	FY 2022: 75% Target: Not Defined (Historical Actual)	Not Defined	Discontinued	N/A
5020.07: The number of blood stem cell transplants facilitated for domestic patients by the Program. (Outcome)	FY 2022: 5,398 Target: Not Defined (Historical Actual)	Not Defined	Discontinued	N/A
5020.08: The unit cost of human leukocyte antigen (HLA) typing of potential donors. (Efficiency)	FY 2021: $58.00 Target: $58.00 (Target Met)	$62.00	Discontinued	N/A
5020.09: The number of adult volunteer potential donors of blood stem cells from under-represented racial and ethnic populations. (Outcome)	FY 2022: 4 million Target: 4 million (Target Met)	4.02 million	4.02 million	Maintain

[197]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.
[198]This is a long-term measure. The next target will be set for FY 2025.

Performance Narrative:

The 5020.01 Performance Measure 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 Measure 5020.05, the total number of cord blood units available through the BSCTP.

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 for Measure 5020.03.

Measures 5020.04 and 5020.05 are long term measures and will not set targets until FY 2025.

Contract Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	9	9	9
Average Award	$5,475,000	$5,475,000	$5,475,000
Range of Awards	$427,100-$21,343,000	$70,000-$23,364,000	$70,000-$23,131,000

National Hansen's Disease Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$13,706,000	$13,706,000	$13,706,000	---
FTE	36	36	36	---

Authorizing Legislation: Public Health Service Act, Section 320, as amended by Public Law 1057-220

FY 2024 Authorization .....Indefinite

Allocation Methods:
- Direct Federal/Intramural
- Contract

Program Description

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 residing in the United States (U.S.) or its territories. The Program strengthens the safety net infrastructure for patients with this rare disease by focusing on case management, patient compliance, and clinical training on the diagnosis and management of Hansen's disease. The Program makes specific outreach efforts to health care providers who are likely to encounter and treat patients in geographic areas most impacted by the disease. The more complicated HD cases are treated as short-term referrals in the NHDP clinic in Baton Rouge, Louisiana.

Ninety-five percent of the human population is not susceptible to infection with Mycobacterium leprae or Mycobacterium lepromatosis, the bacteria that cause leprosy. Hansen's disease is not highly transmissible, is very treatable, and is not disabling with early diagnosis and treatment. Treatment with standard antibiotic drugs is very effective, and patients become noninfectious after taking only a few doses of medication and need not be isolated from family and friends. However, diagnosis in the U.S. is often delayed because many health care providers are unaware of Hansen's disease and its symptoms. Early diagnosis and treatment prevent nerve involvement and the disability it causes. People with leprosy can generally continue their normal work and other activities while under treatment, which may last several years.

Protect individuals, families, and communities against communicable and infectious disease through effective, innovative, readily available, and equitable delivery of treatment and therapeutics: Increasing health care provider knowledge about Hansen's disease will lead to earlier diagnosis and treatment, which are crucial 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 patient transportation.

Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion: 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 advanced 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 and determine the origin and transmission of infection.

Invest in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, health care, public health, and human services resulting in more effective interventions, treatments, and programs: NHDP is the sole worldwide provider of reagent grade viable leprosy bacilli and collaborates with researchers across the globe to support scientific advances related to the disease. NHDP coordinates and collaborates with Federal, State, local, and private programs to promote and improve the quality of care and health outcomes related to Hansen's disease.

Budget Request

The FY 2024 Budget Request of $13.7 million is equal to the FY 2023 Enacted level. This request supports the Program's primary focus of 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.

NHDP will recompete its ambulatory care contracts in FY 2023 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 request will allow NHDP to continue outreach and education to the medical community about the diagnosis and treatment of Hansen's disease. Finally, the request will provide for the purchase and maintenance of state-of-the-art laboratory equipment to perform PCR testing of patient tissue samples.

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.

Funding History

Fiscal Year	Amount
FY 2020	$13,706,000
FY 2021	$13,706,000
FY 2022	$13,706,000
FY 2023	$13,706,000
FY 2024 President's Budget	$13,706,000

Program Accomplishments

To improve public health by raising awareness, the NHDP used digital and social media platforms to assist individuals in recognizing the signs and symptoms of Hansen's disease, as well as presented on leprosy at national conferences for health professionals.

To improve access to quality health services: NHDP reduced the burden for patients and practitioners served by the National Hansen's Disease Program by completing 1,159 telehealth or teleconsultation sessions in FY 2022.

To accelerate advancements in science and research: NHDP's Lab Research Branch submitted 13 manuscripts for peer-reviewed journals in FY 2022. Additionally, three abstracts were accepted for the International Leprosy Congress in November 2022.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
5050.01 Number of health care providers who have received training from NHDP (Output)	FY 2022: 662 Target: 500 (Target Exceed)	600	700	+100
5050.02 Number of human tissue samples on which clinically diagnostic Polymerase Chain Reactions were performed (Output)	FY 2022: 232 Target: 200 (Target Exceeded)	200	200	Maintain

Performance Narrative

NHDP conducts Polymerase Chain Reactions (PCR) on all tissue samples received. Using PCR in conjunction with histopathological interpretation of tissue samples increases the accuracy of HD diagnosis. Additionally, using PCR alone provides the determination of a positive diagnosis sooner, allowing the provider to start treatment protocols without delay. Finally, PCR is the only test currently available to distinguish between M. leprae and M. lepromatosis infection, which has important implications in the clinical management of the disease.

National Hansen's Disease Program - Payment to Hawaii

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
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 2024 Authorization……Indefinite

Allocation Method……. Direct Federal

Program Description

Payments are made to the State of Hawaii for the medical care and treatment of persons with Hansen's disease. Through the Hansen's Disease Community Program administered by the Hawaii Department of Health, the State monitors and treats Hansen's disease throughout Hawaii. Expenses above the level of the Federal funds appropriated for the support of medical care are borne by the State of Hawaii.

Budget Request

The FY 2024 Budget Request for the National Hansen's Disease Program – Payment to Hawaii of $1.9 million is equal to the FY 2023 Enacted level. This request supports the payment made to the State of Hawaii for the medical care and treatment of persons with Hansen's disease.

Funding History

Fiscal Year	Amount
FY 2020	$1,857,000
FY 2021	$1,857,000
FY 2022	$1,857,000
FY 2023	$1,857,000
FY 2024 President's Budget	$1,857,000

Program Accomplishments

FY 2022 accomplishments focused on continuing the case management of 262 active registered cases along with 595 registered contacts, amid the COVID 19 pandemic. Efforts were made to have protective supplies to both staff and patients so that face to face case management and contact tracing services could be maintained in a safe manner. Staff time and energy went to also educating about COVID 19 precautions and measure to take. Hansen's disease patients in

reaction could have more complications if they also had COVID 19, so program efforts were made to get patients to clinics for vaccines, boosters, and testing when needed.

FY 2023 saw the return of the program doing outreach and mass education and Hansen's disease screening for early detection among the high-risk individuals in the two Job Corp Centers in the State of Hawaii. This also involves travel of staff to neighbor islands which had to be curtailed during the pandemic. Individuals who are screened and show suspicious signs of Hansen's disease are referred for further medical evaluation and the program will cover the cost of biopsies and testing if the person has no access to medical insurance. This FY, we were able to find a willing provider in rural Maui who is willing to see our referrals. Prior to this FY, the area had not had steady medical access for Hansen's disease medical. Another group requiring more intensive case management in this FY is the formerly institutionalized patients who elected to live in the community on their own. This population is steadily aging and requiring additional services and assistive aids to keep them safe in their own homes.

National Hansen's Disease Program – Buildings and Facilities

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$122,000	$122,000	$122,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 320

FY 2024 Authorization…….. Indefinite

Allocation Method……. Direct Federal

Program Description

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.

Budget Request

The FY 2024 Budget Request of $122,000 is equal to the FY 2023 Enacted level. The request will facilitate the upgrade to the floors at the Carville Museum.

The funding request also includes special projects that enhance the safety and/or functionality of the workspace not covered by the lessor.

Funding History

Fiscal Year	Amount
FY 2020	$122,000
FY 2021	$122,000
FY 2022	$122,000
FY 2023	$122,000
FY 2024 President's Budget	$122,000

Program Accomplishments

Past funding has been used to update patient rooms at Carville – eliminating deficiencies and bringing facilities up to acceptable standards of safety, comfort, and human dignity.

Rural Health Policy

TAB

FEDERAL OFFICE OF RURAL HEALTH POLICY

Rural Health Policy Development

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$11,076,000	$11,076,000	$11,076,000	---
FTE	3	3	3	---

Authorizing Legislation: Social Security Act, Section 711, as amended by 21st Century Cures Act, Sections 2012, 2013, 2035, and 2043, Public Law 114-255.

FY 2024 Authorization ……...Indefinite

Allocation Method .....Competitive Grants/Cooperative Agreement

Program Description

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, which is competitive in FY 2024, 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 both the Federal and state levels. 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 and Economic Development Analysis Program supports one award to analyze the economic impacts of local health care sectors on rural economies. The Rural Health Research Dissemination Program, 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. This research also aligns with Administration priorities, such addressing substance use, increasing access to care, and improving health equity.

FORHP funds programs that collect and disseminate information on rural health care issues and identify promising approaches to improving and enhancing health care delivery in rural communities. 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. The National Rural Health Policy, Community, and Collaboration Program engages rural stakeholders to educate and collaborate on national rural health policy issues and promising practices to improve the health of people living in rural communities nationwide. The Rural Telementoring Training Center Program provides 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. The Rural Health Clinic (RHC) Technical Assistance Program identifies key policy, regulatory, programmatic, and clinical issues facing RHCs and informs RHCs and other rural stakeholders about key RHC issues. The Rural Health Innovation and Transformation Technical Assistance Program provides technical assistance to support rural health care through innovative payment models and to promote the value-based care landscape in the context of rural health care.

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.

Budget Request

The FY 2024 Budget Request of $11.1 million is equal to the FY 2023 Enacted level. This request would allow HRSA to fully fund the following: Rural Health Research Center Program; Rapid Response Rural Data Analysis and Issue Specific Rural Research Studies Program; Rural Health Research Gateway; National Rural Health Information Clearinghouse Program; National Rural Health Policy, Community, and Collaboration Program; Rural Telementoring Training Center Program; Rural Health Clinic Technical Assistance Program; Rural Health and Economic Development Analysis Program; Rural Health Innovation and Transformation Technical Assistance Program; and the National Advisory Committee on Rural Health and Human Services. The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Funding History

Fiscal Year	Amount
FY 2020	$10,351,000
FY 2021	$11,076,000

FY 2022	$11,076,000
FY 2023	$11,076,000
FY 2024 President's Budget	$11,076,000

Program Accomplishments

The Rural Health Research Center Program increases the amount of publicly available, policy-relevant research to assist providers and decision/policy-makers at the federal, state, and local levels to better understand health and health care problems faced by rural communities. This work also informs FORHP's statutory charge to advise the HHS Secretary on rural health policy issues. The eight research centers each receiving funding for four research projects per fiscal year with the expectation that each project will result in at least one publication. Examples of recent research include:

- Examining the economic effects of rural hospital closures
- Measuring state and regional differences in the availability of hospital-based obstetric services among rural hospitals
- Assessing rural-urban differences in child and adolescent mental health
- Quantifying trends in health workforce supply in rural areas
- Analyzing counties with no retail pharmacies

Through the Rapid Response Rural Data Analysis and Issue Specific Rural Research Studies Program 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 January 31, 2023, 143 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.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6010.01 Number of rural health research products released during the fiscal year (Output)	FY 2022: 81 Target: 43 (Target Exceeded)	47	47	Maintain

Performance Narrative

In FY 2022, these Federally-funded research programs conducted and disseminated 81 research reports, including policy briefs posted on the Rural Health Research Gateway website and manuscripts published in peer-reviewed journals. This was significantly above the FY 2022 target of 43 research products because several studies resulted in multiple publications. HRSA

has repositioned the rural research program to develop more robust technical research products and comprehensive chartbooks and fewer short research briefs. HRSA anticipates that this adjustment will result in a decrease in the total number of research products in FY 2023 and FY 2024 compared to FY 2022. Targets for this measure in future years remain consistent to reflect the requirement of one publication per research project and level funding of the program.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	16	16	16
Average Award	$830,588	$830,588	$830,588
Range of Awards	$100,000 - $3,000,000	$100,000 - $3,000,000	$100,000 - $3,000,000

Rural Health Outreach Grants

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$85,975,000	$92,975,000	$95,375,000	+$2,400,000
FTE	10	12	12	---

Authorizing Legislation: Public Health Service Act, Section 330A, as amended by CARES Act, Section 3213, Public Law 116-136, and Social Security Act, Section 711, as amended by Public Law 108-173.

FY 2024 Authorization (330A) …… $79,500,000

FY 2024 Authorization (711) ……. Indefinite

Allocation Method ..... Competitive Grants and Cooperative Agreements

Program Description

The Rural Health Care Services Outreach, Network and Quality Improvement Grants (Outreach programs) improve rural community health by focusing on quality improvement, increasing health care access, coordination of care, and integration of services.

Outreach grant programs support collaborative models to deliver basic health care services to rural areas and are uniquely designed to meet rural needs. The grants allow rural communities to compete for funding against other rural communities, rather than competing against larger metropolitan communities with greater resources. The Outreach programs are structured to allow applicants and 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. Eligible entities for these programs are community-based organizations serving rural areas.

- Rural Health Care Services Outreach Program focuses 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 in FY 2024.

- Rural Health Network Development Program supports 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 fund 44 continuing awards in FY 2024.

- Rural Health Network Development Planning Program 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 disorder. HRSA will make over 30 new awards in FY 2024.

- 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 support 21 continuing awards in FY 2024.

- 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 as a pilot program in response to research by the University of Minnesota that revealed a decreasing availability of obstetric units in rural areas.[199] This program intends to demonstrate the impact on access to and continuity of maternal and obstetrics care in rural communities through testing models that address the following focus Areas:
    1) Rural Hospital Obstetric Service Aggregation and Approaches to Risk Appropriate Care
    2) Network Approach to Coordinating a Continuum of Care
    3) Leveraging Telehealth and Specialty Care
    4) Financial Sustainability

  As part of an HHS-wide initiative to improve maternal health, HRSA will support 7 continuing awards and 2 new awards.

- Delta Region Community Health Systems Development Programs enhance healthcare delivery in the rural counties and parishes of the Mississippi Delta region. HRSA implements these programs in coordination with the Delta Regional Authority. The Delta Region Community Health Systems Development technical assistance 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 performance. HRSA will continue to support this award in FY 2024. This single awardee provides resources to help rural communities develop partnerships and jointly address health problems that

[199] 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

affect the Delta region. HRSA will support 20 continuing communities and 10 new communities in FY 2024. The Delta Region Rural Health Workforce Training Program helps improve healthcare delivery in rural areas by training future and current health professionals for high-quality jobs in the rural counties and parishes of the Mississippi Delta Region in the following critical administrative support professions: medical coding and billing, insurance claims processing, health information management, clinical documentation, business operations for healthcare organizations, and supply chain and materials management. HRSA will support five continuing awards in FY 2024.

- The Delta States Rural Development Network Grant Program provides network development grants to the eight states in the Mississippi Delta for network and rural health infrastructure development. This program is geographically targeted, given the health care disparities across this eight-state region. The program supports chronic disease management, oral health services, and recruitment and retention efforts for health professionals. The program requires grantees to focus on diabetes, cardiovascular disease, and obesity and to develop programs based on promising practices or evidence-based models. HRSA will make 12 continuing awards in FY 2024.

- Rural Northern Border Region Healthcare Support Program provides technical assistance to rural communities in the region of the Northern Border Regional Commission (NBRC) in their efforts to enhance access to health (including behavioral health); improve recruitment and retention of health care providers; and assist rural hospitals and clinics in their efforts to take part in health care value efforts. HRSA will support 1 continuing award in FY 2024.

- 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 coordination strategies in rural communities. HRSA will make 10 continuing awards in FY 2024.

Budget Request

The FY 2024 Budget Request of $95.4 million is $2.4 million above the FY 2023 Enacted level. This request will support the continuation of 158 existing grantees, and 32 new competitive grants that will positively affect health care service delivery for over 520,000 people. This investment includes $10.4 million for RMOMS, an increase of $2.4 million above the FY 2023 Enacted level. The Budget will help address unmet needs for rural communities which include populations who have historically suffered from poorer health outcomes, health disparities and other inequities. 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

Fiscal Year	Amount
FY 2020	$79,500,000
FY 2021	$82,153,000
FY 2022	$85,975,000
FY 2023	$92,975,000
FY 2024 President's Budget	$95,375,000

Program Accomplishments

Across the most recent 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 so that rural communities from across the country can benefit from Outreach program investments and results. Grant funds supported the technical assistance for grantees to ensure successful implementation of their programs and evaluation to demonstrate outcomes of the program.

In FY 2021, 434,448 unique individuals received services through the Outreach, Delta and Quality Improvement Programs and has consistently increased throughout the years. Additionally, these grants are intended to be demonstration projects for rural communities to kick start an initiative that may not be otherwise be implemented with scarce resources and level of competition within the federal grants process. Therefore, sustainability of their projects has been a critical element of these grants. Sustainability is assessed as each program's project period ends. While sustainability rates may vary across grantee cohorts, HRSA expects the majority of projects to continue after Federal funding. In FY 2021, the Small Healthcare Provider Quality Improvement Program grantees reported that 100% will sustain all or part of their projects. This is partly accomplished by the technical assistance provided by FORHP to the grantees during their grant cycle.

Grantees use the newly redesigned Rural Health Information (RHI) Hub's Economic Impact Analysis 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. In FY 2021, the work of Small Healthcare Provider Quality Improvement Program grantees generated an average of $1.85 of economic impact into their rural communities for every HRSA dollar spent.

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. Beginning in FY 2021, FORHP assessed grantees that showed improvement in one or more clinical quality measures. Clinical measures include reductions in diabetic

hemoglobin A1c scores (HgbA1c), blood pressure scores, and body mass index (BMI's) calculation. For FY 2020, the Small Healthcare Provider Quality Improvement Grants showed that 97% of grantees showed improvement in at least one or more improvement in clinical measures.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6020.01 Number of unique individuals who received direct services through Federal Office of Rural Health Policy Outreach grants (Output)	FY 2021: 434,448 Target: 430,000 (Target Exceeded)	516,000	525,000	+9,000
6020.02 Percent of Outreach Authority grantees that will continue to offer services after the Federal grant funding ends. (Output)	FY 2021: 100% Target: 75% (Target Exceeded)	80%	85%	+5 percentage points
6020.03 Percentage of grantees that showed improvement in one or more clinical quality measures. (Outcome)	FY 2021: 97% Target: Not Defined (Baseline)	Not Defined	90%	N/A

Performance Narrative

A new measure was added this fiscal year to demonstrate the impact of Outreach programs with clinical focused activities. Due to the flexible nature of Outreach programs, not all grantees have projects with clinical projects/outcomes and associated measures. Grantees report on the measures that are applicable to their funded project. For the purposes of measure 6020.03, "Improvement" is defined as showing an improvement from baseline (either year 1 or year 2, as not all grantees report in year 1) compared to the end (final year) of the grant.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	179	184	188
Average Award	$321,370	$329,615	$330,921
Range of Awards	$100,000 - $13,000,000[200]	$100,000 - $15,000,000[201]	$100,000 - $15,000,000[202]

[200] This represents six awardees worth up to $15 million for the Delta Region Community Health Systems Development Cooperative Agreement.
[201] This represents six awardees worth up to $15 million for the Delta Region Community Health Systems Development Cooperative Agreement.
[202] This represents six awardees worth up to $15 million for the Delta Region Community Health Systems Development Cooperative Agreement.

Rural Hospital Flexibility Grants

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$62,277,000	$64,277,000	$64,277,000	---
FTE	3	3	3	---

Authorizing Legislation: Social Security Act, Section 1820(j), as amended by Patient Protection and Affordable Care Act, Section 3129, Public Law 111-148. Social Security Act, Section 711, as amended by Public Law 108-173

FY 2024 Authorization …….. Expired

Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts

Program Description

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, financial, and performance improvement activities, as well as help eligible rural hospitals convert to CAH status and enhance CAH-related emergency medical services. The Flex Program's goal is to help CAHs maintain high-quality and economically viable facilities to ensure that rural community residents, particularly Medicare beneficiaries, have access to high-quality health care services. States use Flex resources to address identified CAH needs and to achieve improved and measurable outcomes in each selected program area. In FY 2022, HRSA funded a new two-year initiative supporting emergency medical services (EMS) across six states focused on quality improvement efforts. There will be a new competition in FY 2024 for the initiative supporting EMS. Additionally, the general Flex program will be re-competed in FY 2024 and 45 awards are anticipated.

  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.

- Small Rural Hospital Improvement Program (SHIP) provides support to states who assist 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-11 standards, and for software that captures patient satisfaction data.

- Flex Rural Veterans Health Access Program focuses on increasing the delivery of mental health services or other health care services to meet the needs of Operation Iraqi Freedom and Operation Enduring Freedom veterans living in rural areas. Grantees focus 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.

- Rural Emergency Hospital Technical Assistance: In FY 2022, HRSA awarded funds to a national center to ensure rural hospitals and the communities they serve have the information and resources needed to make informed decisions as to whether the Rural Emergency Hospital model of care is best for their communities and facilitate a successful implementation of Rural Emergency Hospital requirements for those hospitals converting to this new provider type.

