# DEPARTMENT of HEALTH and HUMAN SERVICES

## Fiscal Year 2023

Health Resources and Services Administration

***Justification of Estimates for Appropriations Committees***

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville, MD 20857

# MESSAGE FROM THE ADMINISTRATOR

I am pleased to transmit the Congressional Justification of the Health Resources and Services Administration (HRSA) request for the fiscal year (FY) 2023 Budget. Our FY 2023 budget request includes $13.3 billion to support HRSA's vital work to advance health equity; expand access to health care services in the communities that need it most; reduce maternal and infant mortality; and grow, diversify and promote the well-being of the health workforce.

With ongoing appropriations and resources from the American Rescue Plan, HRSA-supported programs have played a critical role in combatting the COVID-19 pandemic in the hardest hit communities across the country over the past year. With HRSA's support, Federally Qualified Health Centers and Rural Health Clinics have built new capacity to respond to COVID-19 and distributed vaccines, boosters, tests, masks and therapeutics to help prevent, mitigate and treat COVID in underserved communities. At the same time, HRSA has awarded grants to more than 150 national and local organizations to support on-the-ground outreach by trusted messengers to help people make informed decisions about vaccination for themselves and their families.

In addition to delivering essential COVID supplies and resources, HRSA has made critical investments to support and expand the health workforce over the past year, including growing our scholarship and loan repayment programs for health care providers who commit to practicing in underserved communities to the largest numbers in the program's history; launching a new initiative to address the well-being and mental health of the health care workforce; announcing a new program to train more than 13,000 community health workers to better connect individuals to care; and investing in growing the mental health and substance use disorder workforce. Over the last year, we also made billions in relief payments to health care providers to help sustain health care access in their communities and retain and support their workforce as they respond to COVID-19, as well as regularly reimbursing providers for COVID-19 testing, treatment, and vaccine administration for people who are uninsured.

As we've worked to mitigate COVID-19, we have continued to make essential health care available for millions of individuals most in need, including through primary care services for approximately 30 million people through HRSA-supported community health centers; HIV/AIDS services to more than a half a million people through the Ryan White HIV/AIDS Program; HRSA-funded infant screenings, preventive care and other child services for an estimated 60 million pregnant people and children; substance use disorder services for more than 1,500 rural counties; discounts of up to 50 percent on the cost of prescription drugs for the patients of more than 13,000 safety-net providers; organ transplants for approximately 39,000 people – the highest annual number on record; and more than a million interventions by Poison Control Centers. Our FY 2023 Budget Request continues and expands on this critical work.

The HRSA FY 2023 Budget request:

- Prioritizes reducing maternal mortality and addressing the disproportionate burden of poor maternal outcomes on Black women by investing in the social determinants of maternal health, increasing screening and treatment for maternal depression, and increasing and diversifying the midwife and doula workforces;

- Makes strategic investments in growing the mental health and substance use disorder workforce to expand access to behavioral health care and advance integration of these services with primary care to improve health outcomes;

- Expands critical child health programs to support health equity, including extending and expanding the evidence-based, voluntary Maternal, Infant, and Early Childhood Home Visiting Program and funding a new effort to provide early childhood screening and development services in health centers;

- Increases and diversifies the health care workforce to meet growing needs while promoting well-being and preventing burnout for those on the frontlines;

- Reaffirms our commitment to ending the HIV/AIDS epidemic by investing in increasing access to treatment, expanding PrEP (pre-exposure prophylaxis) to prevent infection, and ensuring equitable access to services and supports; and,

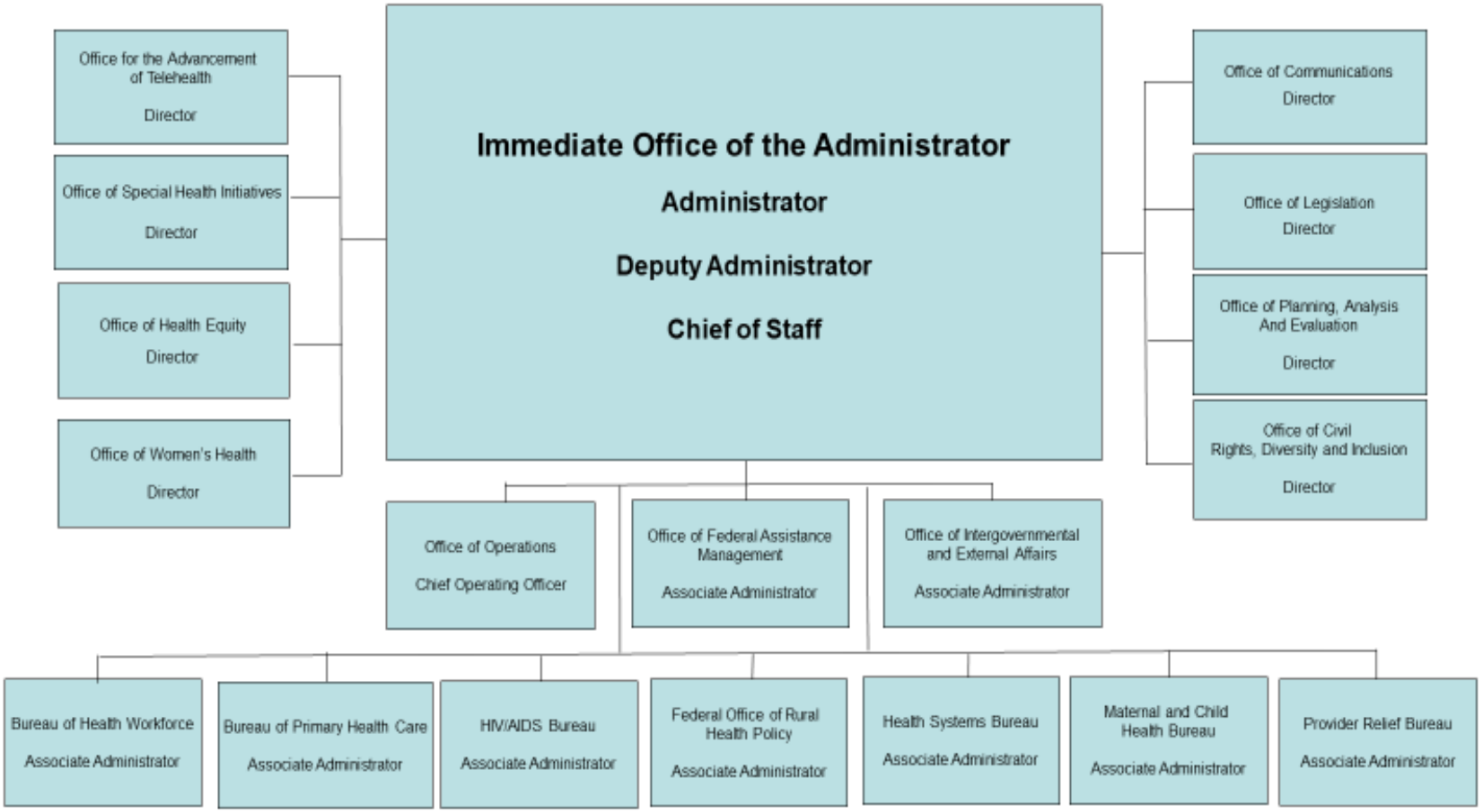
- Strengthens rural health care access by increasing funding for rural health care providers and rural residency programs.

HRSA's FY 2023 Budget request builds on the lessons learned from the pandemic to focus on the critical needs of underserved and rural communities, including the importance of equitable access to high quality primary care and mental and substance use disorder services and the need for a robust and well-supported health workforce. I look forward to working with Congress on its enactment.

Carole Johnson
Administrator

## Organizational Chart

## Health Resources and Services Administration



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# Executive Summary

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# Introduction and Mission

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

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

- Underserved persons who live in rural and poor urban neighborhoods where health care providers and services are scarce;
- Individuals who lack health insurance—many of whom are racial and ethnic minorities;
- African American infants who have 2.3 times the infant mortality rate as non-Hispanic white infants,[1] and African-American mothers who have 3.2 times the pregnancy-related mortality rate as non-Hispanic white mothers[2];
- The 1.2 million people living with HIV infection[3];
- Persons affected by opioid use disorders and other substance use disorders; and
- The 106,444 individuals who are waiting for an organ transplant.[4]

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

[1] Ely DM, Driscoll AK. Infant Mortality in the United States, 2019: Data From the Period Linked Birth/Infant Death File. National Vital Statistics Reports, vol 70 no 14. Hyattsville, MD: National Center for Health Statistics. 2021. https://www.cdc.gov/nchs/data/nvsr/nvsr70/NVSR70-14.pdf. Accessed February 25, 2022.
[2] Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765. DOI: http://dx.doi.org/10.15585/mmwr.mm6835a3. Accessed August 19, 2020.
[3] Centers for Disease Control and Prevention. Basics Statistics, https://www.cdc.gov/hiv/basics/statistics.html. Accessed August 19, 2021.
[4] https://optn.transplant.hrsa.gov/data/. Accessed February 25, 2022.