Budget Request

The FY 2024 Budget Request of $64.3 million is equal to the FY 2023 Enacted level. This request will support the continued efforts to states to support Medicare Rural Hospital Flexibility Grant, Small Rural Hospital Improvement Grant, and the Rural Veterans Health Access Program. Additionally, this request will support funding for the Rural Emergency Hospital Technical Assistance. 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

Fiscal Year	Amount
FY 2020	$53,609,000
FY 2021	$55,442,000
FY 2022	$62,277,000
FY 2023	$64,277,000
FY 2024 President's Budget	$64,277,000

Program Accomplishments

FORHP collaborating with 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. FORHP continued a peer learning program to encourage focus on quality improvement in key priorities even during a pandemic.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6030.03 Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (Output)	FY 2021: 91.5% Target: 86% (Target Exceeded)	71%	78%	+7 percentage points
6030.01 Percentage of Critical Access Hospitals participating in one or more Flex-funded required quality improvement initiatives that showed improvement in one or more specified quality domains. (Outcome)	FY 2021: 71% Target: 70% (Target Exceeded)	75%	75%	Maintain
6030.02 Percentage of Critical Access Hospitals participating in one or more Flex-funded optional quality improvement initiatives that showed improvement in one or more specified quality domains. (Outcome)	FY 2021: 55% Target: 50% (Target Exceeded)	55%	55%	Maintain

Performance Narrative

FORHP increased support to states in 2021 to focus on quality improvement efforts on measures meaningful to the hospitals. The percentage of hospitals demonstrating improvement in both the required and optional quality improvement initiatives increased. The participation in CAHs in the Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) patient

experience reporting continued to improve. With the increased focus on improvement efforts through the program, the targets for FY 2024 are to maintain the efforts of hospitals focusing on quality, recognizing the continued challenges rural hospitals face coming out of the pandemic.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	95	95	95
Average Award	$615,000	$635,000	$635,000
Range of Awards	$39,033 - $2,500,000	$39,033 - $2,5000,000	$39,033 - $2,500,000

State Offices of Rural Health

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$12,500,000	$12,500,000	$12,500,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Services Act, Section 338J, as reauthorized by State Offices of Rural Health Reauthorization Act of 2022, Section 2, Public Law 117-356.

FY 2024 Authorization ……Expires FY 2027

Allocation Method .....Competitive Grants/Cooperative Agreement

Program Description

This 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.

Budget Request

The FY 2024 Budget Request for the State Offices of Rural Health program of $12.5 million is equal to the FY 2023 Enacted level. This request will continue to invest in the State Offices of Rural Health who will continue to support rural communities by connecting them with resources about funding opportunities, information on health care policy changes. The State Offices of Rural Health will partner with federal, regional, state, local agencies, and communities to improve access to high quality maternal health and behavioral health services in rural areas.

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

Funding History

Fiscal Year	Amount
FY 2020	$12,500,000
FY 2021	$12,462,000
FY 2022	$12,500,000
FY 2023	$12,500,000
FY 2024 President's Budget	$12,500,000

Program Accomplishments

The State Offices of Rural Health were fundamental to the success of Rural Health Clinics (RHC) implementing projects with COVID-19 funding. SORHs built new relationships with these key providers that are part of the rural health care safety net. Beyond their role of providing information and assistance for RHCs to apply for the COVID-19 funding, SORH incorporated new RHC programming within their regular activities. Fifteen states have RHC activities within their workplans, including hosting regular calls and having RHC specific email lists for resource sharing.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6040.01 Number of technical assistance (TA) encounters provided directly to clients by State Offices of Rural Health (Output)	FY 2021: 91,562 Target: 67,695 (Target Exceeded)	69,054	69,804	+750
6040.02 Number of clients (unduplicated) that received technical assistance directly from State Offices of Rural Health. (Output)	FY 2021: 24,544 Target: 23,261 (Target Exceeded)	23,729	24,000	+271

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6040.03 Number of clinician placements facilitated by the State Offices of Rural Health through their recruitment initiatives (Output)	FY 2021: 2,070 Target: 1,260 (Target Exceeded)	1,300	1,350	+50

Performance Narrative

The FY 2021 results are a reflection that all State Offices of Rural Health played a key role in supporting COVID-19 information sharing on public health information during the pandemic, and many SORHs were actively involved in state response efforts, which created the opportunity for SORHs to build new strategic relationships. With a shift to post-pandemic realities the SORH program anticipates the number of technical assistance encounters to reduce as rural communities rebalance their priorities.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 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

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$1,889,000	$1,889,000	$2,734,000	+$845,000
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 417C, as amended by National Institutes of Health Reform Act of 2006, Section 103, 104, Public Law 109-482.

FY 2024 Authorization ……. Indefinite

Allocation Method ..... Competitive Grants

Program Description

Established in 2000 under the Radiation Exposure Compensation Act (RECA), 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. Eligible entities include organizations located in the high-impact states cited in the Radiation Exposure Compensation Act (42 U.S.C. 2210 and Public Law 106-245). These high-impact states include Arizona, Colorado, Idaho, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas, Utah, Washington, or Wyoming.

Budget Request

The FY 2024 Budget Request of $2.7 million is $1 million more than the FY 2023 Enacted level. This request will continue to support activities such as: implementing cancer screening programs; developing education programs; disseminating information on radiogenic diseases and the importance of early detection; screening eligible individuals for cancer and other radiogenic diseases; providing appropriate referrals for medical treatment; and facilitating documentation of Radiation Exposure Compensation Act claims.

On June 7, 2022, the President signed into law the RECA Extension Act of 2022. This law extends the termination of the RECA Trust Fund and the filing deadline for all claims for two years from its date of enactment, extending the statutory deadline to June 10, 2024. With this change, increased resources will assist RESEP grantees on furthering outreach and education to facilitate RECA claims documentation.

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

Fiscal Year	Amount
FY 2020	$1,834,000
FY 2021	$1,828,000
FY 2022	$1,889,000
FY 2023	$1,889,000
FY 2024 President's Budget	$2,734,000

Program Accomplishments

RESEP grantees have continued to implement cancer screening and education programs, share information on radiogenic diseases and the importance of early detection, screen eligible individuals for cancer and other radiogenic disease, provide appropriate referrals for medical treatment, and facilitate documentation of Radiation Exposure Compensation Act claims.

Grantees use evidence-based practice strategies to accomplish their work, incorporating elements including clinical expertise, current best evidence and patient perspectives. Performance has remained consistent compared with previous years. The number of individuals screened increased from 738 in FY 2020 to 832 in FY 2021.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6050.01 Total number of individuals screened per year through the Radiation Exposure Screening and Education Program (Output)	FY 2021: 832 Target: 1,300 (Target Not Met but Improved)	300	750	+450

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6050.02 Percentage of successful Radiation Exposure Compensation Act claims filed by Radiation Exposure Screening and Education Program clinics. (Outcome)	FY 2021: 90% Target: Not Defined (Historical Actual)	80%	80%	Maintain

Performance Narrative

Due to statutory requirements and demographic realities the population utilizing RESEP services and the eligible population for RECA compensation are decreasing. These realities have a direct impact on the results of RESEP performance measures.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	8	8	8
Average Award	$212,510	$212,510	312,594
Range of Awards	$$110,446 - $231,132	$$110,446 - $231,132	$162,500 - $340,000

Black Lung

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$11,845,000	$12,190,000	$12,190,000	---
FTE	---	---	---	---

Authorizing Legislation: Federal Mine Safety and Health Act, Public Law 91-173, Section 427(a), as amended by Black Lung Benefits Reform Act of 1977, Section 9, Public Law 95-239.

FY 2024 Authorization……...Indefinite

Allocation Method……Competitive Grants/Cooperative Agreement

Program Description

Established in 1979, through authorization from the Federal Mine Safety and Health Act of 1977, 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. Black Lung Clinics work to reduce 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, grantees have been able to use funds to upgrade equipment, enhance their workforce capacity and increase behavioral health screenings and care integration.

HRSA also funds the Black Lung Data and Resource Center (BLDRC)in supporting and strengthening the operations of BLCP awardees and their ability to examine and treat respiratory and pulmonary impairments in active and inactive coal miners. BLDRC supports Black Lung Clinics through improved data collection, analysis and expanding the body of knowledge of the health status and needs of coal miners nationally.

Budget Request

The FY 2024 Budget Request of $12.2 million is equal to the FY 2023 Enacted level. HRSA will continue to fund 15 Black Lung Clinic Program awards that provide primary care and other services to coal miners and one cooperative agreement with the Black Lung Data and Resource Center to enhance the quality of services provided by BLCP grantees and work closely with HRSA to strengthen the quality of data collection and analysis.

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

Funding History

Fiscal Year	Amount
FY 2020	$11,500,000
FY 2021	$11,565,000
FY 2022	$11,845,000
FY 2023	$12,190,000
FY 2024 President's Budget	$12,190,000

Program Accomplishments

In FY 2021, the BLCP achieved 100% participation by grantees for the new patient-level data (PLD) reporting system first piloted in FY2019-2020. As a result, a more accurate image of grantee productivity has begun to develop. In FY 2021, the grantees predominately leaned on HRSA funding to maintain a community presence to the greatest extent possible in the face of COVID restrictions. In FY 2022, funds were deployed to take advantage of the proliferation of vaccines and loosening of restrictions to spur a push towards pre-pandemic productivity. According to the patient-level data reporting system, BLCP grantees achieved a 32% average increase in number of miners served between FY 2021 and FY 2022.

As well as supporting internal BLCP data management, the Black Lung Data and Resource Center has utilized HRSA funding, and BLCP data, to begin improving the quantity, and quality, of available scientific literature on the health concerns facing coal communities. Most recently, the Black Lung Data and Resource Center published an article detailing the increased mortality rates of miners from non-malignant respiratory diseases as compared to the general population.[203]

According to the Black Lung Data and Resource Center's findings from a study population of 235,550 deceased miners aged >45 years, odds of death from non-malignant respiratory diseases in "all miner cohorts averaged twice those of US males." They also noted that "there was an eightfold increase in odds of death from non-malignant respiratory diseases among miners born after 1940" and that "miners with Progressive Massive Fibrosis (PMF) were younger at death" than those without it. These findings help support the need and level of non-malignant respiratory disease and PMF services BLCP grantees provide.

[203] Almberg KS, Halldin CN, Friedman LS, Go LHT, Rose CS, Hall NB, Cohen RA. Increased odds of mortality from non-malignant respiratory disease and lung cancer are highest among US coal miners born after 1939. Occup Environ Med. 2023 Jan 12:oemed-2022-108539. doi: 10.1136/oemed-2022-108539. Epub ahead of print. PMID: 36635098.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6060.01 Number of miners served each year through the Black Lung Clinics Program (Output)	FY 2021: 6,345 Target: 13,800 (Target Not Met But Improved)	12,200	12,300	+100
6060.02 Number of miners screened each year through the Black Lung Clinics Program (Output)	FY 2021: 4,209 Target: Not Defined (Historical Actual)	Not Defined	3,300	+50
33.I.A.2 Number of medical encounters from Black Lung each year. (Output)	FY 2021: 5,478 Target: 19,000 (Target Not Met)	19,100	Discontinued	N/A

Performance Narrative

Many of the medical services provided by Black Lung grantees focus on direct pulmonary and respiratory treatments. Due to the infectious nature of COVID-19, Black Lung grantees were forced to take precautionary measures that reduced the number of medical encounters and services provided but ensured that spread of infectious diseases were kept at a minimum. The result of these precautionary measures means Black Lung Clinics Program was unable to achieve targets established prior to the COVID-19 pandemic.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	16	16	16
Average Award	$654,634	$729,918	$729,918
Range of Awards	$70,568 - $2,196,939	$125,000 - $2,120,763	$125,000 - $2,120,763

Rural Residency Planning and Development

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$10,500,000	$12,500,000	$12,700,000	+$200,000
FTE	2	2	2	---

Authorizing Legislation: Social Security Act, Section 711(b)(5), as amended by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Section 432, Public Law 108-173.

FY 2024 Authorization ……. Indefinite

Allocation Method .....Competitive Grants/Cooperative Agreement

Program Description

Established in FY 2018, the Rural Residency Planning and Development Program seeks to expand the number of rural residency training programs, increase the number of physicians training in rural settings, and subsequently increase the number of physicians choosing to practice in rural areas. For the purpose of this program, rural residencies are accredited allopathic and osteopathic physician residency programs that primarily train residents in rural training sites for greater than 50 percent of their total time in residency and focus on producing physicians who will practice in rural communities. This includes Rural Training Programs (RTPs) a specific model of rural residency training in which residents gain both urban and rural experience with more than half of the education and training taking place in rural areas. Eligible primary care and high need rural residency specialties include family medicine, family medicine with enhanced obstetrical training, internal medicine, preventive medicine, psychiatry, general surgery, and obstetrics and gynecology.

Research has shown that residents often practice near where they complete their residency training. Spending more than half of training time in rural locations during family medicine residency is associated with a 5- to 6-fold increase in subsequent rural practice[204] . The Federal Office of Rural Health Policy collaborates with HRSA's Bureau of Health Workforce (BHW) to fund two activities to create new rural residencies:

- Rural Residency Planning and Development (RRPD) program creates new physician residency training programs that support physician workforce expansion in rural areas and that are sustainable beyond the grant period of performance through public (i.e., Medicare or Medicaid), other state, or private funding. Recipients may use grant funds to cover planning and development costs incurred while achieving program accreditation through the Accreditation Council for Graduate Medical Education (ACGME). The

[204] Russell, DJ, et al. "Family Medicine Residencies: How Rural Training Exposure in GME Is Associated With Subsequent Rural Practice," Journal of Graduate Medical Education, August 2022.

program began in FY 2018. Since FY 2018, the program has made new awards each fiscal year and HRSA plans a new competition for FY 2024. The RRPD grants have a three-year period of performance and are fully funded when issued to allow flexibility for the varied schedules necessary to develop new residency programs.

- Rural Residency Planning and Development Technical Assistance (RRPD-TA) funds one cooperative agreement that creates a technical assistance center to support RRPD grant applicants and recipients. The program began in FY 2018. Eligible entities include domestic non-profit organizations with the capability to be national in scope to reflect the distribution of current and future RRPD cohorts. The most recent competition was in FY 2021 and the cooperative agreement has a five-year period of performance.

Since program inception in FY 2018, the RRPD Program has issued 58 RRPD awards across four cohorts as well as continuous funding for technical assistance under RRPD-TA.

Budget Request

The FY 2024 Budget Request of $12.7 million is $200,000 above the FY 2023 Enacted level. With the FY 2024 Budget request, HRSA anticipates making 15 new 3-year awards of $750,000 each under RRPD and providing additional support for technical assistance under RRPD-TA. The new awards and increased technical assistance will support new rural residency programs to train physicians in rural areas. The previous RRPD competitions generated significant interest from rural stakeholders and HRSA received more competitive applications than they were able to fund; HRSA anticipates similar interest in the FY 2024 competition.

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

Fiscal Year	Amount
FY 2020	$10,000,000
FY 2021	$10,468,000
FY 2022	$10,500,000
FY 2023	$12,500,000
FY 2024 President’s Budget	$12,700,000

Program Accomplishments

Nine grant recipients from RRPD Cohort 1 (FY 2019) finished their period of performance in FY 2022 and all achieved Accreditation Council for Graduate Medical Education (ACGME) accreditation as new rural residency programs. An additional 22 recipients have achieved ACGME accreditation ahead of schedule and are strengthening their new residency programs as they complete their period of performance. As of September 30, 2022, across all RRPD cohorts, 31 award recipients have achieved ACGME accreditation, for a total of 418 new approved residency positions at full complement in the following specialties:

- 24 New Family Medicine Residency Programs and 315 Residency Positions
- 5 New Psychiatry Medicine Residency Programs and 52 Residency Positions
- 1 New Internal Medicine Residency Program and 36 Residency Positions
- 1 New General Surgery Residency Program and 15 Residency Positions

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6080.01 Percentage of Rural Residency Planning and Development grantees who achieve Accreditation Council for Graduate Medical Education accreditation by the end of the period of performance (Outcome)	FY 2022: 100% Target: Not Defined (Historical Actual)	Not Defined	90%	N/A

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	13	15	15
Average Award	$749,845	$750,000	$750,000
Range of Awards	$749,005 - $750,000	$750,000 - $750,000	$750,000 - $750,000

Rural Communities Opioid Response

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$135,000,000	$145,000,000	$165,000,000	+$20,000,000
FTE	19	21	21	---

Authorizing Legislation: Social Security Act, Section 711, as amended by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Section 432, Public Law 108-173.

FY 2024 Authorization ……. Indefinite

Allocation Method .....Competitive Grants/Cooperative Agreement

Program Description

The Rural Communities Opioid Response Program (RCORP) aims to reduce the morbidity and mortality associated with substance use disorder (SUD), including opioid use disorder (OUD), in high need rural communities by establishing, expanding, and sustaining prevention, treatment, and recovery services at the county, state, and/or regional levels. Since RCORP's inception in FY 2018, the program has invested over $500 million in grants and technical assistance to rural communities serving more than 1,800 counties across 47 states and two territories.

HRSA supports the following grant and cooperative agreement programs through RCORP:

- The RCORP-Implementation program will provide funding to rural organizations to establish new SUD/OUD prevention, treatment, and recovery access points and service lines where they do not currently exist and to build their capacity to sustain services after the grant period ends. HRSA will support approximately 16 new awards in FY 2024.

- RCORP-Psychostimulant Support provides funding to rural communities to strengthen prevention, treatment, and recovery services for individuals who misuse psychostimulants. HRSA will support approximately 22 new awards in FY 2024.

- RCORP-Overdose Response provides funding to rural communities to meet their immediate needs related to the overdose crisis. HRSA will support approximately 30 new awards in FY 2024.

- The RCORP-Behavioral Health Care Support program provides support to rural communities to respond to new and ongoing behavioral health needs of rural residents at risk for, or diagnosed with, SUD/OUD and/or co-occurring disorders. The program focuses on building the infrastructural capacity of rural communities to deliver behavioral health, including SUD/OUD, services across the continuum; enhancing care coordination to provide effective care; and addressing social determinants of health to promote health equity. HRSA will support the continuation of 58 awards in FY 2024.

- RCORP-Neonatal Abstinence Syndrome reduces the incidence and impact of neonatal abstinence syndrome in rural communities by improving systems of care, family supports, and social determinants of health. HRSA will support the continuation of approximately 40 awards in FY 2024.

- RCORP-Medication Assisted Treatment Access provides support to establish new MAT access points and increase the capacity for sustainable MAT service provision in rural areas that do not currently have access to MAT for SUD/OUD. HRSA will support the continuation of approximately 37 awards in FY 2024.

- RCORP-Child and Adolescent Behavioral Health strengthens and expands behavioral health care services across the prevention, treatment, and recovery continuum for rural children and adolescents aged 5-17 years. HRSA will support the continuation of approximately 9 awards in FY 2024.

- The RCORP-Rural Centers of Excellence on Substance Use Disorders program supports the dissemination of best practices related to the treatment for and prevention of substance use disorders within rural communities, with a focus on the current opioid crisis. The program was re-competed in FY 2023 with limited eligibility to continue $10 million in support of the three Centers of Excellence. HRSA will support the continuation of these 3 cooperative agreements in FY 2024.

- Rural Behavioral Health Workforce Centers develop and implement training and mentorship programs that build the capacity of rural health care providers, paraprofessionals, non-clinical staff, and community members to care for individuals with behavioral health, including SUD/OUD, needs in rural locations within the Northern Border Regional Commission. HRSA will support the continuation of these 4 cooperative agreements in FY 2024.

- RCORP-Technical Assistance and Evaluation provide technical assistance and evaluation support encompassing the entire RCORP initiative. HRSA will support the continuation of funding for one technical assistance and one evaluation cooperative agreement in FY 2024.

Budget Request

The FY 2024 Budget Request of $165 million is $20 million above the FY 2023 Enacted level. This request will support the development and continuation of community-based grant programs and technical assistance that provide needed behavioral health, including SUD/OUD, services to rural residents. Drug overdose death rate in rural areas rose from 19.6[205] in 2019 to 26.2 per 100,000 standard population in 2020[206] and over 60 percent of mental health professional

[205] https://www.cdc.gov/nchs/products/databriefs/db403.htm#:~:text=Data%20from%20the%20National%20Vital,to%2019.6%20in%20rural%20counties.
[206] https://www.cdc.gov/nchs/products/databriefs/db440.htm#:~:text=Overall%2C%20the%20rate%20of%20drug,in%20rural%20counties%20(26.2).

shortage designations are located in rural areas.[207] Through progress reports, listening sessions, and town halls, RCORP award recipients and other rural stakeholders have described continued workforce shortages, reimbursement issues, and the need for additional resources to address substances beyond opioids and co-occurring mental health disorders.

This request will enable HRSA to continue expanding RCORP's focus to include other, emergent behavioral health needs in rural communities. In FY 2023, HRSA piloted new programs that provided funds to rural communities to rapidly address their immediate SUD needs (including lifesaving naloxone) and addressed health equity. They also provided needed prevention, treatment, and recovery services to rural residents, including for children and adolescents, and pregnant and postpartum people.

In FY 2024, HRSA plans to continue funding for these programs and existing cooperative agreements that provide technical assistance, evaluation, and workforce development support. Additionally, HRSA will support approximately 16 new awards aimed at building the capacity of rural health organizations to establish, implement, and sustain new behavioral health care, including SUD, service lines in rural areas. HRSA will also re-compete the RCORP-Overdose Response and RCORP-Psychostimulant Support awards for 52 awards, totaling 68 new awards in FY 2024. HRSA will 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 ensure HRSA's efforts are aligned with Administration priorities.

Finally, this request will enable HRSA to strengthen RCORP's commitment to reducing disparities in health outcomes and access among vulnerable populations.

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

Fiscal Year	Amount
FY 2020	$110,000,000
FY 2021	$109,670,000
FY 2022	$135,000,000
FY 2023	$145,000,000
FY 2024 President's Budget	$165,000,000

Program Accomplishments

In FY 2021, RCORP award recipients provided direct prevention, treatment, and recovery services to 2,050,439 rural individuals across the country, including medication-assisted treatment services to 112,456 rural individuals.[208] Between September 1, 2021 and February 28,

[207] https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport
[208] Self-reported performance data submitted to HRSA by RCORP award recipients, covering the September 1, 2021-August 31, 2022 time period.

2022, approximately 45 percent of RCORP award recipients reported using RCORP funding to establish or expand access to prevention services in their communities; approximately 35 percent established or expanded harm reduction services; and approximately 43 percent established or expanded recovery support services.[209] To increase the likelihood of sustaining these services and enhance community buy-in, RCORP award recipients have collectively engaged with approximately 2,800 state and local agencies and organizations representing a diverse array of sectors, including school systems, health centers, hospitals, law enforcement agencies, community-based organizations, and others to implement their programs.[210] Finally, RCORP expanded the number of rural counties served by the initiative from around 1,500 in FY 2021 to over 1,800 in FY 2022.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6090.01 Number of individuals screened for Substance Use Disorder (Output)	FY 2021: 1,881,042 Target: Not Defined (Target Exceeded)	Not Defined	1,400,000	N/A
6090.02 Percentage of Rural Communities Opioid Response Program (RCORP) grantees with other sources of funding for sustainability (aside from RCORP grant) (Output)	FY 2021: 75% Target: Not Defined (Historical Actual)	Not Defined	80%	N/A
6090.03 Number of providers who have provided Medication-Assisted Treatment (Output)	FY 2021: 2,872 Target: Not Defined (Historical Actual)	2,100	2,150	+50

[209] Subset of award recipients that self-reported performance data submitted to HRSA covering the September 1, 2021-February 28, 2022 time period.
[210] Self-reported information submitted to HRSA by RCORP award recipients in FY 2020.

Grant Awards Table

Activity	FY 2022 Final[211]	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	167	193	221
Average Award	$753,892	$692,209	$ 696,730
Range of Awards	$131,454 - $10,000,000	$300,000 - $10,000,000	$300,000 - $10,000,000

[211] Data represents awards funded using one-year funds appropriated in FY 2022. Awards made during the FY22 project period using multi-year funds are not included.

Rural Health Clinic Behavioral Health Initiative

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	---	---	$10,000,000	+$10,000,000
FTE	---	---	1	+1

Authorizing Legislation: Social Security Act, Section 711, as amended by Public Law 108-173.

FY 2024 Authorization ……. Indefinite

Allocation Method .....Competitive Grants/Cooperative Agreement

Program Description

In FY 2024, the Rural Health Clinic Behavioral Health Initiative will provide funding support directly to Medicare-participating Rural Health Clinics (RHC) to expand access to behavioral health care services provided by the RHC. RHCs are key safety net providers for rural residents and serve as a vital link to primary and ambulatory care services in approximately 712 counties where there is no FQHC.[212] This initiative targets areas where there is inadequate access to behavioral health services being provided. Long-standing systemic health and social inequities have put some rural residents at increased risk of having severe illness including behavioral health issues. Rural areas represent nearly 60 percent of Mental Health Professional Shortage Areas, encompassing more than 25 million people who do not have adequate access to mental health care providers.[213] Over 13 percent of rural counties have no behavioral health care providers at all.[214] Rural suicide rates outpace urban suicide rates, and this difference has continued to widen over time.[215] Additionally, one in five rural residents identify with one of more of the following groups, Black, Hispanic, American Indian/Alaska Native (AI/AN), Asian American/Pacific Islander (AA/PI), or mixed race. RHCs serve two-thirds of the majority-minority counties in the U.S., and provide essential services to populations that experience health disparities at a higher rate than people who identify as non-Hispanic White.[216]

This Initiative will focus on the rural areas where there are gaps in access to essential behavioral health care services. RHCs are an underutilized critical health care resource for rural communities and through this RHC Behavioral Health Initiative will be able to provide them the ability to address service delivery gaps by receiving targeted financial resources and technical assistance.

[212] HRSA analysis of 2021 CMS Provider of Services data
[213] Designated HPSA Quarterly Summary, 2020
[214] WWAMI, 2019
[215] https://www.cdc.gov/nchs/products/databriefs/db373.htm
[216] National Association of Rural Health Clinics

Less than 10 percent of RHCs employ either a social worker and/or psychologist. To address this inequity, RHCs funded through this program will utilize grant funds to cover the salary of a behavioral health provider, address provider burnout by supporting the resilience and mental well-being of providers, and expand the availability of services such as mental health and substance use disorder screenings, counseling, and therapy. This program will also afford RHCs the ability to build up the volume of their behavioral health patient base and enhance their billing and coding practices to ensure revenue from these vital health care services, which will allow these activities to sustain beyond the three-year grant program. This short-term investment allows for long-term impact, with sustainability from Federal funds a key tenet of this program.

Budget Request

The FY 2024 Budget Request of $10 million is $10 million above the FY 2023 Enacted level. The request will fund approximately 12 awardees up to $750,000 for a three-year period of performance. The RHCs will work to establish new and expanded behavioral health care service lines and adding providers within their RHCs to increase access, beginning in year one. Award recipients will further be anticipated to be able to expand access in additional rural communities in years two and three by further establishing and/or expanding services within additional RHCs beyond those that were included in year one. This funding is necessary to allow RHCs to build access to critical behavioral health care services in rural communities where those services do not currently exist. This initiative will result in an increase in the number of rural residents who receive behavioral health care services, the number of behavioral health care professionals in rural communities, and the number of RHCs that are able to bill for and sustain behavioral health care 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.

Funding History

Fiscal Year	Amount
FY 2020	---
FY 2021	---
FY 2022	---
FY 2023	---
FY 2024 President’s Budget	$10,000,000

Program Accomplishments

This is a new initiative that has not previously been funded; therefore there are not accomplishments to report.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6100.01 Number of individuals receiving mental health services (Output)	FY 2022: N/A Target: Not Defined (Result Expected November 30, 2023)	Not Defined	Not Defined	N/A
6100.02 Number of rural health clinics that offer new and/or expanded behavioral health services as a result of the program (Outcome)	FY 2022: N/A Target: Not Defined (Result Expected November 30, 2023)	Not Defined	Not Defined	N/A

Performance Narrative

This program has not previously been funded or operated; therefore, there are no data to project future targets for these measures.

The intended outcome of the Rural Health Clinic Initiative is to ensure RHCs remain equipped to provide high quality, accessible health care services to rural residents across the United States. The estimated outcome of this program is to support the integration of mental health services into existing primary care services at RHCs and increase the availability of mental health services in rural communities.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	---	---	12
Average Award	---	---	$750,000
Range of Awards	---	---	$50,000 - $750,000

The Financial and Community Sustainability for At-Risk Rural Hospitals

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	---	---	$10,000,000	+$10,000,000
FTE	---	---	2	+2

Authorizing Legislation: Social Security Act, Section 711, as amended by 21st Century Cures Act, Sections 2012, 2013, 2035, and 2043, Public Law 114-255.

FY 2024 Authorization ……..Indefinite

Allocation Method .....Competitive Grants/Cooperative Agreement

Program Description

The FY 2024 Financial and Community Sustainability for At-Risk Rural Hospitals Program will target technical assistance to rural hospitals severely at-risk for imminent closure and struggling to maintain health care services. Small rural hospitals are often the only health care available in rural counties, and populations most affected by hospital closings tend to be poor, minorities and elderly patients with chronic health conditions.[217]

There have been 143 rural hospital closures from 2010 through January 2023, peaking with a high of 19 in 2020 just as pandemic hit. Closures are happening more often in communities of color. Historically, about half of the closures result in a complete loss of services at those facilities. The pandemic response programs resulted in a much smaller number of closures, only nine rural hospitals closed in 2021 and 2022, as the infusion of funding helped stabilize rural hospital finances. As that funding ends, the factors that can lead to closures continue to impact rural hospitals, such as market consolidation, population loss, and insurance payer mix. HHS-supported research indicates that long term pressures on rural hospitals may put many rural hospitals at higher risk of financial distress as pandemic relief funds are exhausted. Rural hospitals are also likely to see higher uncompensated care costs as patients lose Medicaid coverage once the Public Health Emergency ends and pandemic-related enrollment in public insurance drops. There are also concerns rural hospitals will face additional challenges due to the added burden of higher workforce costs and staffing losses during the pandemic. This program supports a mechanism to help these at-risk facilities through targeted technical assistance and give them a path forward.

Hospitals experiencing high financial distress often reduce services, limiting access for vulnerable populations and exacerbating health disparities. Consequently, providing assistance to hospitals and communities will help to keep some services local, leading to improved access and

[217] Thomas, SR, Pink, GH, Reiter, K. Characteristics of Communities Served by Rural Hospitals Predicted to be at High Risk of Financial Distress in 2019. NC Rural Health Research Program. April 2019. https://www.ruralhealthresearch.org/publications/1252

improved health outcomes. Before the pandemic, research indicated that almost 19% of rural hospitals in the South were at high risk of financial distress, a much higher proportion than other Census regions where slightly more than 4% of rural hospitals were at high risk of financial distress.

This program will work communities nationwide to provide intensive, short-term technical assistance to hospitals struggling with challenges that threaten access to health care in a rural community. The targeted technical assistance will focus on those sites that are essential access points in particularly vulnerable rural communities facing imminent closure.

Budget Request

The FY 2024 Budget Request of $10 million is $10 million above the FY 2023 Enacted level to provide emergency targeted, in-depth high quality technical assistance to rural hospitals within rural communities severely at-risk for imminent closure and struggling to maintain health care services.

The request will fund approximately one national technical assistance center includes and other administrative costs. This program builds on HRSA's experience funding the Vulnerable Rural Hospital Assistance Program and the Delta Region Community Health Systems Development Program. The Delta program focuses solely on that geographic region of the country, leaving out other areas where hospitals may be at high risk. The Vulnerable Rural Hospital Program targets facilities projected to be at medium risk. However, resources and rapid response capabilities do not currently exist for severely distressed rural hospitals who need immediate technical assistance. The Financial and Community Sustainability for At-Risk Rural Hospitals Program is designed to respond to immediate need where a failure to offer support would likely result in closure. This increase is necessary to ensure critical health care services remain available within rural communities.

Funding History

Fiscal Year	Amount
FY 2020	---
FY 2021	---
FY 2022	---
FY 2023	---
FY 2024 President's Budget	$10,000,000

Program Accomplishments

This is a new initiative that has not previously been funded; therefore there are not accomplishments to report.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6110.01 Number of hospitals with improved financial or operational outcomes based on recommendations implemented via technical assistance received.	FY 2022: N/A Target: Not Defined (Pending)	Not Defined	Not Defined	N/A

Performance Narrative

This program has not previously been funded or operated; therefore there are no data to project future targets for these measures.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	---	---	1
Average Award	---	---	$9,500,000
Range of Awards	---	---	$9,500,000 - $9,500,000

The Rural Hospital Stabilization Pilot Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	---	---	$20,000,000	+$20,000,000
FTE	---	---	2	+2

Authorizing Legislation: Social Security Act, Section 711, as amended by 21st Century Cures Act, Sections 2012, 2013, 2035, and 2043, Public Law 114-255.

FY 2024 Authorization ……. Indefinite

Allocation Method .....Competitive Grants/Cooperative Agreement

Program Description

The FY 2024 Rural Hospital Stabilization Pilot Program will provide support to at-risk rural hospitals to enhance and or expand service lines to retain health care services locally and increase service volume and revenue that will enhance hospitals' financial viability.

Since 2010, more than 143 rural hospitals have closed. More than two-thirds of rural hospitals have 50 beds or less and have seen steadily decreasing inpatient utilization. These facilities tend to have low service volume and high fixed costs, creating ongoing structural challenges in terms of remaining financially viable. Though rural hospitals may be serving small populations, they need to ensure that they are able to retain as many local patients as possible to increase volume, thereby billing for more services and increasing revenue that improves their financial viability. Unfortunately, rural hospitals often face situations in which some local patients seek services at other facilities, resulting in lost potential revenue. Research funded by the Centers for Medicare and Medicaid Services (CMS) shows the negative financial impact of bypass as rural hospitals miss out on health care services that could be provided by the local facility are instead spent at more distant facilities.[218]

The program, which would work with approximately 25 hospitals a year, would produce market assessments of participating hospitals to assess gaps in services and those clinical areas where expansion would meet local need and generate additional service volume to improve financial operations for the participating hospital. These facilities would receive start-up capital to enhance existing service lines and start new services lines to ensure services are retained locally. The program would cover expenses for minor renovation, new salary costs, equipment acquisition and promotion of the new services. Examples would include adding services such as pulmonary rehabilitation, infusion/chemotherapy, inpatient psychiatric services, outpatient behavioral health services, obstetric services, cardiac rehabilitation and expanded primary care.

[218] https://www.cms.gov/files/document/examining-rural-hospital-bypass-outpatient-services.pdf; https://www.cms.gov/files/document/ruralhospitalbypassfinalreport.pdf; https://www.cms.gov/files/document/hospitalbypassamongmedicaredatahighlightsept2020.pdf

The funding would also work with rural hospitals to identify and move into those services areas that are linked to broader public health needs such as behavioral health, maternity care and those services that could help rural hospitals reduce disparities identified by the CDC in the five leading causes of avoidable or excess death.[219] The program would also track the number of hospitals that were able to implement new service lines or enhance existing services lines and the collective growth in patient volume as indicators of success. This would have the added effect of helping these facilities address long-standing rural disparities while also enhancing their financial viability by increasing service volume. HRSA would develop an annual report detailing the status of the hospitals assisted and the communities they serve.

Budget Request

The FY 2024 Budget Request of $20 million is $20 million above the FY 2023 Enacted level. This pilot program would provide market assessments of participating hospitals to assess gaps in services and those clinical areas where expansion would meet local need and generate additional service volume for the participating hospital. This program would assist hospitals in stabilizing and enhancing health care service lines in their communities. The funding would also work with rural hospitals to identify and move into those services areas that are linked to broader public health needs such as behavioral health, maternity care and those services that could help rural hospitals reduce disparities identified by the CDC in the five leading causes of avoidable or excess death.

The request will fund approximately three regional technical assistance centers to work with at-risk rural hospitals. The request also includes other administrative costs to support the service-line expansion.

Funding History

Fiscal Year	Amount
FY 2020	---
FY 2021	---
FY 2022	---
FY 2023	---
FY 2024 President's Budget	$20,000,000

Program Accomplishments

This is a new initiative that has not previously been funded; therefore there are not accomplishments to report.

[219] https://www.cdc.gov/nchs/products/databriefs/db417.htm#:~:text=In%202019%2C%20the%20largest%20differences,35.4)%20(Figure%203

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6120.01 Number of new service lines identified for participating hospitals	FY 2022: N/A Target: Not Defined (Pending)	Not Defined	Not Defined	Maintain
6120.02 Number of new service lines developed and or enhanced existing service lines.	FY 2022: N/A Target: Not Defined (Pending)	Not Defined	Not Defined	Maintain

Performance Narrative

This program has not previously been funded or operated; therefore there are no data to project future targets for these measures.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	---	---	3
Average Award	---	---	$6,500,000
Range of Awards	---	---	$6,500,000

HRSA-Wide Activities and Program Support TAB

HRSA-WIDE ACTIVITIES AND PROGRAM SUPPORT

Program Management

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$155,300,00	$163,800,00	$168,971,000	+$5,171,000
FTE	785	801	811	+10

Authorizing Legislation: Public Health Service Act, Section 301 amended by 21st Century Cures Act, Sections 2012, 2013, 2035, and 2043, Public Law 114-255.

FY 2024 Authorization……...……Indefinite

Allocation Method……....Other

Program Description

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.

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. HRSA relies on HHS-provided shared services for many of the services, 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.

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'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.

Budget Request

The FY 2024 Request of $169 million is $5.2 million above the FY 2023 Enacted level. This funding level supports program management activities to effectively and efficiently support HRSA's operations.

HRSA is committed to improving quality at a lower cost and improving the effectiveness and efficiency of government operations. HRSA 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.

Funding History:

Fiscal Year	Amount
FY 2020	$155,300,000
FY 2021	$155,300,000
FY 2022	$155,300,000
FY 2023	$163,800,000
FY 2024 President's Budget	$168,971,000

Program Accomplishments:

Improving Processes and Business Operations

HRSA continues to improve operational processes to maximize efficiencies. In FY 2022, HRSA implemented multiple workflow automation (robotic/Bot) processes to increase efficiency, accuracy, and effectiveness of operations projects. These include: 1) five bots to support daily activities with budget execution and reconciliation for Provider Relief funds; 2) a bot to support management reporting on human resources and space management by pulling data from HRSA employee telework agreements; and 3) a bot to support contract specialists in the contract closeout process.

Developing a 21st Century Workforce

The hiring process has been streamlined, reducing the time it takes to complete the hiring cycle from recruitment to onboarding, which has resulted in enhanced program oversight and integrity, and increased effectiveness and efficiency of the recruitment process. These improvements supported the efficient hiring of 385 new HRSA staff in FY 2022, which is a major feat to

accomplish while also successfully navigating unique hiring requests to support the COVID-19 pandemic and the monkeypox public health emergency.

HRSA is also focused on intense employee engagement improvement efforts. For 7 years in a row, HRSA has had the highest EVS response rate in HHS, nearly 82 percent. HRSA leaders prioritized employee engagement and well-being, holding monthly all hands meetings and regular listening sessions allowing leaders to engage employees at all levels, and gain feedback to inform decision making. HRSA also achieved the highest contractor performance assessment reporting system rating among HHS OPDIVs with a score of 98.2 percent.

HRSA conducted an Enterprise Risk Management (ERM) self-assessment by convening a core team of HRSA leaders to use the Council of Inspectors General on Integrity and Efficiency's Inspectors General Guide to Assessing Enterprise Risk Management. The assessment found that HRSA has a solid governance structure for internal controls, payment integrity and ERM and that it has developed a comprehensive Risk Profile and Portfolio of Risks, through engaging governance board members in thoughtful discussion and rating of risks.

IT Investments

Significant progress has been made in a range of IT investments. In FY 2022, HRSA successfully transitioned the majority of the workforce from remote work to hybrid work schedules, while adapting to changing environments and workplace requirements. HRSA continuously works to enhance employees IT end-user support by enhancing collaboration platforms, including implementing a SharePoint hoteling space system. HRSA continues to utilize Microsoft Teams to provide a feature rich collaboration platform that provides audio/video calling and conferencing, chat, and file sharing all in a secure environment. HRSA piloted several hybrid virtual meeting technology improvements to enhance the collaborative space, including Zoom Rooms.

In FY 2022, HRSA deployed a pilot Snowflake data cloud to enable secure data sharing and support high volume data processing of Provider Relief Fund and Uninsured Program records, a Provider Relief Fund Reconsideration case management system, and enhanced multiple other reporting and case management systems to maximize efficiencies. These systems maximized program efficiency and increased program integrity by creating interactive dashboards for call centers and executive reporting The systems also improved application portal capabilities and audit reporting.

HRSA is also prioritizing the implementation of Zero Trust Strategy in support of the Administration's goals regarding Zero Trust Cybersecurity Principles[220].HRSA continues to improve HRSA IT security incident prevention, detection and response capabilities by improving penetration testing capabilities and deploying Crowdstrike on all IT assets.