# Overview of Budget Request

The FY 2023 President's Budget request is $13.3 billion for the Health Resources and Services Administration (HRSA). This level is $1.4 billion, or 11.7 percent, above the annualized FY 2022 Continuing Resolution. The Budget supports HRSA's vital work to advance health equity; expand access to health care services in the communities that need it most; reduce maternal and infant mortality; and grow, diversify and promote the well-being of the health workforce.

*Highlights of the major changes to programs are listed below:*

Health Centers and Free Clinics: +$155.3 million; total program $5.7 billion – The Budget provides resources for Health Centers to serve approximately 30.0 million patients in FY 2023. The Budget includes an increase of $85.0 million to support the expansion of early childhood screening and development services in 425 health centers. The Budget also includes an increase of $70.0 million to increase access to HIV prevention services, including Pre-Exposure Prophylaxis (PrEP), as part of the HHS-wide initiative to End the HIV/AIDS Epidemic (EHE). This increase will support awards for an additional 100 health centers, resulting in the total participation of approximately 400 health centers.

HIV/AIDS: +$231.0 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 more than half a million low-income people with HIV. This includes $290.0 million, an increase of $185.0 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. Approximately 76,000 clients will be served by this initiative through FY 2023. The Budget also provides an additional $46.0 million to Parts A, B, and C to support jurisdictions, states, and populations with the greatest need, including racial and ethnic minority populations adversely affected by HIV/AIDS.

Health Workforce: +$395.9 million; total programs $2.1 billion – The Budget invests in efforts to grow, diversify and promote the well-being of the health workforce.

- *National Health Service Corps (NHSC): +$90.0 million; total program $502.3 million* The Budget supports scholarships and loan repayment to improve access to quality primary care, dental, and behavioral health in underserved urban, rural, and tribal areas. The request includes an increase of $25 million specifically for mental and behavioral health providers, including peer support specialists, in crisis centers and an additional $60.0 million for loan repayment for clinicians to provide opioid and substance use disorder treatment. The request also includes an additional $5.0 million for Maternity Care Target Areas (MCTAs) to implement requirements contained in the Improving Access to Maternity Care Act. The Act requires HRSA to establish criteria, identify MCTAs, and collect and publish data comparing the availability and need for maternity care health services in health professional shortage areas. The additional resources will fund approximately 1,095 more substance use disorder and mental health providers.

- *Behavioral Health Training Programs: +$247.5 million; total program $397.4 million*
  The Budget prioritizes investments in the behavioral health workforce, including expanding the number of behavioral professionals in underserved communities and provide additional resources to integrate mental health into community based settings. The additional resources will train over 3,500 additional behavioral health professionals per year and over 4,000 paraprofessionals as well as support over 100 individuals with loan repayments for substance use disorder related services.

  *Behavioral Health Integration into Community-Based Settings: +$50 million (non add)*
  The Budget provides an additional $50 million to train community partners and integrate navigators and community health workers in non-traditional community settings. $10 million is provided under the Behavioral Health Workforce Education and Training program to partnership with community to expanding workforce capacity and supporting the behavioral health workforce pipeline. The remaining $40 million is provided in the MCH Block Grant for community based awards to promote the healthy social and emotional development and behavioral health needs of mothers, children and families.

- *Primary Care Training and Enhancement: +$5.0 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: +$2.0 million; total program $48.9 million*
  The Budget supports the development, distribution and retention of a diverse, culturally competent nursing workforce. The additional funding will train nurses to provide behavioral health services in primary care practices in rural and underserved settings.

- *Preventing Burnout in the Health Workforce: +$50.0 million; total program $50.0 million*
  The Budget provides additional funding to support the implementation of evidence-informed strategies to help the health care workforce respond to workplace stressors, avoid burnout, and foster healthy workplace environments that promote mental health and resilience.

- *Health Professions Training for Diversity +$21.6 million; total program $132.8 million*
  The Budget provides an increase of $21.6 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.

- *Geriatrics and Public Health and Preventative Medicine Program: +$4.8 million; total program $64.5 million*
  The Budget includes an increase of $4.8 million to award grants to strengthen the health care workforce, increase outreach and improve health outcomes for older adults by maximizing patient and family engagement.

- *Advanced Nursing Education: +$25.0 million; total program $105.6 million*
  The Budget includes an increase of $25.0 million to award approximately 25 grants to grow and diversify the maternal and perinatal health nursing workforce by increasing and diversifying the number of Certified Nurse Midwives (CNMs), with a focus on practitioners working in rural and underserved communities.

- *Medical Student Education: -$50.0 million; total program $0*
  No funding is requested. In FY 2023, the FY 2019 grantees, which have significant balances, will finish their project period. HRSA will continue to support 5 grants from the FY 2020 cohort with funds appropriated in prior fiscal years.

Maternal and Child Health (MCH): +$362.6 million; total program $1.7 billion
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: +$241.0 million; total program $953.7 million*
  The Budget includes an increase of $212.0 million for Special Projects of Regional and National Significance, and an increase of $29.0 million for formula awards to states. Approximately $158.0 million of the SPRANS increase supports targeted maternal health investments in areas with high rates of adverse maternal health outcomes. The requests includes additional funding to address emerging issues and the social determinants of maternal health, and efforts to increase and diversify the doula workforce. The request also includes $40 million in community based grants to integrate mental health into non-traditional community settings. The Block Grant will serve an estimated 93 percent of pregnant women and 63 percent of children nationwide.

- *Healthy Start: +$17.0 million; total program $145.0 million*
  The Budget provides additional funding to support a new targeted expansion of an enhanced Healthy Start program model in 12 new communities with the highest rates of perinatal health disparity in the country. Approximately 9,600 additional women and infants will receive critical direct and enabling services with this additional funding.

- *Autism and Other Developmental Disabilities: +$4.0 million; total program $57.3 million*
  The Budget serves approximately 125,000 children. Funding will allow expansion of the Developmental-Behavioral Pediatrics Training program including increased fellowship opportunities for existing awardees.

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

- *Screening and Treatment for Maternal Depression and Related Behavioral Disorders: +$5.0 million; total program $10.0 million*
  The Budget supports expanded maternal depression services for five additional states, reaching an estimated total of 12 states.

- *The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: +$67.0 million; total program $467.0 million*
  The Budget proposes a five year expansion of mandatory funding, with an increase of $67.0 million per year over the five years for a total of $3.0 billion. Over 5 years, the increase will provide comprehensive, coordinated home visiting services to over 600 additional communities, including up to 165,000 additional families through targeted, voluntary evidence-based home visiting.

<u>Rural Health: +$78.2 million; total programs $373.7 million</u>
The Budget provides funding to improve access, quality, and coordination of care in rural communities.

- *Rural Health Clinic Behavioral Health Initiative; +$10.0 million; total program $10.0 million*
  The Budget support a new pilot program to enable Rural Health Clinics (RHCs) to bring critical behavioral and mental health services to rural communities. The request will fund approximately 18 Rural Health Clinics.

- *Rural Health Outreach: +$7.5 million; total program $90.0 million*
  The Budget includes an increase of $5.0 million to support Rural Maternity and Obstetrics Management Strategies (RMOMS) grants to expand access and improve maternal health in rural communities. The additional $2.5 million supports the continuation of 104 existing grantees, and 94 new competitive grants that improve health care service delivery in rural communities.

- *Rural Communities Opioid Response: +$55.0 million; total program $165.0 million*
  The Budget supports grants to provide substance use/opioid use disorder prevention, treatment, and recovery services to rural residents. In FY 2023, HRSA plans to continue funding the FY 2022 behavioral health pilot program that provides workforce development support, as well as the expansion of the medication assisted treatment services program. The additional funding will also enable HRSA to continue expanding RCORP's focus to include other, emergent behavioral health needs in rural communities.

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

- *Black Lung and Radiation Exposure Screening and Education programs; +$1.6 million; total programs $14.9 million*
  The Budget provides an increase of $1.6 million to ensure coal miners receive proper screenings, primary care and other services.

- *Rural Residency Planning and Development; +$2.2 million; total program $12.7 million*
  The Budget supports approximately 16 new Rural Residency Planning and Development awards, an increase of 2 awards, to expand the number of rural residency training programs with the goal of increasing the number of physicians choosing to practice in rural areas.

340B Drug Pricing Program/Office of Pharmacy Affairs: +$7.0 million; total program $17.2 million
The 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 $7.0 million to expand HRSA's program integrity efforts, including increased audit and oversight efforts, as well as broad regulatory authority to support the 340B Drug Pricing Program.