[220] https://www.whitehouse.gov/wp-content/uploads/2022/01/M-22-09.pdf

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
35.VII.B.1. Ensure Critical Infrastructure Protection: Security Awareness Training (Output)	FY 2022: 100% Target: 100% (Target Met)	100%	Discontinued	N/A
7010.01 Ensure Critical Infrastructure Protection: Security Authorization to Operate: Percentage of HRSA information systems assessed and Authorized to Operate (ATO) (Output)	FY 2022: 100% Target: 100% (Target Met)	100%	Discontinued	N/A
35.VII.B.2b Ensure Critical Infrastructure Protection: Security Cyber Sprint (Output)	FY 2022: < 30 days Target: 30 days (Target Met)	30 days	Discontinued	N/A
35.VII.B.2c Ensure Critical Infrastructure Protection: Security Privacy Impact Assessment (PIA) or Privacy Threshold Assessment (PTA) (Output)	FY 2022: 100% Target: Identify 95% of systems that require a PIA or a Privacy Threshold Assessment (PTA) (Target Met)	90%	Discontinued	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
7010.02 Ensure Critical Infrastructure Protection: Security Phishing: Number of phishing campaigns completed (Output)	FY 2022: 24 Target: 24 (Target Met)	24	Discontinued	N/A
7010.03 Enterprise Architecture: Percentage of IT systems reported to OMB with mapping to at least one HHS segment and domain (Output)	FY 2022: 90% Target: 90% (Target Met)	90%	90%	N/A
7010.04 Ensure Critical Infrastructure Protection: Average annual overall score for HRSA IT Systems on the HRSA-wide Capital Planning and Investment Control (CPIC) Scorecard.	FY 2022: 94% Target: Not Defined (Historical Actual)	90%	90%	Maintain

Office of Pharmacy Affairs/340B Drug Pricing Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$11,238,000	$12,238,000	$17,238,000	+$5,000,000
FTE	21	23	23	---

Authorizing Legislation: Authorizing Legislation: Public Health Service Act, Section 340B, as amended by Public Law 111-309, Section 204

FY 2024 Authorization …….……..SSAN

Allocation Method .....Contract

Program Description

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, such as Federally Qualified Health Centers, Children's Hospitals, Critical Access Hospitals, Ryan White HIV/AIDS Program Grantees, and certain disproportionate share hospitals. HRSA is responsible for administering the 340B program and providing oversight, including conducting audits of covered entities and manufacturers.

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).

The 340B statute also includes the establishment of a Prime Vendor Program (PVP) to develop, maintain, and coordinate a program capable of facilitating distribution of covered outpatient drugs.

Budget Request

The FY 2024 President's Budget request of $17.2 million is $5 million above FY 2023 Enacted level. This request will support implementation of 340B Program statutory obligations, oversight of participating manufacturers and covered entities, operational improvements, and policy needs, and increased efficiencies using information technology. The FY 2024 budget request provides resources for the 340B Program to educate participating covered entities and prospective sites on compliance with statutory requirements. For participating covered entities, HRSA will continue to expand its oversight and compliance activities. HRSA will continue to conduct audits of manufacturers, which should not only increase compliance, but also guide future technical assistance. PVP data shows education based on oversight measures reduces the risk of future compliance issues. 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 Office of Pharmacy Affairs Information System (OPAIS), which is where covered

entities access 340B ceiling price information via a secure website to provide transparency of data to authorized users. System implementation began in calendar year 2019, and prices have been available to covered entities, after review and validation, since April 1, 2019. System improvements are continuously made to improve the user interface for HRSA, manufacturers, and the covered entities. HRSA also makes improvements to the system to support program needs and system reliability. HRSA will continue to implement improvements to the Administrative Dispute Resolution process. In addition, HRSA will enhance IT system capabilities to support the handling and resolution of claims. Finally, HRSA will increase the audit and oversight functions, including additional manufacturer and covered entities audits.

The FY 2024 Budget Request proposes to enhance 340B Program integrity by requiring covered entities to annually report to HRSA how the savings achieved through the Program benefits the communities they serve and provide HRSA regulatory authority to implement this requirement. HRSA also proposes explicit regulatory authority to define necessary terms. HRSA is also proposing to strengthen compliance and transparency related to the utilization of contract pharmacies.

The FY 2024 Budget Request for budget authority includes program support costs associated with contract award processes, follow-up reviews, information technology and program support.

Funding History

Fiscal Year	Amount
FY 2020	$10,238,000
FY 2021	$10,238,000
FY 2022	$11,238,000
FY 2023	$12,238,000
FY 2024 President's Budget	$17,238,000

Program Accomplishments

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 1,916 covered entity audits, which included review of associated offsite outpatient facilities and contract pharmacies. Final audit results, including statuses of corrective actions, are available on HRSA's website.
- Reviews every non-compliance allegation received through targeted communication and, if necessary, performs on-site audits.

- Performs audits of manufacturers. Since FY 2015, HRSA finalized 36 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 OPAIS, Pricing Component.
- Most recently, quickly implemented Section 121 of the Consolidated Appropriations Act of 2022 which established an eligibility exception for certain hospitals that were or would be terminated from the program due to inability to meet the statutorily-required disproportionate share adjustment (or DSH) percentage), due to impacts of the COVID-19 public health emergency and other criteria.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
5040.01 Number of covered entity audits conducted (Output)	FY 2022: 200 Target: 200 (Target Met)	225	225	Maintain
5040.02 Number of manufacturer audits conducted (Output)	FY 2022: 5 Target: 5 (Target Met)	10	10	Maintain

Contracts Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Contracts	3	3	3
Average Contract	$3,000,000	$3,000,000	$3,000,000
Range of Contracts	$1,000,000-$4,000,000	$2,000,000-$5,000,000	$2,5000,000 - $5,000,000

Office for the Advancement of Telehealth

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$35,050,000	$38,050,000	$44,500,000	$6,450,000
FTE	9	9	9	---

Authorizing Legislation: Public Health Service Act, Section 330I, Section 330L and Section 330N, as amended by CARES Act, Section 3212

FY 2024 Authorization (Section 330I and 330L)……..$44,500,000

Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts

Program Description

The Office for the Advancement of Telehealth (OAT) promotes the use of telehealth technologies for health care delivery, education, and health information services. OAT administers the following programs and activities:

- **Telehealth Network Grant Program (TNGP)** supports the use of telehealth networks to improve health care services for medically underserved populations in urban, rural, and frontier communities. More specifically, the networks: (a) expand access to, coordinate, and improve the quality of health care services; (b) improve and expand the training of health care providers; and/or (c) expand and improve the quality of health information available to health care providers, patients, and their families.

  This program funds different cohorts of grantees, usually with unique clinical or population focus areas, although grantees can also provide other clinical services in their projects. All TNGP grantee cohorts focus on using telehealth technology to expand access to services. In addition, the program conducts project evaluations to establish an evidence-base assessing the effectiveness of telehealth care for patients, providers, and payers. TNGP grantees focus on improving access to health care services in rural and underserved communities. This cohort continues to focus on promoting rural Tele-emergency services by enhancing telehealth networks to deliver 24-hour Emergency Department consultation services via telehealth to rural providers without emergency care specialists. In 2024, HRSA will support 25 new awards.

- **Evidence-Based Direct-to-Consumer Telehealth Network Program (TNP)** increases access to healthcare services utilizing Direct to Consumer technologies. The Evidence-Based TNP for Direct-to-Consumer care enhances the existing health care infrastructure and increases access to care for underserved populations utilizing synchronous video visits and remote patient monitoring for primary focus areas such as behavioral health, primary care, and acute care. The current period of performance for this program began September 1, 2021. In 2024, HRSA will support 11 continuation awards.

- **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 current period of performance for this program began September 1, 2021. In 2024, HRSA will support 12 regional and 2 national TRC continuation awards.

- **Telehealth Center of Excellence** program examines the efficacy of telehealth services in rural and urban areas and serves as a national clearinghouse for telehealth research and resources. The current period of performance for this program began September 30, 2021. In 2024, HRSA will support 2 continuation awards.

- **Telehealth Research Centers** conduct policy-relevant, clinically informed telehealth research to expand the evidence base 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 the Evidence-Based TNP awardees to analyze their results and prepare summaries and publications of Evidence-Based TNP's clinical impact. The Telehealth Research centers will assist rural health providers and decision-makers at the federal, state, and local levels by examining the impact of telehealth services in rural communities. The current period of performance for this program began September 1, 2020. In 2024, HRSA will support 2 continuation awards.

- **Licensure Portability Grant Program** provides support to state professional licensing boards to carry out programs under which the boards cooperate to develop and implement state policies that will reduce statutory and regulatory barriers to telemedicine. The current period of performance for this program began July 1, 2019. In 2024, HRSA will support 2 new awards.

- **Telehealth Technology-Enabled Learning Program** supports the connection of specialists at academic medical centers with primary care providers in rural, frontier, and underserved populations, providing evidence-based training and support to help them treat patients with complex conditions in their communities. The current period of performance for this program began September 30, 2021. In 2024, HRSA will support 9 continuation awards.

- **HHS Telehealth Hub** continues support for the HHS telehealth coordination of resources to patients, providers, and states through the following components:
    - **Telehealth.HHS.gov** will allow for the continuation of this HHS Telehealth Hub. It is a one-stop resource for patients, providers, and states for information about telehealth such as telehealth best practices, policy and reimbursement updates, funding opportunities, and events. The Telehealth Hub was originally funded through the CARES Act. HRSA continues to provide important up-to-date telehealth, licensure, and broadband resources for the public. The Telehealth Hub had nearly 5 million views since it was launched in April 2020, and it has been

expanded to include licensure resources to support those needing assistance with interstate licensure. It also features a research section that links to HHS-supported telehealth research studies that serves as HHS's telehealth research gateway.

- **Telehealth.HHS.gov Promotional Campaign** will allow for the continued dissemination of critical telehealth resources for patients, providers, and states through Telehealth.HHS.gov as telehealth reimbursement and policies continue to evolve since the COVID-19 pandemic. The promotional campaign was originally funded through the CARES Act, and it will continue to support the dissemination of the evolving telehealth policies and resources through Telehealth.HHS.gov.

- **Telehealth Data Collection Infrastructure** will track funding, projects, and data for telehealth services within HRSA. This project will result in a telehealth data assessment for fully usable data solutions, policies, and procedures to increase quality and standards of telehealth data for HRSA. It will provide a systematic way of capturing data from programs and activities within OAT and HRSA that could help inform overall performance of award recipients and their outcomes and could be expanded HHS-wide to increase the sharing of telehealth data across HHS and with the public.

Budget Request

The FY 2024 Budget Request for the Office for the Advancement of Telehealth of $44.5 million is $6.5 million above the FY 2023 Enacted Level. HRSA will continue to utilize telehealth to provide access to healthcare in rural and underserved areas. In FY 2024, HRSA will support the continuation of 38 existing grantees, and 27 new competitive grants to strengthen the networks and the technical assistance providers that support effective implementation of telehealth services. The Telehealth Network Grant Program and Licensure Portability Grant Program will be re-competed in FY 2024. The $6.5 million increase will fund the continuation of the HHS Telehealth Hub, which includes Telehealth.hhs.gov and the corresponding promotional contract for Telehealth.hhs.gov, which allow for the rapid dissemination of critical telehealth resources for patients, providers, states, researchers, and other stakeholders through Telehealth.HHS.gov. In addition, the increase will fund a contract for the Telehealth Data Collection Infrastructure, which is critical in allowing HRSA to track funding, projects, and data for telehealth services within HRSA. 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

Fiscal Year	Amount	Supplemental Funding
FY 2020	$29,000,000	$12,000,000
FY 2021	$34,000,000	---
FY 2022	$35,050,000	---
FY 2023	$44,500,000	---
FY 2024 President's Budget	$44,500,000	---

Program Accomplishments

The Office for the Advancement of Telehealth had several accomplishments through its program activities and collaborative efforts.

- The current Telehealth Network Grant Program for emergency services, which will end in FY 2024, promotes 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. In the most recent reporting cycle, this program has served approximately 13,000 patients. In addition, the EB-TNP for Direct-to-Consumer services served approximately 9,000 patients.

- The TRCs have provided over 6,000 technical assistance requests to assist providers with implementing telehealth and understanding evolving telehealth policy. In addition, the National Telehealth Technology Assessment Resource Center, continues to implement HRSA's Telehealth Broadband Pilot Program, which now has over 350 broadband measurement devices within the four target states – Alaska, Michigan, Texas, and West Virginia—that have resulted in over 290,000 bandwidth tests.

- The Telehealth Centers of Excellence have contributed to the evidence-base for telehealth with over 20 published articles to date on topics such as telehealth costs and utilization and remote patient monitoring.

- The Telehealth Technology-Enabled Learning Program recipients held nearly 3,000 provider-to-provider learning sessions with rural primary care providers focusing on issues such as behavioral health and Long COVID.

- Through the Licensure Portability Grant Program, grantees developed tools such as the Provider Bridge to provide key information for health care professionals across various disciplines, with over 145,000 providers registered to use the platform.

- The HHS Telehealth Hub, through the Telehealth.hhs.gov and Telehealth.hhs.gov promotional campaign, had nearly 5 million views since its launch. The website provides resources and information in English and Spanish. It was also included in the White

House Fact Sheet on Maternal Health in 2022 as well as the State of the Union Fact Sheet in 2023.

- Supported by Telehealth.hhs.gov, OAT hosted its first virtual National Telehealth Conference in 2022, with nearly 4,000 registered participants and over 50 speakers covering a wide range of topics from behavioral health to broadband to licensure portability and more.

- OAT has also led efforts to coordinate telehealth activities across HRSA and HHS by leading the annual telehealth inventory for HRSA activities, an HHS data call for telehealth research, and keeping the federal workforce informed on the latest telehealth issues by convening a Federal Telehealth Workgroup (FedTel).

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
6070.01 Increase the number of communities that have access to tele-behavioral health services where access did not exist in the community prior to Telehealth Network Grant Program (Outcome)	FY 2021: 39 Target: Not Defined (Historical Actual)	Not Defined	40	N/A
6070.02 Increase the number of telehealth encounters provided through the Telehealth Network Grant Program (Output)	FY 2021: 22,011 Target: Not Defined (Historical Actual)	Not Defined	22,100	N/A
6070.03 Increase the number of unduplicated patients receiving care via telehealth through the Telehealth Network Program Grant (Output)	FY 2021: 9,316 Target: Not Defined (Historical Actual)	Not Defined	9,400	N/A
6070.04 Increase the number of clients receiving technical assistance from the Telehealth Resource Centers Program (Output)	FY 2021: 6,476 Target: Not Defined (Historical Actual)	Not Defined	6,500	N/A

Performance Narrative

The Telehealth Network Grant Program measures (6070.01, 6070.02, 6070.03) reflect programs with different focus areas and cohorts. As such, measure results will vary from year-to-year due to expected turnover in grantee cohorts and focus areas, and targets will need to be evaluated on an ongoing basis. In addition, the data represents results from FY 2021 funding and was collected between September 2021 through August 2022, aligning with the program funding period. The targets for FY 2024 have been established based on the current cohorts for both the Telehealth Network Grant program for emergency services and the Evidence-Based Telehealth Network program for Direct-to-Consumer services.

The Telehealth Resource Center (TRC) program measure (6070.04), represents results from FY 2021 funding and was collected between September 2021 through August 2022, aligning with the program funding period. These results will vary based on the need for telehealth-related technical assistance from providers as well as funding for the program. The target for FY 2024 has been established based on level funding for the TRC program, which can affect TRC's capacity in providing technical assistance.

Grant Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	70	70	65
Average Award	$431,919	$478,700	$500,110
Range of Awards	$74,250 - $3,750,000	$74,250 - $4,250,000	$250,000 - $4,250,000

Long COVID

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	---	---	$130,000,000	+$130,000,000
FTE	---	---	16	+16

Authorizing Legislation: New Authority

FY 2024 Authorization……..……..…….$130,000,000

Allocation Method:

Formula grant/co-operative agreement
Competitive grant/co-operative agreement
Contracts

Program Description:

According to the CDC, Long COVID, which is defined as experiencing new symptoms lasting three or more months after first contracting COVID-19, has occurred in 1 in 13 (7.5%) adults in the United States[221]. Populations affected by health inequities, including people from racial or ethnic minority groups and people with disabilities, are at increased risk of Long COVID. Some of these patients will need ongoing support as they manage the multifaceted clinical impacts of these extended symptoms.

HRSA's Long COVID program supports the Administration's goals and memorandum directing an action plan on Long COVID[222] by providing holistic, integrated support to patients who are diagnosed with Long COVID, with a focus on reaching uninsured, low income, and racial and ethnic minority populations who have suffered disproportionately from the COVID pandemic in the U.S. This program will increase capacity in states to provide clinical care to patients with Long COVID, including the expansion of services for uninsured and underinsured patients, by enhancing integrated multispecialty assessment for the most complex patients and providing support to primary care providers who will care for a majority of patients presenting with Long COVID symptoms. This new program integrates treatment and research and thus supports the White House memorandum directing action to be taken in support of research on Long COVID.

The HRSA Long COVID Support Program will have two components: to fund integrated sub-specialty services for people with Long COVID; and to train and increase capacity for primary

[221] https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/20220622.htm
[222] https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/05/fact-sheet-the-biden-administration-accelerates-whole-of-government-effort-to-prevent-detect-and-treat-long-covid/ and https://www.hhs.gov/about/news/2022/08/03/biden-harris-administration-releases-two-new-reports-long-covid-support-patients-further-research.html?utm_source=news-releases-email&utm_medium=email&utm_campaign=august-7-2022

care providers who will provide much of the front-line care. First, HRSA will provide funding to states, or a non-profit if the state decides to not apply, to implement or enhance Long COVID Integrated Diagnostics and Care Units for referral of the most complex patients. This will include support of uninsured or low income patients to access services in these Long COVID Integrated Diagnostics and Care Units. Second, HRSA will fund provider training, capacity building, and consultation to support primary care physicians who will provide services for a majority of patients with Long COVID.

Eligible Entities:

All States, the District of Columbia, Puerto Rico, and the Virgin Islands will be eligible to apply for the Long COVID Integrated Diagnostics and Care Units funding with non-profits eligible to apply if a state decides to not apply. Nonprofit organizations may apply for the training and capacity building component.

Budget Request:

The FY 2024 Budget Request is $130 million for this new program. Funding will provide support to patients diagnosed with Long COVID. This funding will support: 1) integrated specialty care to those patients with the most complex needs, including the access to these specialized services for uninsured and underinsured patients; and 2) training, capacity building, and consultation services to primary care providers who will provide a majority of Long COVID care.

a. Long COVID Integrated Diagnostics and Care Units: $100 million to support approximately 53 awards to states at an average amount of $1.9 million per award for Long COVID Integrated Diagnostics and Care Units throughout the country to provide integrated multispecialty evaluation and care for patients with Long COVID, including through telemedicine. The specialties would include such areas as pulmonary medicine, neurology, cardiology, mental health services, physical rehabilitation, case management, and occupational therapy. The Long COVID Integrated Diagnostics and Care Units would be required to document processes to integrate assessments and treatment plans across specialists and primary care. The funding would include enhancing existing Units in states in addition to providing funding for uninsured and low income patients to access services through these units.

These Long COVID Integrated Diagnostics and Care Units would be associated with NIH funded clinical trial networks to efficiently translate the latest research advances into clinical practice and to give patients opportunities to participate in clinical trials to increase their access to emerging therapies. They would also be associated with the AHRQ proposed grants to study how to develop and implement new or improved care delivery models within multidisciplinary Long COVID clinics and quickly translate lessons learned to the HRSA funded clinical programs.

Funding will also support staffing and administrative costs, including an evaluation to study the effectiveness of the program.

b. Provider Training, Capacity Building, and Consultation: $30 million to support approximately 11 awards at an average amount of $2.7 million per award to nonprofit entities for provider training, capacity building, and consultation for primary care providers. Recipients would provide web-based and regionally based training to primary care providers to increase their knowledge of Long COVID diagnostics and treatment; an ECHO model to increase capacity of clinical sites and clinicians; and a consultation center to support clinicians across the country in the assessment and management of Long COVID through telephone and e-consultation.

Funding will also support staffing and administrative costs, including an evaluation to study the effectiveness of the program.

Funding History:

Fiscal Year	Amount
FY 2020	---
FY 2021	---
FY 2022	---
FY 2023	---
FY 2024	$130,000,000

Program Accomplishments:

As this is a newly funded FY 2024 initiative, program accomplishments are in development.

Outputs and Outcomes Table

Performance Measures are in development.

Grant Awards Tables

Long COVID Integrated Diagnostics and Care Units

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	---	---	53
Average Award	---	---	$1,900,000
Range of Awards	---	---	TBD

Provider Training, Capacity Building, and Consultation

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	---	---	11
Average Award	---	---	$2,700,000
Range of Awards	---	---	TBD

State Table

State awards are in development.

Title X Family Planning Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$286,479,000	$286,479,000	$512,000,000	+$225,521,000
FTE	19	35	37	+2

Authorizing Legislation - Title X of the Public Health Service Act

FY 2024 Authorization…….…....Expired

Allocation Method:

- Direct Federal
- Contract
- Competitive Grant

Program Description:

The Title X Family Planning Program (Title X Program or Title X) 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).

Advancing equity for all, including people from low-income families, people of color, and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality, is a priority for the Department, for OASH/OPA, and for the Title X Program. Grantees, subrecipients, and service sites funded by the Title X Program work to ensure that the predominantly low-income clients, who rely on Title X services as their usual source of medical care, have access to the same quality healthcare, including full medical information and referrals, that higher-income clients and clients with private insurance are able to access. Key strategies for advancing equity include removing barriers to accessing services, improving the quality of services, and providing client-centered services.

Budget Request
The FY 2024 Budget Request for the Title X Family Planning Program of $512 million is $226 million above the FY 2023 Enacted level. This request will fund family planning services for approximately 4.5 million individuals, with 90% having family incomes at or below 250% of the federal poverty level. The additional funds will allow for strategic planning, coordination, and evaluation of demonstration grants to test innovative approaches that support efforts to achieve health equity, including sexual and reproductive health equity, and improved health outcomes for medically underserved populations that rely on Title X as a primary point-of-entry into the healthcare system. By focusing on promising strategies that address an array of the drivers of social determinants of health in the service delivery setting, safety-net providers and the broader public health community will have a larger body of evidence and tested approaches to deliver quality care and support using a comprehensive, integrated approach that centers the lived experiences of the systems' clients.

With the increase in funding, OPA will:

- Provide additional funding to Title X service providers to increase the number of clients receiving Title X services.
- Fund states, territories, tribes, and communities to develop and implement demonstration grants that:
    - advance a multidimensional approach to address social determinants of health within Title X family planning settings,
    - identify value-based payment models for future utilization by Title X providers; and
    - improve access to quality family planning services through telehealth utilizing consistent data collection methods for FPAR reporting.
- Develop a research agenda to advance integrated approaches to sexual and reproductive health equity and fund research projects designed to advance the research agenda.
- Support training initiatives that focus on applying a health equity framework in Title X service delivery.
- Fund national organizations to support a comprehensive, integrated approach to addressing social determinants of health in safety-net healthcare delivery through Title X.
- Support communication and dissemination of findings from family planning, sexual, and reproductive health data, research, programs and services.
- Coordinate interagency efforts to advance patient-centered performance measures on sexual and reproductive health equity and align those measures with payment.

The FY 2024 Budget Request will also allow the program to continue providing training and technical assistance to grantees, including supporting the operation of the Reproductive Health National Training Center and the National Clinical Training Center for Family Planning. OPA is increasing its focus on access, equity, and quality through a number of programmatic activities to support Title X projects. In FY 2024, OPA will continue to update the *Quality Family Planning* guidelines, the nationally recognized standards of care that define quality in a family planning visit. In addition, OPA is continuing to stress the importance of restoring and expanding access to quality services, leveraging community-based education and outreach and telehealth to assist individuals and families with effective family planning services and related preventive healthcare services.

Funding History

Fiscal Year	Amount
FY 2020	$286,479,000
FY 2021	$285,619,000
FY 2022	$286,479,000
FY 2023	$286,479,000
FY 2024 President's Budget	$512,000,000

Program Accomplishments

The Title X Program fulfills its mission through awarding competitive grants to public and private nonprofit organizations. According to the 2021 Family Planning Annual Report (FPAR) data (the most recent data available), in 2021 Title X services were provided through a nationwide network of 3,284 community-based sites that provided clinical and educational services to 1,662,466 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 357,430 unintended pregnancies. Title X also plays an essential role in helping to prevent and treat sexually transmitted diseases (STDs). In 2021, Title X service sites tested 741,278 female and male clients for chlamydia; 861,930 for gonorrhea; 403,492 for syphilis; and 487,995 confidential tests for HIV. Of the confidential HIV tests performed, 1,439 were positive for HIV.

In October 2021, the Department finalized rulemaking to revise the regulations (effective November 8, 2021) that govern the Title X Family Planning Program (authorized by Title X of the Public Health Service Act) by readopting the 2000 regulations (65 FR 41270), with several revisions to ensure access to equitable, affordable, client-centered, quality family planning services for all clients, especially for low-income clients.

In April 2022, OPA restored Title X services nationwide for the first time since 2019. There is now at least one Title X services grantee in all 50 states, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the U.S. Virgin Islands, American Samoa, the Federated State of Micronesia, and the Republic of Palau. The Title X funded clinics are focused on advancing health equity through the delivery of Title X services, bolstering access to Title X services for all who need them, and ensuring delivery of Title X services of the highest quality and aligned with nationally recognized standards of care. In addition to restoring Title X services nationwide, OPA plans to launch FPAR 2.0 in 2023 to allow for encounter-level data collection of Title X systems. Focusing on better data collection will increase the ability to drive policy and report on the outputs and outcomes of Title X projects and the overall program.

OPA funds several family planning research projects to expand our understanding of best practices and promising strategies to advance equity, bolster access, and improve quality of family planning services. OPA continues to provide training and technical assistance support for

all staff, including clinical service providers, working in Title X clinics through the Reproductive Health National Training Center and the National Clinical Training Center for Family Planning.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
8000.01 Total number of unduplicated clients served in Title X service sites.	FY 2021: 1,662,466 Target: 3,300,000 (Target Not Met)	4,250,000	4,500,000	+250
8000.02 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.	FY 2021: 86% Target: 90% (Target Not Met)	90%	90%	Maintain
8000.05 Increase the proportion of females' ages 15 – 24 attending Title X family planning clinics screened for Chlamydia infection.	FY 2021: 53% Target: 64% (Target Not Met)	60%	62%	+2 percentage points
8000.07 Percentage of Title X clinic female clients who adopted or who reported using a contraceptive method at their last visit	FY 2022: Result Expected September 1, 2023 Target: Not Defined (Pending)	77%	79%	+2 percentage points
8000.08 Increase the percentage of Title X clinic clients who are screened for cervical cancer	FY 2022: Result Expected September 1, 2023 Target: Not Defined (Pending)	25%	27%	+2 percentage points
8000.09 Percentage of clients attending a Title X clinic who are uninsured	FY 2022: Result Expected September 1, 2023 Target: Not Defined (Pending)	38%	37%	-1 percentage point

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
8000.10 Percentage of Title X sites with telehealth capabilities	FY 2022: Result Expected September 1, 2023 Target: Not Defined (Pending)	15%	23%	+8 percentage points
8000.11 Increase the proportion of Title X female clients ages 15-24 who are screened for gonorrhea	FY 2022: Result Expected September 1, 2023 Target: Not Defined (Pending)	53%	53%	Maintain
8000.12 Increase the proportion of Title X clients who are screened for syphilis	FY 2022: Result Expected September 1, 2023 Target: Not Defined (Pending)	29%	29%	Maintain
8000.13 Increase the proportion of Title X clients who are screened for HIV	FY 2022: Result Expected September 1, 2023 Target: Not Defined (Pending)	30%	30%	Maintain
8000.03 Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals.	FY2021: 375,430 Target: 810,000 (Target not met)	870,000	Discontinued	N/A
8000.04 Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24.	FY 2021: 259,129 Target: 850,000 (Target Not Met)	920,000	Discontinued	N/A

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
8000.06 Maintain the actual cost per Title X client below the medical care inflation rate.	FY2021: $438 Target: $371 (Target not met)	371	Discontinued	N/A

Performance Narrative

OPA funded 90 Title X service grantees at the beginning of FY 2019. Following implementation of the Title X Final Rule in FY 2019, 19 grantees discontinued participating in the Title X Program, and another 18 grantees reported significant losses to their service networks. OPA funded an additional five Title X grantees in FY 2020; however, there remained six states (HI, ME, OR, UT, VT, and WA) without any Title X services available and another seven states (AK, CT, IL, MA, MN, NH, and NY) with Title X services available on a very limited basis. This resulted in Title X serving fewer clients and therefore not meeting the performance targets for 2019, 2020, and 2021.

In October 2021, HHS finalized rulemaking to revise the regulations (effective November 8, 2021) that govern the Title X family planning program (authorized by Title X of the Public Health Service Act). Then, in April 2022, OPA competed all Title X service delivery funds and funded 78 grantees, who are restoring Title X services nationwide. OPA anticipates these newly funded Title X grantees will increase the total number of clients served. The increases in total number of clients served, however, are not expected to be evident until the 2022 FPAR data, which will not be available until late 2023.

The targets for FY 2024 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.

Measures 8000.03, 8000.04, and 8000.06 have been discontinued to better align with the program mission and available data. Measure 8000.05 has been reworded for accuracy and to align with the new sexually transmitted infection measures. Baselines are not yet available for new measures.

Grants Awards Table

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Number of Awards	78	78	100
Average Award	$3,323,078	$3,323,078	$3,323,078
Range of Awards	$200,000 - $15,400,000	$200,000 - $15,400,000	$200,000 - $15,400,000

Nonrecurring Expenses Fund

(Dollars in Thousands)

Fiscal Year	FY 2022[2]	FY 2023[3]	FY 2024[4]
Notification[1]	$21,990	$41,940	$49,490

Authorizing Legislation:

Authorization…….Section 223 of Division G of the Consolidated Appropriations Act, 2008

Allocation Method……Direct Federal, Competitive Contract

Program Description

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 $141.59 million. 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 utilization of data across HRSA.

Budget Allocation FY 2024

In FY 2024 HRSA is allocated $49.49 million in NEF funding for eight projects:

- Health Workforce Connector Community: This project will expand the Health Workforce to meet evolving community needs, improve the distribution of Health Workforce to reduce shortages, enhance health care equity and quality.

- NCHAW Enhanced and Advanced Data Analytics & Tools: This initiative will improve HRSA's ability to provide Federal and non-Federal stakeholders improved access to valuable methodology and datasets created and managed by the National Center for Health Workforce Analysis.

- Robotic Process: This project will establish an enterprise-wide RPA framework that will focus on bot development and deployment rather than worry about establishing infrastructure, its maintenance and security compliance.

- Tenant Move: This project will support build out a new space for the Hansen's Disease Program Lab Research Branch which includes new laboratory equipment and cost associated from the move.

- Data Warehouse: HRSA will migrate the Data Warehouse system to cloud as well as automate the continuous integration and continuous delivery software delivery pipeline.

- Data Center: HRSA will modernize the End of Life datacenter infrastructure to ensure that various security and file storage functions continue to operate on supported hardware as well as allow HRSA to meet critical OMB mandates, and DHS/HHS security policies and operational requirements.

- ServiceNow: This project supports four key initiatives using the ServiceNow platform to improve operational efficiency at HRSA over time, integrate ServiceNow with Azure cloud services, and monitoring and managing software licenses, reclaiming unused licenses, providing a service portal and reporting capability for audits and compliance, and implement an Enterprise Architecture platform using ServiceNow that can integrate and synchronize with the HHS instance of EANow for secure data exchange about HRSA software and systems to improve governance and productivity.

- SharePoint: HRSA will modernize the existing SharePoint-based custom business workflow solutions using the latest Microsoft cloud-based Power Platform to replace legacy SharePoint technology workflows reaching end-of-life support. HRSA will also use the funding to redesign/modernize the migrated HRSA SharePoint sites using cloud native tools.

Budget Allocation FY 2023

In FY 2023 HRSA received $41.94 million in NEF funding for four projects:

- Tenant Improvement Expense for the National Hansen's Disease Program Lab Research: This project will allow the National Hansen's Disease Program to build new space for the Lab Research Branch.

- Expanding Access to Advances Data Analytics & Tools: This project will improve policy maker's ability to visualize and analyze large health workforce datasets.

- Data Solution Phase 2: This project is a follow-on of a two-part formation and implementation of a Rural Health Data Solution.

- Data Center and Security Infrastructure: HRSA will be replacing existing server hardware and technology, modernizing and replacing the network edge switches, and firewalls to continue securing HRSA's networks and to stay within the standards.

Budget Allocation FY 2022

In FY 2022 HRSA received a total of $21.99 million for seven projects.

- HRSA's SharePoint Cloud Migration Phase 2 moved SharePoint Online and Microsoft Teams to a cloud based platform.

- Rural Health Data Solution and Implementation Phase 2 built and implemented the identified solutions that were identified in Phase 1 to create dashboards and geospatial mapping across all levels of rural health data.
- The Enterprise Site Repository (ESR) modernized, and cloud-enabled the existing legacy implementation of ESR.
- Expanding Access to Advanced Data Analytic Tools allowed for more robust business intelligence to enhance program decision making.
- The Network Infrastructure Refresh ensured HRSA staff is able to connect to network resources securely and reliably
- HRSA's Data Warehouse: Data Enrichment and Security modernized and enriched the HRSA Data Warehouse website.
- Ipv6 and Zero Trust Adoption helped HRSA meet the requirements for the Presidential Executive Order as well as Office of Management and Budget Mandates.

[1] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use
[2] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on June 17, 2021.
[3] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on September 23, 2022.
[4] HHS has not yet notified for FY 2024.

Supplemental Tables

TAB

Object Class Tables

DISCRETIONARY

(dollars in thousands)

OBJECT CLASS	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	186,415	206,456	225,977	+19,521
Other than full-time permanent (11.3)	4,747	4,978	5,229	+251
Other personnel compensation (11.5)	3,874	4,037	4,241	+204
Military personnel (11.7)	17,152	17,873	18,775	+902
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**212,188**	**233,344**	**254,222**	**+20,878**
Civilian benefits (12.1)	69,161	76,139	82,858	+6,719
Military benefits (12.2)	1,974	2,053	2,158	+105
Benefits to former personnel (13.1)	1,448	1,508	1,584	+76
Total Pay Costs	**284,771**	**313,044**	**340,822**	**+27,778**
Travel and transportation of persons (21.0)	727	727	725	-2
Transportation of things (22.0)	119	119	119	-
Rental payments to GSA (23.1)	17,824	17,824	17,824	-
Rental payments to Others (23.2)	94	94	94	-
Communication, utilities, and misc. charges (23.3)	610	610	610	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	152	152	152	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	29,939	29,939	29,939	-
Other services (25.2)	301,835	312,782	351,199	+38,417
Purchase of goods/services from government accounts (25.3)	198,996	198,745	198,289	-456
Operation and maintenance of facilities (25.4)	317	317	317	-
Research and Development Contracts (25.5)	116	116	116	-
Medical care (25.6)	3,348	3,348	3,348	-
Operation and maintenance of equipment (25.7)	4,294	4,277	4,244	-33
Subsistence and support of persons (25.8)	57	57	57	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	597	595	595	-
Subtotal Other Contractual Services	**539,499**	**550,176**	**588,104**	**+37,928**
Equipment (31.0)	10,239	10,239	10,292	+53
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	7,544,158	8,464,843	8,097,614	-367,229
Insurance Claims and Indemnities (42.0)	158,601	107,455	107,343	-112
Total Non-Pay Costs	**8,272,023**	**9,152,239**	**8,822,877**	**- 329,362**
Total Budget Authority by Object Class	**8,556,794**	**9,465,283**	**9,163,699**	**- 301,584**

PRIMARY HEALTH CARE

(dollars in thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	32,844	34,986	36,753	+1,767
Other than full-time permanent (11.3)	554	576	606	+30
Other personnel compensation (11.5)	502	523	550	+27
Military personnel (11.7)	3,604	3,755	3,945	+190
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**37,504**	**39,840**	**41,854**	**+2,014**
Civilian benefits (12.1)	12,120	12,883	13,533	+650
Military benefits (12.2)	322	335	351	+16
Benefits to former personnel (13.1)	16	18	18	-
Total Pay Costs	**49,962**	**53,076**	**55,756**	**+2,680**
Travel and transportation of persons (21.0)	200	200	200	-
Transportation of things (22.0)	1	1	1	-
Rental payments to GSA (23.1)	2,636	2,636	2,636	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	77	77	77	-
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)	200	200	200	-
Other services (25.2)	123,561	123,561	123,561	-
Purchase of goods and services from government accounts (25.3)	50,464	50,464	50,464	-
Operation and maintenance of facilities (25.4)	4	4	4	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	1,381	1,381	1,381	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	62	62	62	-
Subtotal Other Contractual Services	**175,672**	**175,672**	**175,672**	**-**
Equipment (31.0)	3,828	3,828	3,828	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	1,357,981	1,516,014	1,593,445	+77,431
Insurance Claims and Indemnities (42.0)	158,415	107,268	107,157	(-111)
Total Non-Pay Costs	**1,698,810**	**1,805,696**	**1,883,016**	**+77,320**
Total Budget Authority by Object Class	**1,748,772**	**1,858,772**	**1,938,772**	**+80,000**

HEALTH WORKFORCE

(dollars in thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	14,022	14,600	20,390	+5,790
Other than full-time permanent (11.3)	474	494	519	+25
Other personnel compensation (11.5)	255	266	279	+13
Military personnel (11.7)	1,283	1,337	1,405	+68
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**16,034**	**16,697**	**22,593**	**+5,896**
Civilian benefits (12.1)	5,295	5,514	7,476	+1,962
Military benefits (12.2)	204	212	223	+11
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**21,533**	**22,423**	**30,292**	**+7,869**
Travel and transportation of persons (21.0)	21	21	21	-
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	1,202	1,202	1,202	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	91	91	91	-
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)	26,340	35,177	35,089	-88
Purchase of goods and services from government accounts (25.3)	41,350	41,156	40,972	-184
Operation and maintenance of facilities (25.4)	12	12	12	+
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	606	589	556	-33
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**68,308**	**76,934**	**76,629**	**-305**
Equipment (31.0)	1,652	1,652	1,705	+53
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	1,202,935	1,288,053	1,637,546	+349,493
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**1,274,209**	**1,367,953**	**1,717,194**	**+349,241**
Total Budget Authority by Object Class	**1,295,742**	**1,390,376**	**1,747,486**	**+357,110**

MATERNAL AND CHILD HEALTH

(dollars in thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	13,029	15,929	17,268	+1,339
Other than full-time permanent (11.3)	206	215	226	+11
Other personnel compensation (11.5)	201	213	223	+10
Military personnel (11.7)	465	485	510	+25
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**13,901**	**16,842**	**18,227**	**+1,385**
Civilian benefits (12.1)	4,790	5,775	6,087	+312
Military benefits (12.2)	42	43	46	+3
Benefits to former personnel (13.1)	44	45	47	+2
Total Pay Costs	**18,777**	**22,705**	**24,407**	**+1,702**
Travel and transportation of persons (21.0)	160	160	160	-
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	1,925	1,925	1,925	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	129	129	129	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	5	5	5	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	25,394	25,394	25,394	-
Other services (25.2)	12,706	12,706	12,706	-
Purchase of goods and services from govt. accounts (25.3)	16,803	16,803	16,803	-
Operation and maintenance of facilities (25.4)	4	4	4	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	764	764	764	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	12	12	12	-
Subtotal Other Contractual Services	**55,683**	**55,683**	**55,683**	-
Equipment (31.0)	646	646	646	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	967,145	1,090,177	1,274,875	+184,698
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**1,025,693**	**1,148,725**	**1,333,423**	**+184,698**
Total Budget Authority by Object Class	**1,044,470**	**1,171,430**	**1,357,830**	**+186,400**

HIV AIDS

(dollars in thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	20,337	24,077	25,293	+1,216
Other than full-time permanent (11.3)	548	570	599	+29
Other personnel compensation (11.5)	409	427	448	+21
Military personnel (11.7)	3,473	3,619	3,802	+183
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**24,767**	**28,693**	**30,142**	**+1,449**
Civilian benefits (12.1)	7,460	8,743	9,184	+441
Military benefits (12.2)	418	431	454	+23
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**32,645**	**37,867**	**39,780**	**+1,913**
Travel and transportation of persons (21.0)	60	61	61	-
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	3,742	3,742	3,742	-
Rental payments to Others (23.2)	4	4	4	-
Communication, utilities, and misc. charges (23.3)	-	-	-	-
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)	42,944	41,749	41,749	-
Purchase of goods and services from govt. acct (25.3)	64,517	64,460	64,460	-
Operation and maintenance of facilities (25.4)	51	51	51	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	544	544	544	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	32	31	31	-
Subtotal Other Contractual Services	**108,088**	**106,835**	**106,835**	**-**
Equipment (31.0)	1,839	1,839	1,839	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	2,348,398	20,693	2,543,780	+123,087
Insurance Claims and Indemnities (42.0)	-	-		-
Total Non-Pay Costs	**2,462,131**	**2,533,174**	**2,656,261**	**+123,087**
Total Budget Authority by Object Class	**2,494,776**	**2,571,041**	**2,696,041**	**+125,000**

HEALTH SYSTEMS

(dollars in thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	4,561	5,199	7,149	+1,950
Other than full-time permanent (11.3)	125	130	137	+7
Other personnel compensation (11.5)	174	181	190	+9
Military personnel (11.7)	853	888	933	+45
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**5,713**	**6,398**	**8,409**	**+2,011**
Civilian benefits (12.1)	1,804	2,028	2,693	+665
Military benefits (12.2)	89	93	98	+5
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**7,606**	**8,519**	**11,200**	**+2,681**
Travel and transportation of persons (21.0)	23	23	23	-
Transportation of things (22.0)	51	51	51	-
Rental payments to GSA (23.1)	1,980	1,980	1,980	-
Rental payments to Others (23.2)	87	87	87	-
Communication, utilities, and misc. charges (23.3)	210	210	210	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	12	12	12	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	6	6	6	-
Other services (25.2)	64,522	67,414	101,006	+33,592
Purchase of goods and services from government accounts (25.3)	3,381	3,381	3,109	-272
Operation and maintenance of facilities (25.4)	163	163	163	-
Research and Development Contracts (25.5)	116	116	116	-
Medical care (25.6)	3,348	3,348	3,348	-
Operation and maintenance of equipment (25.7)	251	251	251	-
Subsistence and support of persons (25.8)	57	57	57	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	220	220	220	-
Subtotal Other Contractual Services	**72,064**	**74,956**	**108,276**	**+33,320**
Equipment (31.0)	636	636	636	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	13,333	12,528	12,527	-1
Insurance Claims and Indemnities (42.0)	7	7	7	-
Total Non-Pay Costs	**88,403**	**90,490**	**123,809**	**+33,319**
Total Budget Authority by Object Class	**96,009**	**99,009**	**135,009**	**+36,000**