Telehealth: +$10.5 million; total program $44.5 million
The Budget provides resources to promote the use of telehealth to increase access to health services. The Budget supports the expansion of the Evidence-Based Telehealth Network Program with 12 new awards in support of increasing access to healthcare services and improving health outcomes by using direct-to-consumer technologies.

Program Management: +$13.7 million; total program $169.0 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.

Family Planning: +$113.5 million; total program $400.0 million
The Budget request provides funding for family planning methods and related health services, as well as related training, information, education, counseling, and research to improve family planning awareness and service delivery to 4.3 million clients.

Vaccine Injury Compensation Program: +$15.0 million; total program $26.2 million
The Budget requests additional administrative funding to support the significant rise in the number of claims filed, largely due to claims for injuries from the influenza vaccine. The funding supports the additional costs of medical reviewers dedicated to evaluating the increased claims and reduce the current backlog of claims.

Countermeasure Injury Compensation Program; +$15.0 million, total program $15.0 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. This funding will be used to support the review of medical claims and determining compensation eligibility.

# 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) 2023. In collaboration with states, communities, and organizations, the performance examples below illustrate how HRSA will continue to improve health outcomes and address disparities through access to quality services, a skilled health workforce, and innovative, high-value programs for millions of Americans who are geographically isolated and economically or medically underserved.

**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 2023, 516,000 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 2023, HRSA expects to have nearly 150,000 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.

- The Maternal and Child Health (MCH) Block Grant program anticipates the ratio of the Black infant mortality rate to the White infant mortality rate will decrease to 2 to 1 in FY 2023.

*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 2023, the Health Centers Program expects to sustain health centers' provision of affordable, accessible, quality, and cost efficient care to 30.0 million patients.

- HRSA expects to help states serve 63 percent of children through the MCH Block Grant program in FY 2023, providing funding to address states' highest MCH priorities.

- The MCH Block Grant program expects to contribute to the reduction of the national infant mortality rate to 5.3 per 1,000 in FY 2023 by funding state MCH activities to improve the health of mothers, children, and families, particularly among low-income mothers and families or those with limited availability of care.

- In FY 2023, HRSA expects to serve 76,000 new clients under the *Ending the HIV Epidemic* initiative.

- By ensuring the provision of HIV medications and related services to more than 285,000 persons in FY 2023 through the AIDS Drug Assistance Program, HRSA will continue its contribution to reducing AIDS-related mortality for low-income and uninsured people living with HIV/AIDS.

- In FY 2023, 84% of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test are expected to be virally suppressed.

- To increase the number of patients from racially and ethnically diverse backgrounds able to find a suitably matched unrelated adult donor for their blood stem cell transplants, the Blood Stem Cell Transplantation Program projects that it will have nearly 4.02 million adults on the donor registry in FY 2023 from underrepresented racial or ethnic populations.

- The Organ Transplantation program projects that it will facilitate the transplantation of more than 33,300 deceased donor organs in FY 2023.

- The Maternal, Infant, and Early Childhood Home Visiting Program projects that it will serve 163,000 participants in FY 2023.

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

- In FY 2023, 11,000 healthcare providers will be deemed eligible for Federal Tort Claims Act malpractice coverage through the Free Clinics Medical Malpractice program. The program encourages providers to volunteer their time at sponsoring free clinics, thereby expanding the capacity of the healthcare safety net.

*HRSA Goal: Foster a health workforce and health infrastructure able to address current and emerging needs.*

HRSA 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 plans to increase the percentage of completers of its supported health profession training programs who are underrepresented minorities and/or from disadvantaged background to 47 percent in FY 2023.

- 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 performance-related information routinely is used 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 Administrator, including during regularly scheduled one-on-one meetings, mid-year and year-end Senior Staff performance reviews, and ad hoc meetings to address emerging issues. Reviews focus on progress, challenges, and possible course corrections, with particular emphasis on root-causes of performance results.

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

# All Purpose Table
(dollars in thousands)

| | FY 2021 | | FY 2022 | FY 2023 | |
|---|---|---|---|---|---|
| | **Final /1** | **COVID-19 Supplemental /2** | **Continuing Resolution/3** | **President's Budget** | **President's Budget +/- FY 2022 CR** |
| **PRIMARY CARE:** | | | | | |
| **Health Centers:** | | | | | |
| Health Centers | 1,554,203 | - | 1,562,772 | 1,718,022 | +155,250 |
| Health Centers Mandatory | 4,000,000 | 7,600,000 | 3,905,348 | 3,905,348 | - |
| Health Centers Mandatory Proposed | - | - | - | - | - |
| Health Center Tort Claims | 120,000 | - | 120,000 | 120,000 | - |
| ***Subtotal, Health Centers*** | ***5,674,203*** | ***7,600,000*** | ***5,588,120*** | ***5,743,370*** | ***+155,250*** |
| Free Clinics Medical Malpractice | 1,000 | - | 1,000 | 1,000 | - |
| **Subtotal, Bureau of Primary Health Care (BPHC)** | **5,675,203** | **7,600,000** | **5,589,120** | **5,744,370** | **+155,250** |
| *Subtotal, Mandatory BPHC (non-add)* | *4,000,000* | *7,600,000* | *3,905,348* | *3,905,348* | - |
| *Subtotal, Discretionary BPHC (non-add)* | *1,675,203* | - | *1,683,772* | *1,839,022* | *+155,250* |
| **HEALTH WORKFORCE:** | | | | | |
| **National Health Service Corps (NHSC):** | | | | | |
| NHSC | 119,526 | - | 120,000 | 210,000 | +90,000 |
| NHSC Mandatory | 310,000 | 800,000 | 292,330 | 292,330 | - |
| NHSC Mandatory proposed | - | - | - | - | - |
| ***Subtotal, NHSC*** | ***429,526*** | ***800,000*** | ***412,330*** | ***502,330*** | ***+90,000*** |
| Loan Repayment/Faculty Fellowships | 1,186 | - | 1,190 | 2,310 | +1,120 |
| **Health Professions Training for Diversity:** | | | | | |
| Centers of Excellence | 23,510 | - | 23,711 | 36,711 | +13,000 |
| Scholarships for Disadvantaged Students | 51,390 | - | 51,470 | 51,970 | +500 |
| Health Careers Opportunity Program | 14,449 | - | 15,000 | 18,500 | +3,500 |
| ***Subtotal, Health Professions Training for Diversity*** | ***89,349*** | ***-*** | ***90,181*** | ***107,181*** | ***+17,000*** |
| Health Care Workforce Assessment | 5,646 | - | 5,663 | 5,663 | - |
| Primary Care Training and Enhancement | 48,777 | - | 48,924 | 53,924 | +5,000 |

| | FY 2021 | | FY 2022 | FY 2023 | |
|---|---|---|---|---|---|
| | Final /1 | COVID-19 Supplemental /2 | Continuing Resolution/3 | President's Budget | President's Budget +/- FY 2022 CR |
| Oral Health Training Programs | 40,673 | - | 40,673 | 40,673 | - |
| Medical Student Education | 49,850 | - | 50,000 | - | -50,000 |
| **Interdisciplinary, Community-Based Linkages:** | | | | | - |
| Area Health Education Centers | 43,250 | - | 43,250 | 43,250 | - |
| Geriatric Programs | 42,859 | - | 42,737 | 46,537 | +3,800 |
| Behavioral Health Workforce Development Programs | 149,207 | - | 149,916 | 397,374 | +247,458 |
| Behavioral Health Workforce Development Programs Mandatory | - | 100,000 | - | - | - |
| Mental and Behavioral Health Training Mandatory | - | 80,000 | - | - | - |
| Promote Mental and Behavioral Health Mandatory | - | 40,000 | - | - | - |
| ***Subtotal, Interdisciplinary, Community-Based Linkages*** | ***235,316*** | ***220,000*** | ***235,903*** | ***487,161*** | ***+251,258*** |
| **Public Health Workforce Development:** | | | | | |
| Public Health/Preventive Medicine | 17,000 | - | 17,000 | 18,000 | +1,000 |
| **Nursing Workforce Development:** | | | | | - |
| Advanced Nursing Education | 80,581 | - | 80,581 | 105,581 | +25,000 |
| Nursing Workforce Diversity | 19,843 | - | 19,843 | 23,343 | +3,500 |
| Nurse Education, Practice and Retention | 46,757 | - | 46,913 | 48,913 | +2,000 |
| Nurse Faculty Loan Program | 28,414 | - | 28,500 | 28,500 | - |
| NURSE Corps Scholarship and Loan Repayment Program | 88,116 | - | 88,635 | 88,635 | - |
| NURSE Corps Scholarship and Loan Repayment Program Mandatory | | 200,000 | | - | - |
| ***Subtotal, Nursing Workforce Development*** | ***263,711*** | ***200,000*** | ***264,472*** | ***294,972*** | ***+30,500*** |
| Children's Hospital Graduate Medical Education | 349,297 | - | 350,000 | 350,000 | - |
| Teaching Health Center Graduate Medical Education Mandatory | 126,500 | 330,000 | 119,290 | 119,290 | - |
| *National Practitioner Data Bank (User Fees)* | *18,814* | - | *18,814* | *18,814* | - |
| Preventing Burnout in the Health Workforce | - | - | - | 50,000 | +50,000 |
| **Subtotal, Bureau of Health Workforce (BHW)** | **1,675,645** | **1,550,000** | **1,654,440** | **2,050,318** | **+400,878** |
| *Subtotal, User Fees BHW (non-add)* | *18,814* | - | *18,814* | *18,814* | - |
| *Subtotal, Discretionary BHW (non-add)* | *1,220,331* | - | *1,224,006* | *1,619,884* | *+400,878* |