RURAL HEALTH

(dollars in thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	4,083	4,476	5,265	+789
Other than full-time permanent (11.3)	131	136	143	+7
Other personnel compensation (11.5)	86	89	94	+5
Military personnel (11.7)	13	13	14	+1
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**4,313**	**4,714**	**5,516**	**$+802**
Civilian benefits (12.1)	1,536	1,674	1,946	+272
Military benefits (12.2)	1	1	1	-
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**5,850**	**6,389**	**7,463**	**+1,074**
Travel and transportation of persons (21.0)	112	112	112	-
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	643	643	643	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	-	-	-	-
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)	81	81	81	-
Other services (25.2)	14,291	14,291	14,291	-
Purchase of goods and services from govt. accounts (25.3)	3,592	3,592	3,592	-
Operation and maintenance of facilities (25.4)	73	73	73	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	280	280	280	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	7	7	7	-
Subtotal Other Contractual Services	**18,324**	**18,324**	**18,324**	-
Equipment (31.0)	706	706	706	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	305,427	326,233	388,604	+62,371
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**325,212**	**346,018**	**408,389**	**+62,371**
Total Budget Authority by Object Class	**331,062**	**352,407**	**415,852**	**+63,445**

FAMILY PLANNING

(dollars in thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	4,767	6,764	7,330	+566
Other than full-time permanent (11.3)	2	2	3	+1
Other personnel compensation (11.5)	114	118	124	+6
Military personnel (11.7)	271	282	297	+15
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**5,154**	**7,166**	**7,754**	**+588**
Civilian benefits (12.1)	1,786	2,460	2,659	+199
Military benefits (12.2)	15	15	16	+1
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**6,955**	**9,641**	**10,429**	**+788**
Travel and transportation of persons (21.0)	76	76	76	-
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	149	149	149	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	8	8	8	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	9	9	9	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	4,242	4,242	4,242	-
Other services (25.2)	475	475	475	-
Purchase of goods/services from govt. accounts (25.3)	9,858	9,858	9,858	-
Operation and maintenance of facilities (25.4)	9	9	9	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	403	403	403	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	111	111	111	-
Subtotal Other Contractual Services	**15,098**	**15,098**	**15,098**	**-**
Equipment (31.0)	144	144	144	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	264,040	261,354	486,087	+224,733
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**279,524**	**276,838**	**501,571**	**+224,733**
Total Budget Authority by Object Class	**286,479**	**286,479**	**512,000**	**+225,521**

HRSA-WIDE ACTIVITIES AND PROGRAM SUPPORT

PROGRAM MANAGEMENT

(dollars in thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	89,739	95,240	101,175	+5,935
Other than full-time permanent (11.3)	2,724	2,836	2,979	+143
Other personnel compensation (11.5)	2,092	2,178	2,288	+110
Military personnel (11.7)	6,171	6,430	6,755	+325
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**100,726**	**106,684**	**113,197**	**+6,513**
Civilian benefits (12.1)	33,319	35,295	37,452	+2,157
Military benefits (12.2)	779	811	852	+41
Benefits to former personnel (13.1)	1,388	1,445	1,518	+73
Total Pay Costs	**136,212**	**144,235**	**153,019**	**+8,784**
Travel and transportation of persons (21.0)	46	46	46	-
Transportation of things (22.0)	67	67	67	-
Rental payments to GSA (23.1)	5,334	5,334	5,334	-
Rental payments to Others (23.2)	3	3	3	-
Communication, utilities, and misc. charges (23.3)	94	94	94	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	126	126	126	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	16	16	16	-
Other services (25.2)	10,104	10,104	9,280	-824
Purchase of goods and services from government accounts (25.3)	6,459	6,459	-	-6,459
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	43	43	43	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	148	148	148	-
Subtotal Other Contractual Services	**16,770**	**16,770**	**9,487**	**-7,283**
Equipment (31.0)	616	616	616	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	1,053,749	1,518,011	-	-1,518,011
Insurance Claims and Indemnities (42.0)	179	179	179	-
Total Non-Pay Costs	**1,076,984**	**1,541,246**	**15,952**	**-1,525,294**
Total Budget Authority by Object Class	**1,213,196**	**1,685,481**	**168,971**	**-1,516,510**

340B DRUG PRICING PROGRAM//OFFICE OF PHARMACY AFFAIRS

(dollars in thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	2,261	2,579	2,709	+130
Other than full-time permanent (11.3)	-	-	-	-
Other personnel compensation (11.5)	33	34	36	+2
Military personnel (11.7)	1,019	1,062	1,116	+54
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**3,313**	**3,675**	**3,861**	**+186**
Civilian benefits (12.1)	774	881	926	+45
Military benefits (12.2)	107	112	117	+5
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**4,194**	**4,668**	**4,904**	**+236**
Travel and transportation of persons (21.0)	23	23	23	-
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	149	149	149	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	-	-	-	-
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)	5,263	5,789	10,553	+4,764
Purchase of goods and services from government accounts (25.3)	1,437	1,437	1,437	-
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	21	21	21	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	2	2	2	-
Subtotal Other Contractual Services	**6,723**	**7,249**	**12,013**	**+4,764**
Equipment (31.0)	149	149	149	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	-	-	-	-
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**7,044**	**7,570**	**12,334**	**+4,764**
Total Budget Authority by Object Class	**11,238**	**12,238**	**17,238**	**+5,000**

TELEHEALTH

(dollars in thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	773	805	845	+40
Other than full-time permanent (11.3)	17	18	19	+1
Other personnel compensation (11.5)	9	9	10	+1
Military personnel (11.7)	-	-	-	-
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**799**	**832**	**874**	**+42**
Civilian benefits (12.1)	276	287	302	+15
Military benefits (12.2)	-	-	-	-
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**1,075**	**1,119**	**1,176**	**+57**
Travel and transportation of persons (21.0)	5	5	5	-
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	64	64	64	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	-	-	-	-
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)	1,665	1,665	1,665	-
Purchase of goods and services from government accounts (25.3)	1,135	1,135	1,135	-
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	2	2	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	2	2	2	-
Subtotal Other Contractual Services	**2,804**	**2,804**	**2,804**	-
Equipment (31.0)	22	22	22	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	31,080	34,036	40,429	+6,393
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**33,975**	**36,931**	**43,324**	**+6,393**
Total Budget Authority by Object Class	**35,050**	**38,050**	**44,500**	**+6,450**

LONG COVID

(dollars in thousands)

Object Class	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	-	-	1,800	+1,800
Other than full-time permanent (11.3)	-	-	-	-
Other personnel compensation (11.5)	-	-	-	-
Military personnel (11.7)	-	-	-	-
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**-**	**-**	**1,800**	**+1,800**
Civilian benefits (12.1)	-	-	600	+600
Military benefits (12.2)	-	-	-	-
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**-**	**-**	**2,400**	**+2,400**
Travel and transportation of persons (21.0)	-	-	-	-
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	-	-	-	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	-	-	-	-
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)	-	-	-	-
Purchase of goods and services from government accounts (25.3)	-	-	-	-
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**-**	**-**	**-**	**-**
Equipment (31.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	-	-	127,600	+127,600
Insurance Claims and Indemnities (42.0)	-	-	-	-
Total Non-Pay Costs	**-**	**-**	**127,600**	**+127,600**
Total Budget Authority by Object Class	**-**	**-**	**130,000**	**+130,000**

MANDATORY
(dollars in thousands)

OBJECT CLASS	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	63,552	73,261	83,710	+10,449
Other than full-time permanent (11.3)	787	820	861	+41
Other personnel compensation (11.5)	1,201	1,250	1,313	+63
Military personnel (11.7)	7,323	7,631	8,016	+385
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**72,863.0**	**82,962**	**93,900**	**+10,938**
Civilian benefits (12.1)	23,529	26,862	30,469	+3,607
Military benefits (12.2)	862	896	942	+46
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**97,254**	**110,720**	**125,311**	**+14,591**
Travel and transportation of persons (21.0)	330	330	330	-
Transportation of things (22.0)	37	37	37	-
Rental payments to GSA (23.1)	2,400	2,400	2,400	-
Rental payments to Others (23.2)	16	16	16	-
Communication, utilities, and misc. charges (23.3)	1,210	1,210	1,210	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	1	1	1	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	12,606	12,606	12,606	-
Other services (25.2)	42,118	42,118	42,118	-
Purchase of goods and services from government accounts (25.3)	135,839	135,171	135,171	-
Operation and maintenance of facilities (25.4)	259	259	259	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	1,193	1,193	1,193	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**192,016**	**191,348**	**191,347**	**-**
Equipment (31.0)	1,519	1,519	1,519	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	4,404,978	4,514,980	6,319,072	**+1,804,092**
Insurance Claims and Indemnities (42.0)	65	65	65	-
Total Non-Pay Costs	**4,602,572**	**4,711,906**	**6,515,997**	**+1,804,091**
Total Budget Authority by Object Class	**4,699,826**	**4,822,626**	**6,641,308**	**+1,818,682**

Salaries and Expenses
DISCRETIONARY
(*dollars in thousands)*

OBJECT CLASS	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	186,415	206,456	225,977	+19,521
Other than full-time permanent (11.3)	4,747	4,978	5,229	+251
Other personnel compensation (11.5)	3,874	4,037	4,241	+204
Military personnel (11.7)	17,152	17,873	18,775	+902
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**212,188**	**233,344**	**254,222**	**+20,878**
Civilian benefits (12.1)	69,161	76,139	82,858	+6,719
Military benefits (12.2)	1,974	2,053	2,158	+105
Benefits to former personnel (13.1)	1,448	1,508.00	1,584	+76
Total Pay Costs	**72,583**	**313,044**	**340,822**	**+27,778**
Travel and transportation of persons (21.0)	727	727	725	-2
Transportation of things (22.0)	119	119	119	-
Rental payments to Others (23.2)	94	94	94	-
Communication, utilities, and misc. charges (23.3)	610	610	610	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	152	152	152	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	29,939	29,939	29,939	-
Other services (25.2)	301,835	312,782	351,199	+38,417
Purchase of goods/services from government accounts (25.3)	198,996	198,745	198,289	-456
Operation and maintenance of facilities (25.4)	317	317	317	-
Medical care (25.6)	3,348	3,348	3,348	-
Operation and maintenance of equipment (25.7)	4,294	4,277	4,244	-33
Subsistence and support of persons (25.8)	57	57	57	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	597	595	595	-
Subtotal Other Contractual Services	**539,535**	**550,212**	**588,140**	**+37,928**
Total Non-Pay Costs	**541,237**	**551,914**	**589,840**	**+37,926**
Total Budget Authority by Object Class	**613,820**	**864,958**	**930,662**	**+65,704**

MANDATORY

(*dollars in thousands)*

OBJECT CLASS	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Full-time permanent (11.1)	63,552	73,261	83,710	+10,449
Other than full-time permanent (11.3)	787	820	861	+41
Other personnel compensation (11.5)	1,201	1,250	1,313	+63
Military personnel (11.7)	7,323	7,631	8,016	+385
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**72,863**	**82,962**	**93,900**	**+10,938**
Civilian benefits (12.1)	23,529	26,862	30,469	+3,607
Military benefits (12.2)	862	896	942	+46
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**97,254**	**110,720**	**125,311**	**+14,591**
Travel and transportation of persons (21.0)	330	330	330	-
Transportation of things (22.0)	37	37	37	-
Rental payments to Others (23.2)	16	16	16	-
Communication, utilities, and misc. charges (23.3)	1,210	1,210	1,210	-
Commercial Reimbursement (23.6)	-	-	-	-
Network use data transmission service (23.8)	-	-	-	-
Printing and reproduction (24.0)	1	1	1	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	12,606	12,606	12,606	-
Other services (25.2)	42,118	42,118	42,118	-
Purchase of goods/services from govt accounts (25.3)	135,839	135,171	135,171	-
Operation and maintenance of facilities (25.4)	259	259	259	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	1,193	1,193	1,193	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**192,015**	**191,347**	**191,347**	**-**
Total Non-Pay Costs	**193,609**	**192,941**	**192,941**	**-**
Total Budget Authority by Object Class	**290,863**	**303,661**	**318,252**	**+14,591**

Statement of Personnel Resources

Programs	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Bureau of Primary Health Care:									
Direct:									
Health Centers/Tort	311	27	338	318	27	345	318	27	345
Free Clinics Medical Malpractice	-		-			-			-
Total, Direct:	**311**	**27**	**338**	**318**	**27**	**345**	**318**	**27**	**345**
Mandatory:									
Health Centers	248	22	270	263	22	285	323	22	345
Total, Mandatory	**248**	**22**	**270**	**263**	**22**	**285**	**323**	**22**	**345**
Total FTE, BPHC	**559**	**49**	**608**	**581**	**49**	**630**	**641**	**49**	**690**
Health Workforce:									
Direct:									
National Health Service Corps	15	-	15	19	-	19	19	-	19
Loan Repayment/Faculty Fellowships	-	-	-	1	-	1	1	-	1
Centers for Excellence	1		1	4	-	4	4	-	4
Scholarships for Disadvantaged Students	6	1	7	6	1	7	6	1	7
Health Careers Opportunity Program	1	-	1	1	-	1	1	-	1
Health Care Workforce Assessment	3	-	3	3	-	3	3	-	3
Primary Care Training and Enhancement	5	-	5	5	-	5	5	-	5
Oral Health Training	5	1	6	5	1	6	5	1	6
Area Health Education Centers	3	-	3	3	-	3	3	-	3
Geriatric Programs	3	2	5	3	2	5	3	2	5
Behavioral Health Workforce Development Programs	10	2	12	12	2	14	27	2	29
Public Health/Preventive Medicine	4	-	4	4	-	4	4	-	4
NURSE Corps Loan Repayment & Scholarship	22	2	24	26	2	28	26	2	28
Advanced Education Nursing Program	8	1	9	9	1	10	9	1	10
Nurse Workforce Diversity	4	-	4	4	-	4	4	-	4
Nurse Education, Practice & Retention	5	-	5	5	-	5	7	-	7
Nurse Faculty Loan Program	4	-	4	4	-	4	4	-	4

Programs	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Children's Hospitals GME Program	15	1	16	15	1	16	15	1	16
Graduate Medical Student Education	1	-	1	1	-	1	1	-	1
Promoting Mental Health Among the Health Workforce	-	-	-	-	-	-	2	-	2
Health Care Workforce Innovation	-	-	-	-	-	-	3	-	3
Pediatric Subspecialty LRP				1		1	1	-	1
Total, Direct	**115**	**10**	**125**	**131**	**10**	**141**	**153**	**10**	**163**
Reimbursable:									
National Practitioner Data Bank	47	1	48	47	1	48	47	1	48
Total, Reimbursable:	**47**	**1**	**48**	**47**	**1**	**48**	**47**	**1**	**48**
Mandatory:									
National Health Service Corps	197	19	216	235	19	254	235	19	254
Teaching Health Centers	6	5	11	11	5	16	11	5	16
Nurse Corps	7	-	7	11	-	11	11	-	11
Behavioral Health Workforce Education and Training	3	1	4	5	1	6	5	1	6
Mental and Behavioral Health	1	1	2	6	1	7	6	1	7
Promote Mental and Behavioral Health	2	-	2	3	-	3	3	-	3
Community Health Workforce	1	-	1	8	-	8	8	-	8
Public Health Workforce	-	-	-	2	-	2	2	-	2
Total, Mandatory	**217**	**26**	**243**	**281**	**26**	**307**	**281**	**26**	**307**
Total FTE, Health Workforce	**379**	**37**	**416**	**459**	**37**	**496**	**481**	**37**	**518**
Maternal and Child Health Bureau:									
Direct:									
Maternal & Child Health Block Grant	59	-	59	66	-	66	71	-	71
Innovation for Maternal Health	-	-	-	5	-	5	5	-	5
Training for Health Care Providers	-	-	-	-	-	-	1	-	1
Integrated Services for Pregnant and Postpartum Women	-	-	-	1		1	2		2
Maternal Mental Health Hotline	1	-	1	1		1	1		1
Autism and Other Developmental Disorders	8	1	9	8	1	9	8	1	9

Programs	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Sickle Cell Service Demonstrations	2	-	2	2	-	2	2	-	2
Early Hearing Detection and Intervention	5	-	5	5	-	5	5	-	5
Emergency Medical Services for Children	6	-	6	6	-	6	6	-	6
Healthy Start	17	1	18	21	1	22	24	1	25
Heritable Disorders	5	-	5	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	1	1	2
Poison Control Centers	3	-	3	3	-	3	3	-	3
Total, Direct:	**108**	**3**	**111**	**126**	**3**	**129**	**136**	**3**	**139**
Mandatory									
Family to Family Health Info Centers	1	-	1	1	-	1	1	-	1
Home Visiting	47	3	50	52	3	55	52	3	55
Pediatric Mental Health	2	-	2	3	-	3	3	-	3
Total, Mandatory	**50**	**3**	**53**	**56**	**3**	**59**	**56**	**3**	**59**
Total FTE, MCHB	**158**	**6**	**164**	**182**	**6**	**188**	**192**	**6**	**198**
HIV/AIDS Bureau:									
Direct:									
Ryan White Part A	37	5	42	43	5	48	43	5	48
Ryan White Part B	45	5	50	61	5	66	61	5	66
Ryan White Part C	41	10	51	46	10	56	46	10	56
Ryan White Part D	9	1	10	11	1	12	11	1	12
Ryan White Part F	3	1	4	3	1	4	3	1	4
Ryan White Part F Dental	-	-	-	-	-	-	-	-	-
Special Project of National Significance (SPNS)	3	-	3	3	-	3	3	-	3
Ending HIV/AIDS	25	2	27	27	2	29	27	2	29
Total, Direct:	**163**	**24**	**187**	**194**	**24**	**218**	**194**	**24**	**218**
Total FTE, HAB	**163**	**24**	**187**	**194**	**24**	**218**	**194**	**24**	**218**
Healthcare Systems Bureau:									
Direct:									
Organ Transplantation	5	1	6	9	1	10	24	1	25

Programs	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Cell Transplantation and Cord Blood Stem Cell Bank	7	1	8	7	1	8	7	1	8
Hansen's Disease Center	33	3	36	33	3	36	33	3	36
Covered Countermeasures Compensation	10	7	17	21	13	34	29	13	42
Vaccine	16	7	23	16	7	23	25	7	32
Total, Direct:	**71**	**19**	**90**	**86**	**25**	**111**	**118**	**25**	**143**
Reimbursable:									
Hansen's Disease Center	2	-	2	2	-	2	2	-	2
Total, Reimbursable	**2**	**-**	**2**	**2**	**-**	**2**	**2**	**-**	**2**
Mandatory									
Community Based Workforce Vaccine Outreach	9	2	11	9	2	**11**	9	2	11
Vaccine Confidence Initiative	1	-	1	1	-	**1**	1	-	1
Total, Mandatory	**10**	**2**	**12**	**10**	**2**	**12**	**10**	**2**	**12**
Total FTE, HSB	**83**	**21**	**104**	**98**	**27**	**125**	**130**	**27**	**157**
Federal Office of Rural Health Policy:									
Direct:									
Rural Health Policy Development	3	-	3	3	-	3	3	-	3
Rural Health Outreach Grants	10	-	10	12	-	12	12	-	12
Rural Hospital Flexibility Grants	3	-	3	3	-	3	3	-	3
State Offices of Rural Health	-	-	-	-	-	-	-	-	-
Radiation Exposure Screening & Education Program	1	-	1	1	-	1	1	-	1
Black Lung	-	-	-	-	-	-	-	-	-
Rural Communities Opioid Response	19	-	19	21	-	21	21	-	21
Rural Residency	2	-	2	2	-	2	2	-	2
Tribal Programs	2	-	2	2	-	2	2	-	2
Rural Health Clinics	2	-	2	2	-	2	2	-	2
COVID 19 Reporting	1	-	1	1	-	1	1	-	1
Rural Health Clinic Behavioral Health Initiative	-	-	-	-	-	-	1	-	1
At-Risk Rural Hospitals	-	-	-	-	-	-	2	-	2

Programs	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Rural Services Line Pilot	-			-			2		2
Total, Direct:	**43**	**-**	**43**	**47**	**-**	**47**	**52**	**-**	**52**
Mandatory									
Rural Health Clinics		-	-	-	-	-	-	-	-
Rural and Critical Access Hospitals	1	-	1	1	-	1	1	-	1
Rural Health Clinic Vaccine Confidence	2	-	2	2	-	2	2	-	2
ARP Rural Health Public Workforce	1	-	1	1	-	1	1	-	1
Rural Health Clinic Vaccine Distribution	4	-	4	4	-	4	4	-	4
Total, Mandatory	**8**	**-**	**8**	**8**	**-**	**8**	8	-	**8**
				-	-		-	-	
Total, FORHP	**51**	**-**	**51**	**55**	**-**	**55**	**60**	**-**	**60**
HRSA-Wide Activities and Program Support:									
Direct:									
Program Management	751	34	785	767	34	801	777	34	811
Telehealth	9	-	9	9	-	9	9	-	9
340B Drug Pricing Program/Office of Pharmacy Affairs	15	6	21	17	6	23	17	6	23
Long COVID							16	-	16
Total, Direct	**775**	**40**	**815**	**793**	**40**	**833**	**819**	**40**	**859**
OGAC Global AIDS (Reimbursable)	15	2	17	15	2	17	15	2	17
Family Planning (Direct)	18	1	19	34	1	35	36	1	37
Provider Relief Bureau:									
Provider Relief Fund Supplemental Funding	76	1	77	84	1	85	84	1	85
Uninsured Supplemental Funding	4		4	4	-	4	4	-	4
ARP OPS	2		2	2	-	2	2	-	2
Total, Direct	**82**	**1**	**83**	**90**	**1**	**91**	**90**	**1**	**91**
Subtotal Direct (non add)	1,686	125	1,811	1,819	131	1,950	1,916	131	2,047
Subtotal Reimbursable (non add)	64	3	67	64	3	67	64	3	67
Subtotal Mandatory (non add)	533	53	586	618	53	671	678	53	731

Programs	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Subtotal, HRSA FTE	**2,283**	**181**	**2,464**	**2,501**	**187**	**2,688**	**2,658**	**187**	**2,845**

FTEs Funded by P.L. 111-148 and Any Supplementals

(*Dollars in Thousands)*

Program	Section	FY 2013 Total Funding	FY 2013 FTE	FY 2014 Total Funding	FY 2014 FTE	FY 2015 Total Funding	FY 2015 FTE	FY 2016 Total Funding	FY 2016 FTE	FY 2017 Total Funding	FY 2017 FTE	FY 2018 Total Funding	FY 2018 FTE
Community Health Center Fund:													
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(1)	1,500,000	60	2,144,716	95	3,509,111	122	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	3,600,000	240	3.510.661	225	3,800,000	174
Health Centers - Facilities Construction	H.R. 3590, Section 10503(c)	-	-	-	-	-	-	-	-	-	-	-	-
School-Based Health Centers-Facilities	H.R. 3590, Section 4101	47,500	8	-	9	-	7	-	7	-	9	-	9
National Health Service Corps:													
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(2)	300,000	229	283,040	219	287,370	214	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	310,000	226	288,610	225	310,000	206
GME Payments Teaching Health Centers:													
P.L. 111-148 Mandatory	H.R. 3590, Section 5508	-	6	-	5	-	4	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	60,000	8	55,860	8	126,500	10
Family to Family Health Information Centers:													
Non-P.L. 111-148 Mandatory	H.R. 3590, Section 5507	5,000	-	5,000	1	5,000	1	5,000	1	4,655	1	6,000	1
Home Visiting Program:													
P.L. 111-148 Mandatory	H.R. 3590, Section 2951	379,600	22	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	371,200	22	400,000	25	400,000	37	372,400	44	400,000	42
Total		**2,232,100**	**325**	**2,803,956**	**351**	**4,201,481**	**373**	**4,375,000**	**519**	**4,232,186**	**512**	**4,642,500**	**442**

Program	Section	FY 2013 Total Funding	FY 2013 FTE	FY 2014 Total Funding	FY 2014 FTE	FY 2015 Total Funding	FY 2015 FTE	FY 2016 Total Funding	FY 2016 FTE	FY 2017 Total Funding	FY 2017 FTE	FY 2018 Total Funding	FY 2018 FTE
Community Health Center Fund:													
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(1)	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		4,000,000	177	4,000,000	203	4,000,000	285	3,905,348	270	3,905,348	285	5,170,000	345
Health Centers - Facilities Construction	H.R. 3590, Section 10503(c)	-	-	-	-	-	-	-	-	-	-	-	-
School-Based Health Centers-Facilities	H.R. 3590, Section 4101	-	8	-	4	-	-	-	-	-	-	-	-
National Health Service Corps:													
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(2)	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		310,000	209	310,000	205	310,000	222	292,330	216	292,330	254	790,000	254
GME Payments Teaching Health Centers:	H.R. 3590, Section 5508												
P.L. 111-148 Mandatory		-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		126,500	7	126,500	8	126,500	8	119,290	11	119,290	16	157,000	16
Family to Family Health Information Centers:													
Non-P.L. 111-148 Mandatory	H.R. 3590, Section 5507	6,000	1	6,000	1	5,658	1	5,658	1	5,658	1	5,658	1
Home Visiting Program:													
P.L. 111-148 Mandatory	H.R. 3590, Section 2951	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		400,000	39	376,40000	38	377,200	41	377,200	50	500,000	55	518,650	55
Total		**4,818,900**	**441**	**4,819,358**	**441**	**4,819,358**	**557**	**4,699,826**	**557**	**4,822,626**	**643**	**6,641,308**	**643**

Physicians' Comparability Allowance (PCA) Worksheet

1) Department and component:

Department of Health and Human Service, 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.)*

FY22 included (2) Separations of which (1) resigned and (1) retired. The average length of service was 13.5 years.
In FY22, we have (10) vacancies. At this time, (8) vacancies announcement have been posted and (3) vacancies have been filled at this point. Quality applicants have been limited. For example, an average of 28 applications are received for a vacancy, however, only 7 applicants were considered qualified for the position.
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 2022 (Actual)	**CY 2023 (Estimates)**	**BY* 2024 (Estimates)**
3a) Number of Physicians Receiving PCAs	27	35	35
3b) Number of Physicians with One-Year PCA Agreements	1	0	0
3c) Number of Physicians with Multi-Year PCA Agreements	26	35	35
4a) Average Annual PCA Physician Pay (without PCA payment)	$173,660	$170,800	$170,800
4b) Average Annual PCA Payment	$22,060	$21,658	$21,658

*BY data will be approved during the BY Budget cycle. Please ensure each column is completed.

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

In FY21 included (2) Separations of which (1) resigned and (1) retired. The average length of service was 8.5 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

Cybersecurity

Cyber Category	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Cyber Human Capital	5.990	13.443	15.993	+2.550
Sector Risk Management Agency (SRMA)	0.239	0.538	0.640	+0.102
Securing Infrastructure Investments	1.916	4.302	5.118	+0.816
Technology Ecosystems	0.479	1.075	1.279	+0.204
Zero Trust Implementation		22.500	26.310	+3.810
Other NIST CSF Capabilities	15.327	34.413	40.942	+6.529
Detect	0.940	1.128	1.162	+0.034
Identity	5.254	8.676	8.936	+0.260
Protect	7.282	22.501	28.880	+6.379
Recover	0.974	1.003	1.033	+0.031
Respond	0.877	1.105	0.930	-0.174
Total Cyber Request	**23.952**	**76.270**	**90.281**	**+14.011**

Drug Control Budget

Health Resources and Services Administration

Resource Summary

***Budget Authority (in millions)**

Resource Summary	FY 2022* Enacted	FY 2023* Enacted	FY 2024* President's Budget
Drug Resources by Function			
Prevention	**$116.250**	**$142.000**	**$202.500**
Health Center Program	$54.000	$54.000	$124.000
Rural Communities Opioid Response Program	$62.250	$88.000	$78.500
Treatment	**$711.750**	**$713.000**	**$1,397.500**
Health Center Program	$486.000	$486.000	$1,116.000
National Health Service Corps SUD Workforce Program	$105.000	$105.000	$130.000
Addiction Medicine Fellowship Program	$24.000	$25.000	$25.000
SUD Treatment and Recovery Loan Repayment	$24.000	$40.000	$40.000
Rural Communities Opioid Response Program	$72.750	$57.000	$86.500
Total Drug Resources by Function	**$828.000**	**$855.000**	**$1,600.000**
Drug Resources by Decision Unit			
Health Center Program	$540.000	$540.000	$1,240.000
National Health Service Corps SUD Workforce Program	$105.000	$105.000	$130.000
Addiction Medicine Fellowship Program	$24.000	$25.000	$25.000
SUD Treatment and Recovery Loan Repayment	$24.000	$40.000	$40.000
Rural Communities Opioid Response Program	$135.000	$145.000	$165.000
Total Drug Resources by Decision Unit	**$828.000**	**$855.000**	**$1,600.000**
Drug Resources Personnel Summary			
Total FTEs (direct only)	--	--	--
Drug Resources as a percent of Budget			
Total Agency Budget (in Billions)	$13.3	$14.3	$15.9
Drug Resources percentage	6.2%	6.0%	10.1%

METHODOLOGY

Health Center Program

For each of Fiscal Years (FYs) 2016-2019, HRSA provided new annual ongoing grant funding supporting substance use disorder (SUD)/mental health (MH) service expansion in health centers totaling $545 million projected to remain in Health Center Program base continuation funding in future 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. The remaining $540 million in ongoing supplemental SUD/MH funding initiated in prior fiscal years and incorporated in annual health center continuation awards is scored as drug control funding. The FY 2024 President's Budget includes an additional $700 million in ongoing supplemental SUD/MH funding for health centers.

National Health Service Corps (NHSC) SUD Workforce Loan Repayment Program

Funds are used to provide loan repayment assistance to reduce the educational financial debt of qualified SUD providers in exchange for service at SUD treatment facilities in underserved areas. Funds reflect the portion of NHSC discretionary budget requests dedicated to the SUD Workforce Loan Repayment Program. As these funds support providers of SUD treatment services, 100 percent of the amount is scored as treatment funding.

Addiction Medicine Fellowship (AMF) Program

Funds are used to support the clinical training of addiction medicine or addiction psychiatry physicians in underserved, community-based settings. Funds reflect the portion of Behavioral Health Workforce budget line requests dedicated to the AMF program. As these funds support providers of SUD treatment services 100 percent of the amount is scored as treatment funding.

Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program (LRP)

Funds are used to provide loan repayment assistance to reduce the educational financial debt of qualified SUD providers in exchange for service at SUD treatment facilities in underserved areas. Funds reflect the portion of Behavioral Health Workforce budget line requests dedicated to the STAR Loan Repayment Program. As these funds support providers of SUD treatment services 100 percent of the amount is scored as treatment funding.

Rural Communities Opioid Response Program (RCORP)

The allocation of funds for RCORP is through competitive grants and cooperative agreements. The entirety of these programs is scored as drug control funding.

The prevention-treatment splits for FY 2022 and FY 2023 reflect the enacted budget levels. The FY 2024 prevention-treatment split reflects the President's Budget, which is $20 million above the FY 2023 enacted level.

BUDGET SUMMARY

The drug control Budget for the Health Resources and Services Administration is $1.6 billion at the President's Budget request. HRSA is requesting an additional $745 million of drug control funding above the FY 2023 enacted level.

Health Center Program

FY 2024 President's Budget request: $1.24 billion ($700 million over the FY 2023 enacted level)

In FY 2024, the Health Center Program plans to support over 1,400 grantees and provide primary health care services to 33.5 million patients at the President's Budget Level. HRSA will require the provision of mental health and substance use disorder services in all HRSA-funded health centers.

The FY 2020 through FY 2023 Health Center Program enacted levels include $540 million in ongoing SUD/MH targeted funding in health center continuation awards. The reported amount of estimated drug resources for FY 2022 and FY 2023, and those projected for FY 2024, reflect the ongoing annual SUD/MH awards initiated in prior fiscal years. The total drug resource budget projections for FY 2024 include the ongoing annual SUD/MH amount of $540 million plus the additional $700 million included in the FY 2024 President's Budget.

National Health Service Corps SUD Workforce Loan Repayment Program

FY 2024 President's Budget request: $130 million ($25 million over the FY 2023 enacted level)

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 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.

In FY 2024, HRSA will grant approximately 1,500 new awards to clinicians who are combating the opioid crisis in rural and underserved communities.

Addiction Medicine Fellowship Program

FY 2024 President's Budget request: $25 million (level with the FY 2023 enacted level)

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. The AMF Program is designed to foster robust community-based clinical training of addiction medicine or addiction psychiatry physicians in underserved, community-based settings who see patients at various access points of care and provide addiction prevention, treatment, and recovery services across healthcare sectors. In FY 2024, funding will support continuation awards to AMF grantees.

Substance Use Disorder Treatment and Recovery Loan Repayment Program

FY 2024 President's Budget request: $40 million (level with the FY 2023 enacted level)

The STAR LRP 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. The STAR LRP complements the NHSC SUD Workforce LRP as it is able to award loan repayment to more provider types and at a broader range of site types that those that are eligible for the NHSC SUD Workforce LRP. In FY 2024, HRSA will grant approximately 160 new awards to eligible providers.

Rural Communities Opioid Response Program

FY 2024 President's Budget request: $165 million ($20 million over the FY 2023 enacted level)

The RCORP initiative aims to reduce the morbidity and mortality associated with SUD, including opioid use disorder (OUD), in high need rural communities by establishing, expanding, and sustaining prevention, treatment, and recovery services at the county, state, and/or regional levels. Since RCORP's inception in FY 2018, the program has invested over $500 million in grants and technical assistance to rural communities serving more than 1,800 counties across 47 states and two territories. The most recent full-year of performance measurement data collection shows that a cohort of FY 2021 RCORP grantees provided direct SUD/OUD prevention, treatment, and recovery services to over 2 million rural residents, and ensured that 112,456 rural residents received medication assisted treatment (MAT) services.

In FY 2024, HRSA will support the following continuing grant and cooperative agreement programs through RCORP:

- **RCORP-Behavioral Health Care Support** provides support to rural communities to respond to new and ongoing behavioral health needs of rural residents at risk for, or diagnosed with, SUD/OUD and/or co-occurring disorders. The program focuses on

building the infrastructural capacity of rural communities to deliver behavioral health, including SUD/OUD, services across the continuum; enhancing care coordination to provide effective care; and addressing social determinants of health to promote health equity. In FY 2024, HRSA will support the continuation of grants awarded in FY 2022.

- **RCORP-Medication Assisted Treatment Access** provides support to establish new MAT access points and increase the capacity for sustainable MAT service provision in rural areas that do not currently have access to MAT for SUD/OUD. In FY 2024, HRSA will support the continuation of grants awarded in FY 2022 and 2023.

- **RCORP-Rural Centers of Excellence on Substance Use Disorders** support the dissemination of best practices related to the treatment for and prevention of substance use disorders within rural communities, with a focus on the current opioid crisis. In FY 2024, HRSA will support the continuation of these cooperative agreements.

- **RCORP-Technical Assistance and Evaluation** provide technical assistance and evaluation support encompassing the entire RCORP initiative. HRSA will support the continuation of funding for each of the initiative-wide technical assistance and evaluation cooperative agreements in FY 2024.

- **Rural Behavioral Health Workforce Centers** develop and implement training and mentorship programs that build the capacity of rural health care providers, paraprofessionals, non-clinical staff, and community members to care for individuals with behavioral health, including SUD/OUD, needs in rural locations within the Northern Border Regional Commission. HRSA will continue funding these cooperative agreements in FY 2024.

Additionally, the FY 2024 Budget request will support new grants and cooperative agreements for RCORP to strengthen the infrastructure and capacity within rural communities at high risk for SUDs, rural communities to rapidly address their immediate SUD needs (including lifesaving naloxone), address health equity, and provide needed prevention, treatment, and recovery services to rural residents. The FY 2024 budget request will also support the continuation of grants awarded in FY 2023 which provide targeted support to address neonatal abstinence syndrome as well as children and adolescents living in rural communities. HRSA will 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 ensure HRSA's efforts are aligned with the HHS Overdose Prevention Strategy and other Administration priorities.

EQUITY

Health Center Program

The health center model of care uniquely positions health centers to address health disparities and advance health equity. As community-based and patient-directed organizations, health

centers ensure access to affordable, quality, and cost-effective primary health care to the nation's underserved and most socially vulnerable populations. Nearly 1,400 HRSA-funded health centers operate nearly 15,000, providing comprehensive primary and preventive care on a sliding fee scale to over 30 million patients annually. Approximately 90% of health center patients are individuals or families living at or below 200% of the Federal Poverty Guidelines and approximately 63% of health center patients are racial/ethnic minorities. Health centers also serve over 1 million agricultural workers, about 1.3 million individuals experiencing homelessness, and approximately 5.7 million individuals living in or near public housing. In addition to ensuring access to primary and preventive care, health centers' model of care includes the provision of non-clinical enabling services, including translation, transportation, outreach and education, care coordination, and eligibility assistance, that recognize and help to address the social and environmental barriers to health and to health care experienced by their patients.

National Health Service Corps SUD Workforce Loan Repayment Program

The NHSC SUD LRP has worked to increase access to evidence-based SUD treatment to communities in need. Providers recognized through this program are dedicated to caring for underserved communities in urban, rural, and tribal areas. Each NHSC clinician serves patients in Health Professional Shortage Area (HPSA) – communities with limited access to health care. In addition, the NHSC SUD Workforce LRP clinicians work at NHSC-approved SUD treatment facilities that have implemented a Sliding Fee Discount Program that enables the site to offer services to patients regardless of their ability to pay.

Addiction Medicine Fellowship Program

The AMF Program aims to improve equity by improving the health of the underserved and connecting skilled professional to communities in need. Awardees are to collaborate and establish relationships with underserved, community-based settings. Within these settings, the addiction medicine/addiction psychiatry fellows are to practice knowledge and skills acquired in the treatment of the populations served by the facility during a clinical rotation. They may also complete a clinical rotation at a community-based setting that specializes in the treatment of infants, children, adolescents, or pregnant or postpartum women where they are also practicing the knowledge and skills acquired.

Substance Use Disorder Treatment and Recovery Loan Repayment Program

The STAR LRP aims to improve equity by reducing the barriers to access to SUD, including opioid treatment and recovery services. The workforce supported through this program work in both mental Health Professional Shortage Areas and areas where the drug overdose mortality rates are above the national average. The STAR LRP also recognizes SUD support services provided by behavioral health paraprofessionals as an eligible provider types and new community-based settings (e.g. faith-based settings, crisis management centers, etc.) as eligible access points for treatment or recovery services.

Rural Communities Opioid Response Program

RCORP addresses the disproportionate challenges rural communities face in accessing behavioral health care services, which include limited workforce, transportation barriers, and stigma, through community-based grants and technical assistance. RCORP funding also targets behavioral health care disparities within rural communities. For example, applicants to RCORP programs are encouraged to include populations that have historically suffered from poorer health outcomes, health disparities, and other inequities as compared to the rest of the population. Examples of these populations include, but are not limited to: racial and ethnic minorities, people who are pregnant, adolescents and youth, LGBTQ+ individuals, veterans, socioeconomically disadvantaged populations, the elderly, individuals with disabilities, etc. Since FY 2021, RCORP recipients have been required to produce a Disparities Impact Statement during the course of their grant to enable them to monitor and assess the impact their programs have on vulnerable populations within their service areas. In accordance with Executive Order 13985, RCORP programs will continue to emphasize consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment.

Significant Items
TAB

SIGNIFICANT ITEMS FOR INCLUSION IN L-HHS APPROPRIATIONS COMMITTEE FY 2024 CONGRESSIONAL JUSTIFICATION

HOUSE REPORT 117-403 (June 5, 2022)

1) **Health Center Controlled Networks (HCCNs).—**These networks are the foundation of health information technology (HIT) services for the nation's community health centers. Health centers function as the largest primary care network in the country, caring for 30 million patients. HCCNs are voluntary associations of community health centers that band together to invest in HIT tools, optimize the use of these technologies, digitally connect to health care and community partners, and more. The HIT infrastructure requires robust Federal investment to support the demand caused by the COVID–19 pandemic's resulting shift in how health care is provided. The Committee encourages HRSA to provide robust support for these networks and requests as part of the fiscal year 2024 Congressional Budget Justification an update on the status of the network HIT infrastructure. **(Page 44)**

Action to be Taken

HRSA will continue to support HCCNs in FY 2023. Below is the requested update.

Health IT has become essential in supporting the delivery of high-quality, culturally competent, equitable, and comprehensive primary health care, which has increased the need for health centers to expand their use of digital health tools. Health Center Controlled Networks (HCCNs) are groups of health centers that are funded by HRSA to support health IT adoption and implementation for BPHC's Health Center Program (HCP). The HCP functions as one of the largest primary care networks in the country, with approximately 1,400 health centers and over 14,000 service delivery sites that provide care for 30 million patients annually.

HCCNs have provided health IT and data integration support to health centers for more than 20 years, with approximately 90 percent of current health centers formally partnering with an HCCN. HCCNs support health centers with health IT and data needs with a specific focus on improvements in clinical quality, patient-centered care, and provider and staff well-being. HCCNs support health centers that participate in their networks individually and collectively to address clinical and operational needs that include strengthening care coordination, reducing administrative burden through improved patient workflows, utilizing digital health tools, and facilitating data exchange with local, state/territory, and national public health bodies. HCCNs provide specialized training and technical assistance to leverage economies of scale, such as group purchasing power, shared resources and training, and data analytics to support quality measurement and improvement.

In addition, health IT and data systems support health centers in addressing health disparities by enabling providers to develop data-informed and coordinated interventions. Annual HCP funding allows HCCNs to build upon the demonstrated success of previous HCCN awards. Health centers will continue to benefit from their participation in the networks, working together to strengthen and leverage health IT to improve health centers' operational and

clinical practices that result in better health outcomes for the communities the health centers serve.