| | FY 2021 | | FY 2022 | FY 2023 | |
|---|---|---|---|---|---|
| | **Final /1** | **COVID-19 Supplemental /2** | **Continuing Resolution/3** | **President's Budget** | **President's Budget +/- FY 2022 CR** |
| *Subtotal, Mandatory BHW (non-add)* | *436,500* | *1,550,000* | *411,620* | *411,620* | - |
| **MATERNAL & CHILD HEALTH:** | | | | | |
| Maternal and Child Health Block Grant | 710,545 | - | 712,700 | 953,700 | +241,000 |
| *Grants to States (non-add)* | *561,617* | - | *563,308* | *592,308* | *+29,000* |
| *SPRANS (non-add)* | *138,755* | - | *139,116* | *351,116* | *+212,000* |
| *CISS (non-add)* | *10,173* | - | *10,276* | *10,276* | - |
| Autism and Other Developmental Disorders | 53,184 | - | 53,344 | 57,344 | +4,000 |
| Sickle Cell Service Demonstrations | 7,183 | - | 7,205 | 7,205 | - |
| Early Hearing Detection and Intervention | 17,765 | - | 17,818 | 17,818 | - |
| Emergency Medical Services for Children | 22,267 | - | 22,334 | 28,134 | +5,800 |
| Healthy Start | 127,616 | - | 128,000 | 145,000 | +17,000 |
| Heritable Disorders | 18,826 | - | 18,883 | 18,883 | - |
| Pediatric Mental Health Care Access Grants | 9,970 | - | 10,000 | 10,000 | - |
| Pediatric Mental Health Care Access Grants Mandatory | - | 80,000 | - | - | - |
| Screening and Treatment for Maternal Depression | 5,000 | - | 5,000 | 10,000 | +5,000 |
| Poison Control Centers | 24,846 | - | 24,846 | 24,846 | - |
| Family-to-Family Health Information Centers Mandatory | 5,658 | - | 5,658 | 5,658 | - |
| **Maternal, Infant and Early Childhood Home Visiting (MIECHV):** | | | | | |
| MIECHV Mandatory | 377,200 | 150,000 | 377,200 | - | -377,200 |
| MIECHV Mandatory Proposed | - | - | - | 467,000 | +467,000 |
| ***Subtotal, MIECHV*** | ***377,200*** | ***150,000*** | ***377,200*** | ***467,000*** | ***+89,800*** |
| **Subtotal, Maternal and Child Health Bureau (MCHB)** | **1,380,060** | **230,000** | **1,382,988** | **1,745,588** | **+362,600** |
| *Subtotal, Discretionary MCHB (non-add)* | *997,202* | - | *1,000,130* | *1,272,930* | *+272,800* |
| *Subtotal, Mandatory MCHB (non-add)* | *382,858* | *230,000* | *382,858* | *472,658* | *+89,800* |

| | FY 2021 | | FY 2022 | FY 2023 | |
|---|---|---|---|---|---|
| | Final /1 | COVID-19 Supplemental /2 | Continuing Resolution/3 | President's Budget | President's Budget +/- FY 2022 CR |
| **HIV/AIDS:** | | | | | |
| Emergency Relief - Part A | 655,706 | - | 655,876 | 665,876 | +10,000 |
| Comprehensive Care - Part B | 1,314,622 | - | 1,315,005 | 1,345,005 | +30,000 |
| *AIDS Drug Assistance Program (non-add)* | *900,313* | - | *900,313* | 900,313 | - |
| Early Intervention - Part C | 201,079 | - | 201,079 | 207,079 | +6,000 |
| Children, Youth, Women & Families - Part D | 72,888 | - | 75,088 | 75,088 | - |
| AIDS Education and Training Centers - Part F | 33,510 | - | 33,611 | 33,611 | - |
| Dental Reimbursement Program Part F | 13,083 | - | 13,122 | 13,122 | - |
| Special Projects of National Significance (SPNS) | 25,000 | - | 25,000 | 25,000 | - |
| Ending HIV Epidemic Initiative | 105,000 | - | 105,000 | 290,000 | +185,000 |
| **Subtotal, HIV/AIDS Bureau** | **2,420,888** | - | **2,423,781** | **2,654,781** | **+231,000** |
| **HEALTH SYSTEMS:** | | | | | |
| Organ Transplantation | 29,549 | - | 29,049 | 29,049 | - |
| Cell Transplantation Program and Cord Blood Stem Cell Bank | 48,063 | - | 49,275 | 49,275 | - |
| Hansen's Disease Center | 13,165 | - | 13,706 | 13,706 | - |
| Payment to Hawaii | 1,851 | - | 1,857 | 1,857 | - |
| National Hansen's Disease Program - Buildings and Facilities | 122 | - | 122 | 122 | - |
| **Subtotal, Health Systems Bureau** | **92,750** | - | **94,009** | **94,009** | **-** |
| **RURAL HEALTH:** | | | | | |
| Rural Health Policy Development | 11,043 | - | 11,076 | 11,076 | - |
| Rural Health Outreach Grants | 82,153 | - | 82,500 | 90,000 | +7,500 |
| Rural Hospital Flexibility Grants | 55,442 | - | 55,609 | 57,509 | +1,900 |
| State Offices of Rural Health | 12,462 | - | 12,500 | 12,500 | - |
| Radiation Exposure Screening and Education Program | 1,828 | - | 1,834 | 2,734 | +900 |
| Black Lung | 11,565 | - | 11,500 | 12,190 | +690 |
| Rural Communities Opioid Response | 109,670 | - | 110,000 | 165,000 | +55,000 |
| Rural Residency Planning and Development | 10,468 | - | 10,500 | 12,700 | +2,200 |

| | FY 2021 | | FY 2022 | FY 2023 | |
|---|---|---|---|---|---|
| | Final /1 | COVID-19 Supplemental /2 | Continuing Resolution/3 | President's Budget | President's Budget +/- FY 2022 CR |
| Tribal Health | - | - | - | - | - |
| Rural Health Clinic Behavioral Health Initiative | | | | 10,000 | +10,000 |
| **Subtotal, Federal Office of Rural Health Policy** | **294,631** | - | **295,519** | **373,709** | **+78,190** |
| **PROGRAM MANAGEMENT** | 154,834 | - | 155,300 | 168,971 | +13,671 |
| **FAMILY PLANNING** | 285,619 | - | 286,479 | 400,000 | +113,521 |
| **FAMILY PLANNING Mandatory** | - | 50,000 | - | - | - |
| **340B Drug Pricing Program/Office of Pharmacy Affairs** | 10,207 | - | 10,238 | 17,238 | +7,000 |
| **Telehealth** | 33,898 | - | 34,000 | 44,500 | +10,500 |
| **Appropriation Table Match** | **7,185,563** | - | **7,207,234** | **8,485,044** | **+1,277,810** |
| **Funds Appropriated to Other HRSA Accounts:** | | | | | |
| **Vaccine Injury Compensation:** | | | | | |
| Vaccine Injury Compensation Trust Fund (HRSA Claims) | 246,415 | | 251,343 | 256,370 | +5,027 |
| VICTF Direct Operations - HRSA | 11,200 | | 11,200 | 26,200 | +15,000 |
| **Subtotal, Vaccine Injury Compensation** | **257,615** | - | **262,543** | **282,570** | **+20,027** |
| **Countermeasures Injury Compensation Program /3** | - | - | - | 15,000 | +15,000 |
| **Discretionary Program Level:** | | | | | |
| **HRSA** | 7,204,377 | - | 7,226,048 | 8,503,858 | +1,277,810 |
| Vaccine Direct Operations Budget Authority | 11,200 | - | 11,200 | 26,200 | +15,000 |
| Countermeasures Injury Compensation Program /4 | - | - | - | 15,000 | +15,000 |
| **Total, HRSA Discretionary Program Level** | **7,215,577** | - | **7,237,248** | **8,545,058** | **+1,307,810** |
| **Mandatory Programs:** | **4,819,358** | **9,430,000** | **4,699,826** | **4,789,626** | **+89,800** |
| **Total, HRSA Program Level** | **12,034,935** | **9,430,000** | **11,937,074** | **13,334,684** | **+1,397,610** |
| **Less Programs Funded from Other Sources:** | | | | | |
| *User Fees* | *-18,814* | - | *-18,814* | *-18,814* | - |

| | FY 2021 | | FY 2022 | FY 2023 | |
|---|---|---|---|---|---|
| | **Final /1** | **COVID-19 Supplemental /2** | **Continuing Resolution/3** | **President's Budget** | **President's Budget +/- FY 2022 CR** |
| *Mandatory Programs* | *-4,819,358* | *-9,430,000* | *-4,699,826* | *-4,789,626* | *-89,800* |
| **Total, HRSA Discretionary Budget Authority** | **7,196,763** | **-** | **7,218,434** | **8,526,244** | **+1,307,810** |

1/ Reflects amounts appropriated and any reprogrammings or reallocations notified to Congress. Totals may display differently than operating plan due to rounding.

2/ Excludes $8.5 billion allocated to HRSA for Rural Provider Relief. Excludes permissive transfers and additional funding allocated to HRSA (PL 117-002).

3/Reflects the annualized amounts provided in the continuing resolution ending 03/11/2022.

4/ Since October 2009, CICP has received funding from the Public Health and Social Services Emergency Fund (PHSSEF).

# 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, $1,839,022,000: 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, the Health Care Quality Improvement Act of 1986, $1,619,884,000: 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 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, the Institutional Requirement in section 756(c) of the PHS Act shall apply to paragraphs (1) through (4) of section 756(a) of the PHS Act: Provided further, That $210,000,000 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, $15,000,000 shall remain available until expended for the purposes of making payments under the NHSC Loan Repayment Program under section 338B of the PHS Act to individuals participating in such program who provide primary health services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (as those terms are defined by the Secretary), notwithstanding the assignment priorities and limitations under section 333(b) of such Act: Provided further, That within the amount made available in the proviso that precedes 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: Provided further, That for purposes of the previous 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 funds made available under this heading may be used to make grants to establish or expand optional community-based nurse practitioner fellowship programs that are accredited or in the accreditation process, with a preference for those in Federally Qualified Health Centers, for practicing postgraduate nurse practitioners in primary care or behavioral health.*

***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, $1,272,930,000: Provided, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than $351,116,000 shall be available for carrying out special projects of regional and national significance pursuant to section 501(a)(2) of such Act and $10,276,000 shall be available for projects described in subparagraphs (A) through (F) of section 501(a)(3) of such Act.*

***RYAN WHITE HIV/AIDS PROGRAM***

*For carrying out title XXVI of the PHS Act with respect to the Ryan White HIV/AIDS program, $2,654,781,000, of which $2,010,881,000 shall remain available to the Secretary through September 30, 2025, 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 $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, $94,009,000, of which $122,000 shall be available until expended for facilities renovations and other facilities-related expenses of the National Hansen's Disease Program.*

### *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, $373,709,000, of which $57,509,000 from general revenues, notwithstanding section 1820(j) of the Social Security Act, shall be available for carrying out the Medicare rural hospital flexibility grants program: Provided, That of the funds made available under this heading for Medicare rural hospital flexibility grants, 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 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 $12,700,000 shall remain available through September 30, 2025, to support the Rural Residency Development Program.*

### *FAMILY PLANNING*

*For carrying out the program under title X of the PHS Act to provide for voluntary family planning projects, $400,000,000: 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 for program support for activities funded in other appropriations included in this Act for the Health Resources and Services Administration, $230,709,000: of which $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: Provided further, 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".*

### *GENERAL PROVISIONS*

*Sec. 233 Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—*

*(a) in subsection (a)(5)(C)—*

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

*(2) by inserting at the end the following:*

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

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

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

*SEC. 239. The Secretary of Health and Human Services may waive penalties and administrative requirements in title XXVI of the Public Health Service Act for awards under such title from amounts provided under the heading "Department of Health and Human Services—Health Resources and Services Administration" in this or any other appropriations Act for this fiscal year, including amounts made available to such heading by transfer.*

## Language Analysis

| LANGUAGE PROVISION | EXPLANATION |
|---|---|
| Provided, That section**[**s] 751(j)(2) **[**and 762(k)**]** of the PHS Act and the proportional funding amounts in paragraphs (1) through (4) of section 756(f) of the PHS Act shall not apply to funds made available under this heading: | Section 762(k) of the PHS Act is no longer in law. |
| **[**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 Institutional 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 improves ability of Historically Black Colleges and Universities and Minority Serving Institutions to successfully apply for funding to train behavioral health providers. |
| Provided further, That *$210,000,000* shall remain available until expended for the purposes of providing primary health services, assigning National Health Service Corps ("NHSC") **[**members**]***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: | Language to change to "participants" because Corps "members" has a defined meaning within the statue that excludes NHSC participants operating under the private practice option under section 338D of the PHSA. |
| *Provided further, That, within the amount made available in the previous proviso, $15,000,000 shall remain available until expended for the purposes of making payments under the NHSC Loan Repayment Program under section 338B of the PHS Act to individuals participating in such program who provide primary health services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (as those terms are defined by the Secretary), notwithstanding the* | Language facilitates funding of tribal communities. |

| LANGUAGE PROVISION | EXPLANATION |
|---|---|
| *assignment priorities and limitations under section 333(b) of such Act:* | |
| *Provided further, That within the amount made available in the proviso that precedes 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 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 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.* | Language to add "certified peer support specialists" to the list of providers covered under the term "primary health services" |
| *Provided further, That funds made available under this heading may be used to make grants to establish or expand optional community-based nurse practitioner fellowship programs that are accredited or in the accreditation process, with a preference for those in Federally Qualified Health Centers, for practicing postgraduate nurse practitioners in primary care or behavioral health.* | Language added to provide preference for Federally Qualified Health Centers in the nurse practitioner fellowship programs. |
| **[**Of the funds made available under this heading, $50,000,000 shall remain available until expended for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions: Provided, That, in awarding such grants, the Secretary shall give priority to public institutions of higher education | Program not funded in budget request. |

| LANGUAGE PROVISION | EXPLANATION |
| --- | --- |
| located in States with a projected primary care provider shortage in 2025, as determined by the Secretary: Provided further, That grants so awarded are limited to such public institutions of higher education in States in the top quintile of States with a projected primary care provider shortage in 2025, as determined by the Secretary: Provided further, That the minimum amount of a grant so awarded to such an institution shall be not less than $1,000,000 per year: Provided further, That such a grant may be awarded for a period not to exceed 5 years: Provided further, That amounts made available in this paragraph shall be awarded as supplemental grants to recipients of grants awarded for this purpose in fiscal years 2019 and 2020, pursuant to the terms and conditions of each institution's initial grant agreement, in an amount for each institution that will result in every institution being awarded the same total grant amount over fiscal years 2019 through 2021, provided the institution can justify the expenditure of such funds: Provided further, That such a grant awarded with respect to a year to such an institution shall be subject to a matching requirement of non-Federal funds in an amount that is not less than 10 percent of the total amount of Federal funds provided in the grant to such institution with respect to such year.**]** | |
| **[**HEALTH CARE SYSTEMS**]***HEALTH SYSTEMS* | Account name change to reflect HRSA re-organization effective August 25, 2021. |
| Provided, That of the funds made available under this heading for Medicare rural hospital flexibility grants, **[**shall**]** *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 and up to $1,000,000 shall be to carry out section 1820(g)(6) of the Social Security Act, with funds provided for | Language amended to provide greater flexibility to fund successful programs that benefit rural veterans. |

| LANGUAGE PROVISION | EXPLANATION |
| --- | --- |
| 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*, **[**including pilots and demonstrations on the use of electronic health records**]** to coordinate rural veterans care between rural providers and the Department of Veterans Affairs **[**electronic health record system**]**: | |
| **[PROGRAM MANAGEMENT]*HRSA-WIDE ACTIVITIES AND PROGRAM SUPPORT***<br><br>**[**For program support in the**]** *For carrying out title III of the Public Health Service Act and for cross-cutting activities and for program support for activities funded in other appropriations included in this Act for the* Health Resources and Services Administration, **[***$167,971,000$230,709,000*: *of which $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::* Provided *further*, That funds made available under this heading may be used to supplement program support funding provided under the headings "Primary Health Care", "Health Workforce", "Maternal and Child Health", "Ryan White HIV/AIDS Program", "Health **[**Care**]** Systems", and "Rural Health". | Account name change and authorizing language for the Office for the Advancement of Telehealth needed to reflect HRSA re-organization effective August 25, 2021. |