2) **Sickle Cell Anemia Demonstration Program.—**The Committee includes $8,205,000 for this program, an increase of $1,000,000 above the fiscal year 2022 enacted level and the fiscal year 2023 budget request. The Committee recognizes the importance of the program in supporting the comprehensive sickle cell disease (SCD) centers in the provision of coordinated comprehensive, culturally competent, and family-centered care to people with SCD. The Committee affirms the goals of the program to improve care delivery and access to high quality care for people with SCD, with a focus on increasing access to SCD specialists; increase the number of providers with SCD expertise and knowledge of SCD treatment methods; and enable access to the latest treatment options following evidence-based guidelines. With the start of new five-year grant awards in fiscal year 2022, the Committee requests an update in the fiscal year 2024 Congressional Justification on how the program is supporting the growth of comprehensive sickle cell disease centers that provide the latest treatment options following evidence-based guidelines and have mechanisms to identify and serve patients with SCD who are not currently being cared for by SCD specialists. **(Page 58)**

Actions to be Taken

In FY 2021, HRSA initiated a 5-year award cycle to fund five regional treatment demonstration programs (TDPs), through the Sickle Cell Disease Treatment Demonstration Program. The TDPs improve outcomes of individuals with sickle cell disease (SCD) and their families by supporting and strengthening a regional SCD infrastructure that extends access to comprehensive services to individuals with SCD and their families throughout the region. While the TDP does not directly support one comprehensive SCD Center within each region, the TDPs partner with clinics or practices in at least seven states within each region to:

- Develop and support comprehensive SCD care teams;
- Implement telehealth technologies for health care delivery, education, and health information services;
- Increase access to evidence-based care and the latest treatment options; and
- Collaborate and support care coordination within each region.

TDPs work with local community-based organizations (CBOs), including 25 CBOs funded starting in FY 2021 through the Sickle Cell Disease Newborn Screening Follow-up Program, and two community health centers funded through the Hemoglobinopathies National Coordinating Center. Together, these partnerships facilitate adoption and implementation of the latest evidence-based treatments, increase the number of patients with SCD receiving care by SCD specialists, and strengthen the network of services and supports. In FY 2021, the program's network providers served over 30,000 patients with SCD and 38% of individuals with SCD received disease modifying therapies within an TDP.

3) **Healthy Start.—**The Committee recommends $145,000,000 for the Healthy Start program, $13,160,000 above the fiscal year 2022 enacted level and the fiscal year 2023 budget request.

The program provides grants to communities with high rates of infant mortality to support primary and preventive health care services for mothers and their infants. The primary purpose of Healthy Start is to reduce maternal and infant mortality and to generally improve maternal and infant health. Grants are awarded to nonprofits, State and local health departments and community health centers in eligible communities with high rates of infant mortality and other adverse birth outcomes, to develop a package of innovative health and social services for pregnant women and infants, and evaluate those services. Funding is provided to both increase funding to existing grantees so they can increase the number of individuals served and to support new, additional awards to community-based organizations for targeted initiatives to reduce disparities in maternal and infant health outcomes. The Committee requests an update in the fiscal year 2024 Congressional Justification on existing evaluations of Healthy Start's effectiveness. **(Page 59)**

Actions to be Taken

Healthy Start is committed to data-driven and evidence-based decision-making. In FY 2021, HRSA invested in a four-year contract to conduct a national evaluation of the Healthy Start program to determine the effectiveness of the program. Using a mixed methods approach, the evaluation will assess program implementation, service utilization, health outcomes, and transformational changes in Healthy Start communities. The evaluation concludes in FY 2025, and results will be used to inform decision-making and develop recommendations to improve implementation of the Healthy Start program.

These efforts continue to build from evaluation work that began in 2017 when Healthy Start initiated a national evaluation that showed positive outcomes related to program goals.[223] These include earlier and more frequent prenatal care visits, greater engagement in infant safe sleep practices, and lower rates of low-birth-weight deliveries. Healthy Start participants also met or exceeded targets with respect to usual source of care and depression screening.

4) **HRSA Chief Dental Officer.**—The Committee is disturbed to learn that despite its directive to have HRSA ensure that the Chief Dental Officer (CDO) is functioning at an executive level with resources and staff to lead oral health programs and initiatives across HRSA, no such authority has been delegated. The Committee urges HRSA to hire a CDO and restore the position with executive level authority and resources to oversee and lead dental programs and initiatives across the agency. The CDO is also expected to serve as the agency representative on oral health issues to international, national, State, and/or local government agencies, universities, and oral health stakeholder organizations. The Committee requests an update as part of the fiscal year 2024 Congressional Justification 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 67)**

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

Actions to be Taken

In an August 2021 reorganization, HRSA moved the CDO position into a new office under the Office of the Administrator, the Office of Special Health Initiatives (OSHI). OSHI provides a crosscutting focal point for HRSA to deliver on population health and Secretarial priorities, especially those that may be more clinical in nature. In May of 2022, OSHI successfully recruited and onboarded a new CDO. As part of the new office formed by HRSA, the CDO position at HRSA is responsible for leading the following executive functions: coordinating oral health activities across HRSA programs and leading HRSA on oral health priorities throughout the various programs in the agency. OSHI reports directly to the Immediate Office of the Administrator, which provides the CDO regular opportunities to engage with the Administrator and as directed, lead initiatives and efforts for all of HRSA. In addition to the resources and staff support that OSHI now brings to the CDO position, the CDO also has access to resources and staff across the agency due to the agency wide leadership and role the CDO plays. Since joining HRSA, he has been integrated into the process to review and advise on proposed oral health-related investments across the agency; represented the agency at stakeholder engagements and meetings; provided presentations on the agency's oral health portfolio and key topics of interest and led efforts on the Oral Health Literacy, Awareness and Education Campaign (OHLAE).

The Chief Dental Officer has played a critical role in leading the design, planning and development, monitoring and oversight of an oral health awareness and education campaign for health center patients, people with HIV/AIDS, parents and caregivers of young children, and rural populations. The campaign incorporates messaging around early detection, disease prevention, and oral health promotion and HRSA is expecting to launch it in Spring 2023. Amplification efforts on campaign messaging are in development to ensure maximum reach to underserved areas, including a key role for the Chief Dental Officer in meeting with stakeholders and HRSA's grantees. Under the leadership of the Chief Dental Officer, the campaign also provides a foundation for HRSA to begin development of an agency-wide oral health strategy and broaden content focuses for underserved populations. Areas such as the oral-systemic connection, impact of prevention services, oral health during pregnancy, and innovative care delivery models such as teledentistry, medical dental integration, mobile dental services, and community-based programs will be targeted in order to increase access to care. HRSA intends for this campaign to be a valuable piece of a larger vision for oral health efforts for the agency.

Legislative Proposals
TAB

Legislative Proposals

1. Modify the National Organ Transplant Act to Improve HHS Oversight of the Organ Procurement and Transplantation Network

HRSA is seeking to modernize the statutory tools governing the Organ Procurement and Transplantation Network (OPTN) to improve oversight and accountability and better allow the network to evolve as medical science, information technology, and patient needs change. HRSA proposes changes aimed at increasing competition for OPTN contracts and updating OPTN's data collection requirements to improve transparency about and monitoring of equity, access, and long-term outcomes. Specifically, HRSA is seeking a statutory change to strengthen OPTN functions and improve outcomes for patients and families by enhancing oversight and transparency, increasing competition around OPTN procurements, and improving efficiency in the organ transplantation system.

2. 340B Drug Pricing Program Integrity: Establishment of Reporting Requirements and Definitions for the Use of Savings and Contract Pharmacy Utilization

The FY 2024 Budget Request proposes to enhance 340B Program integrity by requiring covered entities to annually report to HRSA how the savings achieved through the Program benefits the communities they serve and provide HRSA regulatory authority to implement this requirement. HRSA also proposes explicit regulatory authority to define necessary terms. HRSA is also proposing to strengthen compliance and transparency related to the utilization of contract pharmacies.

3. Extending Tax-Exempt Status to Specific Scholarship and Loan Repayment Programs

HRSA proposes extending the tax-exempt status that is provided to the National Health Service Corps Program recipients to HRSA's similar health care workforce programs, including the Nurse Corps Scholarship and Loan Repayment Programs, Native Hawaiian Health Scholarship Program, the Faculty Loan Repayment Program, the Child and Adolescent Mental Health Pediatric Subspecialty Loan Repayment Program, and the Substance Use Disorder Treatment and Recovery Loan Repayment Program. The savings would allow HRSA to make additional awards through these programs to grow and expand the health workforce, including behavioral health providers.

Requiring Health Centers to Provide Behavioral Health Services

HRSA is seeking to add behavioral health services to the statutory list of required primary health services that health centers must provide. Requiring health centers to provide these services will improve access to behavioral health services in the nation's most medically underserved communities, reducing disparities and improving health outcomes. With approximately 40 percent of health centers located in rural areas, this proposal will have a meaningful impact in rural communities.

4. Reauthorization of Mandatory Appropriations for the Community Health Center Fund

HRSA is seeking a 3-year extension of mandatory funding for the Health Center Program, which will currently expire at the end of FY 2023. The Health Center Program provides equitable access to health care services for millions of medically underserved individuals across the country. With continued and increased funding of the Community Health Center Fund, the Health Center Program will further strengthen and expand this vital source of primary care for millions of patients seeking a quality source of care.

5. Reauthorization of Mandatory Appropriations for the National Health Service Corps (NHSC) Fund

HRSA is requesting a 3-year extension of mandatory funding for the NHSC, which currently expires at the end of FY 2023. Since its inception in 1972, the NHSC has worked to support qualified health care providers dedicated to working in underserved communities. NHSC clinicians serve patients in Health Professional Shortage Areas (communities with limited access to health care) in return for scholarships and loan repayment. The proposed funding levels will maintain current investments and ensure that the NHSC recruitment and retention programs continue to be a significant source of highly qualified clinicians working in areas of greatest need across the country.

6. Reauthorization of Mandatory Appropriations for the Teaching Health Center Graduate Medical Education (THCGME) Program

HRSA is requesting a 3-year extension of mandatory funding for the THCGME Program, which currently expires at the end of FY 2023. The program focuses on supporting residents in primary care, including obstetrics and gynecology and psychiatry, and dental residency training programs to meet the medical and mental health care needs of rural and underserved communities. Increased funding for the THCGME Program will maintain current residents' investments and allow them to complete residency training and graduate from their respective programs. In addition, HRSA is proposing removal of the statutory annual cap on payments made through the THCGME program. Removing this limitation would enable HRSA to utilize all funds appropriated for the THCGME program (including those recouped after reconciliation).

Vaccine Injury Compensation Program

TAB

VACCINE INJURY COMPENSATION PROGRAM

Table of Contents

FY 2024 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 [$15,200,000] *$26,200,000* shall be available from the Trust Fund to the Secretary.

Amounts Available for Obligation

Obligation	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Discretionary Appropriation:	$42,050,000	$56,913,000	$68,933,000
Transfer to Other Accounts	-$13,200,000		
Transfer from Other Accounts	$13,200,000		
Subtotal, adjusted Discretionary Appropriation	**$42,050,000**	**$56,913,000**	**$68,933,000**
Mandatory Appropriation	$230,238,000	$256,370,000	$261,497,000
Transfer to Other Accounts	-$230,238,000		
Transfer from Other Accounts	$230,238,000		
Subtotal, adjusted Mandatory Appropriation	**$230,238,000**	**$256,370,000**	**$261,497,000**
Spending Auth Offsets	--		
Administrative Expenses	$42,050,000	$56,913,000	$68,933,000
Total HRSA Claims	$230,238,000	$256,370,000	$261,497,000
Total New Obligations	**$272,288,000**	**$313,283,000**	**$330,430,000**

Budget Authority by Activity

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Trust Fund Obligations: Post-10/1/88 claims	$230,238,000	$256,370,000	$261,497,000
Administrative Expenses: HRSA Direct Operations	$13,200,000	$15,200,000	$26,200,000
Total Obligations	$243,438,000	$271,570,000	$287,697,000

Budget Authority by Object

Object	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Insurance claims and indemnities	$256,370,000	$261,497,000	+$5,127,000
Salaries & Expenses/Other Services	$15,200,000	$26,200,000	+$11,000,000
Total	$271,570,000	$287,697,000	+$16,127,000

Authorizing Legislation

Legislation	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:			
Pre-FY 1989 Claims	---	---	---
Post-FY 1989 Claims	$230,238,000	$256,370,000	$261,497,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):			
HRSA Operations	$13,200,000	$15,200,000	$26,200,000

Appropriation History Table

(Pre-1988 Claims Appropriation)

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1996	110,000,000	110,000,000	110,000,000	110,000,000
1997	110,000,000	110,000,000	110,000,000	110,000,000
1998	---	---	---	---
1999	---	---	100,000,000	100,000,000
2000	---	---	---	---
2001	---	---	---	---
2002	---	---	---	---
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2015	---	---	---	---
2016	---	---	---	---
2017	---	---	---	---
2018	---	---	---	---
2019	---	---	---	---
2020	---	---	---	---
2021	---	---	---	---
2022	---	---	---	---
2023	---	---	---	---
2024	---	---	---	---

Vaccine Injury Compensation Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
Claims BA	$230,238,000	$256,370,000	$261,497,000	+$5,127,000
Admin BA	$13,200,000	$15,200,000	$26,500,000	+$11,000,000
Total	$243,438,000	$271,570,000	$287,697,000	+$16,127,000
FTE	23	23	32	+9

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 2024 Authorization……...…....Indefinite

Allocation Method……..Other

Program Description

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 pediatric and adult medicine review these claims, including supporting documentation. HRSA also contracts with health care professionals for claim reviews and other medical specialists to provide independent claim reviews and 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 has nine voting members, including health care professionals, attorneys, 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 compensation for 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 $4 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, the influenza vaccine is taxed $0.75 because it prevents one disease, while the 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.

VICP Administration

VICP claims have increased more than fivefold from 402 claims filed in FY 2012 to 2,057 claims filed in FY 2021, while the administrative funding has barely doubled from $6.5 million to $11.2 million during the same period, as shown in Table 1. In FY 2022, petitioners filed 1,029 claims and $13.2M was appropriated for administrative funding.

In FY 2017, HRSA began experiencing a backlog of vaccine injury claims awaiting medical review since the volume of claims exceeded the resources available to conduct medical reviews. The cumulative claims backlog was 966 claims at the end of FY 2020. Even though the number of claims filed decreased in FY 2022 to 1,029 and the funding to administer the VICP increased by $2 million from $11.2 million in FY 2021 to $13.2 million in FY 2022, the backlog was 1,580 by the end of FY 2022, which is slightly higher than the1,568 backlog at the end of FY 2021. The backlog results in compensation delays since claims are on the waiting list for about 12 months pending review.

Table 1. 10-Year Trend in Number of Claims Filed and Administrative Costs
(*dollars in millions)*

Fiscal Year	Number of Claims Filed	Administrative Funding
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	1,192	$10.20
2021	2,057[1]	$11.20
2022	1,029	$13.20

1/Significant influx of 800 claims in January 2021 due to the expected implementation of the final rule proposed to remove Shoulder Injury Related to Vaccine Administration (SIRVA) from the Vaccine Injury Table.

Budget Request

VICP Claims Compensation

The FY 2024 Budget Request for the VICP Claims Compensation Program of $261.5 million is $5.1 million more than the FY 2023 Enacted level. This request will help provide funds to compensate petitioners and pay their attorneys' fees and costs.

VICP Administration

The FY 2024 Budget Request for the VICP Administration Program of $26.2 million is $11 million more than the FY 2023 Enacted level. This request will support administrative expenses to process approximately 2,310 claims. This request will also support administrative expenses for medical review staff, contractors to conduct medical reviews to reduce the backlog of claims, and medical experts for reviews and expert testimony to the Court. The funding request also covers costs associated with the claims award process, follow-up performance reviews, and information technology and other program support costs.

Funding History

Funding History – VICP Claims

Fiscal Year	Amount
FY 2020	$218,203,026
FY 2021	$246,414,977
FY 2022	$316,778,000
FY 2023	$256,370,000
FY 2024 President's Budget	$261,498,000

Funding History - VICP Administration

Fiscal Year	Amount
FY 2020	$10,200,000
FY 2021	$11,200,000
FY 2022	$13,200,000
FY 2023	$15,200,000
FY 2024 President's Budget	$26,200,000

Program Accomplishments

Table 2 shows the number of petitioners awarded compensation and vaccine injury compensation provided over the last five years.

Table 2. Growth in Families and Individuals Receiving Compensation

Fiscal Year	No. of Petitioners	Compensation ($ in millions)
2018	521	$227
2019	653	$226
2020	733	$218
2021	719	$245
2022	927	$230

Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
9000.03 Average time that lump sum only awards are paid from the receipt of all required documentation to make a payment. (Outcome)	FY 2022: 1 day Target: 4 days (Target Exceeded)	3 days	4 days	+1 day
9000.07 Percentage of medical reports that are completed within 90 days of the date the claim is assigned to a medical reviewer (Efficiency)	FY 2022: 93% Target: Not Defined (Baseline)	80%	93%	+13 percentage points

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
9000.08 Percentage of filed claims assigned for medical review within 9 months of the date the claim is activated by the Court (Efficiency)	FY 2022: 74% Target: Not Defined (Baseline)	75%	75%	Maintain
9000.01 Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed. (Outcome)	FY 2022: 0% Target: 0% (Target Met)	0%	Discontinued	N/A
9000.02 Average time settlements are approved from the date of receipt of the DOJ settlement proposal. (Outcome)	FY 2022: 10 days Target: 10 days (Target Met)	5 days	Discontinued	N/A
9000.04 Percentage of cases in which court-ordered annuities are funded within the carrier's established underwriting deadline. (Outcome)	FY 2022: 100% Target: 98% (Target Exceeded)	99%	Discontinued	N/A

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2023 Target	FY 2024 Target	FY 2024 +/- FY 2023
9000.05 Percentage of medical reports that are completed within 90 days of receipt of any medical records. (Outcome and Developmental)	FY 2022: 93% Target: 75% (Target Exceeded)	80%	Discontinued	N/A
9000.06 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 2022: 26% Target: 65% (Target Not Met)	65%	Discontinued	N/A

Performance Narrative

In FY 2024, the VICP will discontinue five performance measures that do not effectively capture the current work of the VICP. The remaining measure (9000.02) and the two new measures (9000.07 and 9000.08) reflect HRSA's two roles in administering the VICP. First, HRSA conducts the medical review of VICP claims. Second, HRSA makes Court-ordered payments to VICP claimants. The measure has been revised and captures the efficiency of conducting medical reviews.

Countermeasures Injury Compensation

TAB

COUNTERMEASURES INJURY COMPENSATION PROGRAM

Table of Contents

FY 2024 Budget

Appropriations Language

COVERED COUNTERMEASURE PROCESS FUND

For carrying out section 319F-4 of the PHS Act, [$7,000,000] *$15,000,000* shall remain available until expended.

Amounts Available for Obligation

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Discretionary Appropriation:			
Direct Appropriation	$5,000,000	$7,000,000	$15,000,000
Unobligated Balance:			
Unobligated Balance, start of year	$3,003,278	$4,713,970	---
Unobligated Balance, Transfer from Other Accounts	$9,291,389	$7,000,000	---
Subtotal, Unobligated Balance	**$12,294,667**	**$11,713,970**	---
Administrative Expenses	$11,176,342	$10,576,604	$9,000,000
Compensation Funding	$1,118,325	$1,137,366	$6,000,000
Total New Obligations	**$12,294,667**	**$11,713,970**	**$15,000,000**

Budget Authority by Activity

	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget
Countermeasures Injury Compensation Program[224]	$5,000,000	$7,000,000	$15,000,000

Authorizing Legislation

Activity	FY 2023 Amount Authorized	FY 2023 Amount Appropriated	FY 2024 Amount Authorized	FY 2024 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	$7,000,000	Not Specified	$15,000,000

[224] Since October 2009, CICP has received funding from the Public Health and Social Services Emergency Fund (PHSSEF).

Countermeasures Injury Compensation Program

Activity	FY 2022 Final	FY 2023 Enacted	FY 2024 President's Budget	FY 2024 +/- FY 2023
BA	$5,000,000	$7,000,000	$15,000,000	+$8,000,000
FTE	16	34	42	+8

Authorizing Legislation: Public Health Service Act, Sections 319F-3 and 319F-4, as amended by Public Law 116-136.

FY 2024 Authorization .....Indefinite

Allocation Method ..... Other

Program Description:

The Countermeasures Injury Compensation Program (CICP) provides benefits to individuals seriously injured as a result of the administration or use of covered countermeasures. 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 covered serious physical injuries 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 PREP Act declarations identify the countermeasures covered by CICP.

Budget Request

The FY 2024 Budget Request for the CICP of $15 million is $8 million more than the FY 2023 Enacted level. This FY 2024 funding will be used to improve the CICP information technology (IT) infrastructure, increase process efficiencies, enhance communication with requesters and substantially increase the CICP's capacity to review and complete at least 2,000 claims reviews, and provide compensation to eligible individuals for injuries and deaths directly resulting from the use of covered countermeasures, including COVID-19 countermeasures. In FY 2022, the $5 million appropriation allowed the CICP to increase staffing and initiate review of over 600 claims compared to 30 claim reviews initiated in FY 2021, and awarded a contract that provided system enhancements, data aggregation, and business process improvements.

Funding History

Fiscal Year	Amount	Supplemental Funding
FY 2020	---	$612,000
FY 2021	---	$4,167,619
FY 2022	$5,000,000	$4,270,381
FY 2023	$7,000,000	$4,400,000
FY 2024 President's Budget	$15,000,000	---

Program Accomplishments

As of January 1, 2023, nearly 11,100 claims alleging injuries/deaths from COVID-19 countermeasures have been filed with the Countermeasures Injury Compensation Program, including 7,780 claims alleging injuries from COVID-19 vaccines. Since FY 2022, the CICP has made determinations for over 500 COVID-19 claims. During the prior ten years, the CICP received and closed approximately 500 claims in total.