# Amounts Available for Obligation[5]

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **General Fund Discretionary Appropriation:** | | | |
| Appropriation | $ 7,207,234,000 | $ 7,207,234,000 | $ 8,485,044,000 |
| Disc: Approps transferred to other accounts | -21,671,000 | | |
| **Subtotal, adjusted general fund discr. Appropriation** | **7,185,563,000** | **7,207,234,000** | **8,485,044,000** |
| **Mandatory Appropriation:** | | | |
| Family to Family Health Information Centers | +6,000,000 | +6,000,000 | +6,000,000 |
| *Primary Health Care Access:* | | | |
| Community Health Center Fund/2 | +4,000,000,000 | +4,000,000,000 | +4,000,000,000 |
| National Health Service Corps/3 | +310,000,000 | +310,000,000 | +310,000,000 |
| ***Subtotal Primary Health Care Access*** | **+4,310,000,000** | **+4,310,000,000** | **+4,310,000,000** |
| Maternal, Infant, and Early Childhood Home Visiting Program/6 | +400,000,000 | +400,000,000 | +467,000,000 |
| Teaching Health Centers Graduate Medical Education | +126,500,000 | +126,500,000 | +126,500,000 |
| American Rescue Plan Act | +9,430,000,000 | - | - |
| Transfer to the Department of Justice | -5,000,000 | -5,000,000 | -5,000,000 |
| Mandatory Sequestration | | -143,000,000 | -120,000,000 |
| **Subtotal, adjusted mandatory appropriation** | **14,267,500,000** | **4,694,500,000** | **4,784,500,000** |
| **Subtotal, adjusted appropriation** | **21,453,063,000** | **11,901,734,000** | **13,269,544,000** |
| 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 | +467,222,000 | +1,873,000,000 | + 766,000,000 |
| Unobligated balance, end of year | +1,873,000,000 | +766,000,000 | +727,000,000 |
| Recoveries from prior year unpaid obligations | +75,876,000 | - | - |
| Unobligated balance, lapsing | -3,983,056 | - | - |
| **Total obligations** | **$23,883,991,944** | **$14,559,548,000** | **$14,781,358,000** |

[5] Excludes the following amounts for reimbursable activities carried out by this account: FY 2021 -$32,000,000 and 22 FTE; FY 2022- $39,000,000 and 22 FTE; FY 2023 $39,000,000 and 21 FTE.

[6] FY 2023 level includes proposed mandatory funding for Maternal and Child Health Home Visiting Program

# Authorizing Legislation[7,8]

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 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<br><br>Note: P.L. 117-2, American Rescue Plan Act, Title II, Subtitle G, Section 2601 | Authorized for FY 2022 (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 | $1,562,722,000 | 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 | $1,718,022,000 |
| 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 | $4,000,000,000 | $3,905,348,000[9] | $4,000,000,000 | $3,905,348,000[10] |

[7] 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.

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

[9] Post-sequestration funding level.

[10] Post-sequestration funding level.

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
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| by P.L. 116-136, CARES Act, Division A, Title III, Section 3831; as amended by P.L. 116-159, Continuing Appropriations Act, 2021 and Other Extensions Act, Division C, Title I, Section 2101; as amended by P.L. 116-215, Further Continuing Appropriations Act, 2021, and Other Extensions Act, Division B, Title II, Section 1201; as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Division BB, Title III, Sec. 301<br><br>(see 42 U.S.C. 254b-2) | | | | |
| Federal Tort Claims Act Coverage for Health Centers:<br>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:<br>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 | $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 | $1,000,000 |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| | paragraph shall be made separate from appropriations made for purposes of sections 254b, 254b and 256a of this title | | paragraph shall be made separate from appropriations made for purposes of sections 254b, 254b and 256a of this title | |
| **HEALTH WORKFORCE:** | | | | |
| National Health Service Corps (NHSC) (Discretionary)<br>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 2022 (and each subsequent year), based on previous year's funding, subject to adjustment formula | $120,000,000 | Authorized for FY 2023 (and each subsequent year), based on previous year's funding, subject to adjustment formula | $210,000,000 |
| NHSC (Fund) (Mandatory):<br>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<br><br>(see 42 U.S.C. 254b-2) | $310,000,000 | $292,330,000[11] | $310,000,000 | $292,330,000[12] |

[11] Post-sequestration funding level.
[12] Post-sequestration funding level.

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| Mental Health and Substance Use Disorder Training for Health Care Professionals, Paraprofessionals, and Public Safety Officers: | --- | --- | --- | --- |
| Grants for Health Care Providers to Promote Mental Health Among Their Health Professional Workforce | --- | --- | --- | --- |
| Students to Service Loan Repayment Program:<br>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<br><br>Note: An amount based on previous year's funding, subject to adjustment formula | --- | Indefinite<br><br>Note: An amount based on previous year's funding, subject to adjustment formula | --- |
| State Loan Repayment Program (SLRP):<br>PHS Act, Section 338I(a)-(i), as amended<br>by P.L. 107-251, Section 315; as further amended by P.L. 110-355, Section 3(e)(2) | Expired<br><br>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<br><br>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):<br>PHS Act, Section 738(a) and 740(b), as amended by P.L. 111-148, Sections 5402 and 10501(d); as amended by P.L. 116-136, CARES Act, Section 3401 | $1,190,000 | $1,190,000 | $1,190,000 (through FY 2025) | $2,310,000 |
| Centers of Excellence:<br>PHS Act, Section 736, as amended by P.L. 111-148, Section 5401); as amended by P.L. 116-136, CARES Act, Section 3401 | $23,711,000 | $23,711,000 | $23,711,000 (through FY 2025) | $36,711,000 |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
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| Scholarships for Disadvantaged Students:<br>PHS Act, Section 737, as amended by P.L. 111-148, Section 5402(b), authorization of appropriations in Section 740(a); as amended by P.L. 116-136, CARES Act, Section 3401 | $51,470,000 | $51,470,000 | $51,470,000 (through FY 2025) | $51,970,000 |
| Health Careers Opportunity Program:<br>PHS Act, Section 739, as amended by P.L. 111-148, Section 5402, authorization of appropriation in Section 740(c); as amended by P.L. 116-136, CARES Act, Section 3401 | $15,000,000 | $15,000,000 | $15,000,000 (through FY 2025) | $18,500,000 |
| National Center for Workforce Analysis:<br>PHS Act, Section 761(e), as amended by P.L. 111-148, Section 5103; as amended by P.L. 116-136, CARES Act, Section 3401 | $5,663,000 | $5,663,000 | $5,663,000 (through FY 2025) | $5,663,000 |
| Primary Care Training and Enhancement:<br>PHS Act, Section 747, as amended by P.L. 111-148, Section 5301; as amended by P.L. 116-136, CARES Act, Section 3401 | $48,924,000 | $48,924,000 | $48,924,000 (through FY 2025) | $53,924,000 |
| Oral Health Training Programs (Training in General, Pediatric, and Public Health Dentistry):<br>PHS Act, Section 748, as added by P.L. 111-148, Section 5303; as amended by P.L. 116-136, CARES Act, Section 3401 | $28,531,000 | $40,673,000 | $28,531,000 | $40,673,000 |
| Graduate Medical Education for Physicians:<br>as added by P.L. 115-245, Title II as amended by H.R.133, Consolidated Appropriations Act, 2021 | $50,000,000 (shall remain available until expended for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions) | $50,000,000 | $50,000,000 (shall remain available until expended for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions) | --- |
| *Interdisciplinary, Community-Based Linkages:*<br><br>Area Health Education Centers:<br>PHS Act, Section 751, as amended by P.L. 111-148, Section 5403; as amended by P.L. 113-128, Section 512(z)(2); as amended by P.L. 116-136, CARES Act, Section 3401 | $41,250,000 | $43,250,000 | $41,250,000 | $43,250,000 |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
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| Education and Training Related to Geriatrics [Geriatric Workforce Enhancement Program (GWEP) and Geriatric Academic Career Awards (GACA)]:<br>PHS Act, Section 753, as amended by P.L. 111-148, Section 5305; as amended by P.L. 116-136, CARES Act, Section 3403 | $40,737,000 for each of fiscal years 2021 through 2025 | $42,737,000 | $40,737,000 for each of fiscal years 2021 through 2025 | $46,537,000 |
| Behavioral Health Workforce Education and Training(BHWET):<br>PHS Act, Sections 755, 756, and 760; as amended by P.L. 114-255, Section 9021 and P.L. 115-271, Section 7073<br><br>Mental and Behavioral Health Education and Training Programs (MBHET):<br>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)<br><br>Note: PHS Act, Section 781(j) provides the authorization of appropriations for Substance Use Disorder Treatment Workforce (STAR) Loan Repayment Program (LRP)<br>• Graduate Psychology Education (GPE)<br>• Opioid Workforce Expansion Program (OWEP)<br>• Opioid Impacted Family Support Program (OIFSP)<br>• Behavioral Health Workforce Technical Assistance and Evaluation (BHWD TAE) Program<br>• Addiction Medicine Fellowship (AMF)<br>• Integrated Substance Use Disorder Training Program (ISTP)<br>• Substance Use Disorder Treatment Workforce (STAR) Loan Repayment Program (LRP) | BHWET:<br>$50,000,000 for each of fiscal years 2021 through 2023<br><br>MBHET:<br>(through FY 2023)<br><br>PHS Act, Section 756, Subsection (a)(1)-- $15,000,000<br><br>Subsection (a)(2) $15,000,000;<br><br>Subsection (a)(3): $10,000,000;<br><br>Subsection (a)(4): $10,000,000<br><br>PHS Act, Section 781, Subsection (j): $25,000,000 | $149,916,000 | BHWET:<br>$50,000,000 for each of fiscal years 2021 through 2023<br><br>MBHET:<br>(through FY 2023)<br><br>PHS Act, Section 756, Subsection (a)(1)-- $15,000,000<br><br>Subsection (a)(2) $15,000,000;<br><br>Subsection (a)(3): $10,000,000;<br><br>Subsection (a)(4): $10,000,000<br><br>PHS Act, Section 781, Subsection (j): $25,000,000 | $397,374,000 |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| Public Health /Preventive Medicine:<br>PHS Act, Sections 765-7686, as amended by P.L. 111-148, Section 10501; as amended by P.L. 116-136, CARES Act, Section 3401 (amends PHS Act, Section 766)<br><br>Note: PHS Act, Section 770 provides the authorization of appropriations for subpart 2 of Part E of Title VII, which includes Sections 765-768 | $17,000,000 | $17,000,000 | $17,000,000 | $18,000,000 |
| *Nursing Workforce Development:*<br><br>Advanced Education Nursing:<br>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<br>Note: PHS Act, Section 871(a) provides an authorization of appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D, which includes PHS Act, Section 811 | See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D. | $80,581,000 | See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D. | $105,581,000 |
| Nursing Workforce Diversity<br>PHS Act, Section 821, as amended by P.L. 111-148, Section 5404; as amended by P.L. 116-136, CARES Act, Section 3404<br><br>Note: PHS Act, Section 871(a) provides an authorization of appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D, which includes PHS Act, Section 821 | See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D. | $19,843,000 | See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D. | $23,343,000 |
| Nurse Education, Practice, Quality and Retention :<br>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<br><br>(*Note: PHS Act, Section 831A was struck by P.L. 116-136, CARES Act)<br><br>Note: PHS Act, Section 871(a) provides an authorization of appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D, which includes PHS Act, Section 831 | See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D. | $46,913,000 | See PHS Act, Section 871(a), which authorizes appropriations of $137,837,000 for all programs under Title VIII Parts B, C, and D. | $48,913,000 |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
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| Nurse Faculty Loan Program:<br>PHS Act, Section 846A, as amended by P.L. 111-148, Section 5311; as amended by P.L. 116-136, CARES Act, Section 3404<br>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(b), which authorizes appropriations of $117,135,000 for all programs under Title VIII Part E. | $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):<br>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<br><br>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. | $88,635,000 | See PHS Act, Section 871(b), which authorized appropriations of $117,135,000 for all programs under Title VIII Part E. | $88,635,000 |
| Children's Hospitals Graduate Medical Education (GME) Program:<br>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<br>Indirect Medical Education: $220,000,000 | $350,000,000 | Direct GME: $105,000,000<br>Indirect Medical Education: $220,000,000 | $350,000,000 |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
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| Teaching Health Centers (THC) Graduate Medical Education (GME) Program:<br>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 (for each of FYs 2018 through 2023, to remain available until expended) | $119,290,000[13] | $126,500,000 (for each of FYs 2018 through 2023, to remain available until expended) | $119,290,000[14] |
| Teaching Health Centers (THC) Development Grants:<br>PHS Act, Section 749A, as added by P.L. 111-148, Section 5508) | Indefinite – at such sums as may be-necessary (Teaching Health Centers Development Grants, PHS Act, Section 749A) | --- | Indefinite – at such sums as may be-necessary (Teaching Health Centers Development Grants, PHS Act, Section 749A) | --- |
| *National Practitioner Data Bank: (User Fees)*<br>*Title IV, P.L. 99-660; Section 5, P.L. 100-93, Social Security Act (SSA), Section 1921; Section 221(a), P.L. 104-191, SSA, Section 1128E*<br>*(also includes: Health Care Integrity and Protection Data Bank (HIPDB), SSA, Section 1128E)* | *Not Specified* | *$18,814,000* | *Not Specified* | *$18,814,000* |

[13] Post-sequestration funding level.
[14] Post-sequestration funding level.

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| Health Professional Shortage Areas:<br><br>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"* | ---- | --- | ---- | --- |
| Grants for Innovative Programs:<br>PHS Act, Section 340G, as amended by P.L. 115-302, , Section 3 | FY 2019-2023<br>$13,903,000 | --- | FY 2019-2023<br>$13,903,000 | --- |
| Preventing Burnout in the Health Workforce: PHS Act, Section 764, as amended by P.L. 117-105 | $35,000,000 | --- | $35,000,000 | $50,000,000 |
| **MATERNAL & CHILD HEALTH:** | | | | |
| Maternal and Child Health Block Grant: Social Security Act, Title V | Indefinite at $850,000,000 | $712,700,000 | Indefinite at $850,000,000 | $953,700,000 |
| Autism Education, Early Detection and Intervention:<br>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<br>(through FY 2024) | $53,344,000 | $50,599,000<br>(through FY 2024) | $57,344,000 |
| Sickle Cell Service Demonstration Grants:<br>P.L. 108-357, American Jobs Creation Act of 2004, Section 712(c ), as amended by P.L. 115-327, Section 3(b) (which transferred Section 712(c) of P. L. 108–357, and re-designated it as PHS Act, Section 1106 | $4,455,000 (each of FY 2021 through FY 2023) | $7,205,000 | $4,455,000 (each of FY 2021 through FY 2023) | $7,205,000 |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
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| Universal Newborn Hearing Screening:<br>PHS Act, Section 399M, as amended by P.L. 106-310, Section 702; as amended by P.L. 111-337, Section 2; as amended by P.L. 115-71, Section 2 | $19,522,758 | $17,818,000 | Expiring (Authorized through to the end of FY 2022) | $17,818,000 |
| Emergency Medical Services for Children:<br>PHS Act, Section 1910, as amended by P.L. 105-392, Section 415; as amended by P.L. 111-148, Section 5603(1); as amended by P.L. 113-180, Section 2; as amended by the Emergency Medical Services for Children Program Reauthorization Act of 2019, P.L. 116-49, Section 2 | $22,334,000 (through FY 2024) | $22,334,000 | $22,334,000 (through FY 2024) | $28,134,000 |
| Healthy Start:<br>PHS Act, Section 330H, as added by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2; as amended by P.L. 116-136, CARES Act, Section 3225 | $125,500,000 | $128,000,000 | $125,500,000 (through FY2025) | $145,000,000 |
| Heritable Disorders:<br>PHS Act, Section 1109-1112 and 1114, as amended by P.L. 106-310, Section 2601; as amended by P.L. 110-204, Section 2; as amended by P.L. 110-237, Section 1; as amended by P.L. 113-240, Section 10 (see PHS Act, Section 1117-relating to authorization levels for FY 2015 through 2019) | Expired (as of end of FY 2019) | $18,883,000 | Expired (as of end of FY 2019) | $18,883,000 |
| Pediatric Mental Health Care Access Grants:<br>PHS Act, Section 330M, as added by P.L. 114-255, Section 10002 | $9,000,000 (each of FY 2021 through FY 2022) | $10,000,000 | Expiring (at end of FY 2022) | $10,000,000 |
| Screening and Treatment for Maternal Depression:<br>PHS Act, Section 317L-1, as added by P.L. 114-255, Section 10005 | $5,000,000 (each of FY 2021 through FY 2022) | $5,000,000 | Expiring (at end of 2022) | $10,000,000 |
| Poison Control:<br>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<br><br>Media campaign: $800,000<br><br>Grant program: $28,600,000<br><br>(through FY 2024) | $24,846,000 | Toll-free number: $700,000<br><br>Media campaign: $800,000<br><br>Grant program: $28,600,000<br><br>(through FY 2024) | $24,846,000 |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| Family to Family Health Information Centers:<br>Social Security Act, Section 501(c)(1)(A), as added by P.L. 109-171, Section 6064; reauthorized by P.L. 111-148, Sec. 5507(b), as amended by P.L. 112-240, Section 624; as amended by P.L. 113-67, Section 1203; as amended by P.L. 113-93, Section 207; as amended by P.L. 114-10, Section 216; as amended by P.L. 115-123, Section 50501; as amended by P.L. 116-39, Sustaining Excellence in Medicaid Act of 2019, Section 5 | $6,000,000 (each of fiscal years 2021 through 2024) | $5,658,000[15] | $6,000,000 (each of fiscal years 2021 through 2024) | $5,658,000[16] |
| Maternal, Infant and Early Childhood Visiting (MIECHV) Program:<br>Social Security Act, Section 511, as added by P.L. 111-148, Section 2951; as amended by P.L. 113-93, Section 209; as amended by P.L. 114-10, Sec. 218; as amended by P.L. 115-123, Sections 50601-50607; as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Section 10; as amended by P.L. 117-2, American Rescue Plan Act, Title IX, Part 4, Section 9101 (new Social Security Act, Section 511A added after Section 511) | $400,000,000 (each of FY 2021 through FY 2022) | $377,200,000[17] | Expiring (Authorized through to the end of FY 2022) | $467,000,000 |
| **HIV/AIDS:**[18] | | | | |
| Emergency Relief - Part A<br>PHS Act, Sections 2601-10, as amended by P.L. 106-345; as amended by P.L. 109-415; as amended by P.L. 111-87 | Expired | $655,876,000 | Expired | $665,876,000 |
| Comprehensive Care - Part B:<br>PHS Act, Sections 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87 | Expired | $1,315,005,000 | Expired | $1,345,005,000 |
| *AIDS Drug Assistance Program (Non-Add)*<br>*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* |

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

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| Early Intervention Services – Part C:<br>PHS Act, Sections 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87 | Expired | $201,079,000 | Expired | $207,079,000 |
| Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D:<br>PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87 | Expired | $75,088,000 | Expired | $75,088,000 |
| AIDS Education and Training Centers - Part F:<br>PHS Act, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87 | Expired | $33,611,000 | Expired | $33,611,000 |
| Dental Reimbursement Program - Part F:<br>PHS Act, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415, as amended by P.L.111-87 | Expired | $13,122,000 | Expired | $13,122,000 |
| Special Projects of National Significance - Part F:<br>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:<br>PHS Act, Section 311and PHS Act, Title XXVI | Not Specified | $105,000,000 | Not Specified | $290,000,000 |
| **HEALTHCARE SYSTEMS:** | | | | |
| Organ Transplantation:<br>PHS Act, Sections 371-378, as amended by P.L. 108-216,<br>P.L. 109-129, P.L. 110-144, P.L. 110-413, and P.L. 113-51 | Expired | $29,049,000 | Expired | $29,049,000 |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| National Cord Blood Inventory:<br>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 (Reauthorized through FY 2026) | | $23,000,000 (Reauthorized through FY 2026) | |
| C.W. Bill Young Cell Transplantation Program:<br>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 (Reauthorized through FY 2026) | $49,275,000 | $31,009,000 (Reauthorized through FY 2026) | $49,275,000 |
| National Hansen's Disease Program:<br>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:<br>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:<br>PHS Act, Section 320 | Not Specified | $122,000 | Not Specified | $122,000 |
| **RURAL HEALTH:** | | | | |
| Rural Health Policy Development:<br>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:<br>PHS Act, Section 330A, as amended by P.L. 107-251, Section 201; as amended by P.L. 110-355, Section 4; as amended by P.L. 116-136, CARES Act, Section 3213 | $79,500,000 (for each fiscal year through 2025) | $82,500,000 | $79,500,000 (for each fiscal year through 2025) | $90,000,000 |
| Rural Hospital Flexibility Grants:<br>SSA, Section 1820(j), as amended by P.L. 105-33, Section 4201(a) and Section 4002(f), and P.L. 108-173, Section 405(f), as amended by P.L. 110-275, Section 121; as amended by P.L. 111-148, Section 3129(a) | Expired | $55,609,000 | Expired | $57,509,000 |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| State Offices of Rural Health:<br>PHS Act, Section 338J, as amended by P.L. 105-392, Section 301, and P.L. 115-408, Section 2 | $12,500,000 (each of fiscal years 2021 through 2022 | $12,500,000 | Expiring (Authorized through to the end of FY 2022) | $12,500,000 |
| Radiogenic Diseases (Radiation Exposure Screening and Education Program):<br>PHS Act, Section 417C, as amended by P.L. 106-245, Section 4, as amended by P.L. 109-482, Sections. 103, 104 | Not Specified (Note: FY 2009 expiration was struck by P.L. 109-482, Section 103) | $1,834,000 | Not Specified (Note: FY 2009 expiration was struck by P.L. 109-482, Section 103) | $2,734,000 |
| Black Lung:<br>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 | $11,500,000 | $10,000,000 | $12,190,000 |
| Rural Communities Opioid Response:<br>SSA, Section 711, as added by P.L. 100-203, Section 4401; as amended by P.L. 100-360, Section 411(m)(1); as amended by P.L. 101-239, Section 6213(g); as amended by P.L. 108-173, Section 432 | Not Specified | $110,000,000 | Not Specified | $165,000,000 |
| Rural Residency:<br>SSA, Section 711(b)(5), as added by P.L. 108-173, Section 432 | Not Specified | $10,500,000 | Not Specified | $12,700,000 |
| Rural Health Clinic Behavioral Health:<br>SSA, Section 711 | Not Specified | --- | Not Specified | $10,000,000 |
| **OTHER PROGRAMS:** | | | | |
| Family Planning:<br>Grants: PHS Act Title X | Expired | $286,479,000 | Expired | $400,000,000 |
| Program Management | Indefinite | $155,300,000 | Indefinite | $168,971,000 |
| 340B Drug Pricing Program:<br>PHS Act, Section 340B, as added by P.L. 102-585, Section 602(a); as amended by P. L. 103-43, Section 2008(i)(1)(A); as amended by P.L. 111-148, Sections. 2501(f)(1), 7101(a) –(d), 7102; as amended by P.L. 111-152, Section 2302; as amended by P.L. 111-309, Section 204(a)(1) | Indefinite – at such sums as may be necessary | $10,238,000 | Indefinite – at such sums as may be necessary | $17,238,000 |
| Telehealth:<br>PHS Act, Section 330I, as amended by P.L. 107-251, as amended by P.L. 108-163; as amended by P.L. 113-55, | $29,000,000 | $34,000,000 | $29,000,000 (Authorized through 2025) | $44,500,000 |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| Section 103; as amended by P.L. 116-136, CARES Act, Section 3212 | | | | |
| Vaccine Injury Compensation Program (VICP) (funded through the VICP Trust Fund):<br>PHS Act, Title XXI, Subtitle 2, Sections 2110-2134, as amended by P.L. 114-255, Section 3093(c). | Indefinite | $262,543,000 | Indefinite | $282,570,000 |
| Countermeasures Injury Compensation Program: PHS Act, Sections 319F-3 and 319F-4, as added by P.L. 109-148, Division C, Sections. 1 and 2, as amended by P.L. 113-5, Section. 402 (to Section 319F-3); as amended by P.L. 116-127, Families First Coronavirus Response Act, Sec.6005 (amends PHS Act, Section. 319F-3); as amended by P.L. 116-136, CARES Act Section 3103 (amends PHS Act, Sec. 319F-3) | Not Specified | --- | Not Specified | $15,000,000 |
| **<u>UNFUNDED AUTHORIZATIONS</u>:** | | | | |
| Health Center Demonstration Project for Individualized Wellness Plans:<br>PHS Act, Section 330(s), as added to PHS Act by P.L. 111-148, Section 4206<br><br>Note: P.L. 115–123, Section 50901(b)(14) struck PHS Act, Subsection (s) | ---- | --- | ---- | --- |
| School Based Health Centers - Facilities Construction:<br>P.L. 111-148, Section 4101(a); as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Title III, Subtitle A, Section 317 | Such Sums As May Be Necessary through FY 2026 | --- | Such Sums As May Be Necessary through FY 2026 | --- |
| School Based Health Centers – Operations:<br>PHS Act, Section 399Z-1, as added by P.L. 111-148, Section 4101(b); as amended by P.L. 116-260, Consolidated Appropriations Act, 2021, Title III, Subtitle A, Section 317 | Such Sums As May Be Necessary through FY 2026 | --- | Such Sums As May Be Necessary through FY 2026 | --- |
| Health Information Technology Innovation Initiative:<br>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:<br>PHS Act, Section 330(c)(1)(B)-(C), as amended | Such Sums As Are Necessary (within the Section 330 authorization) | --- | Such Sums As Are Necessary (within the Section 330 authorization) | --- |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| Electronic Health Record Implementation Initiative:<br>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:<br>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:<br>PHS Act, Section 741, as amended by P.L. 111-148, Section 5307 | Expired | --- | Expired | --- |
| Training Opportunities for Direct Care Workers<br>PHS Act, Section 747A, as added by P.L. 111-148, Section 5302 | Expired | --- | Expired | --- |
| Comprehensive Geriatric Education:<br>PHS Act, Section 865, as re-designated by<br>P.L. 111-148, Section 5310(b) | Expired | --- | Expired | --- |
| Continuing Education Support for Health Professionals Serving in Underserved Communities:<br>PHS Act, Section 752, as amended by P.L. 111-148, Section 5403 | Such Sums As May Be Necessary | --- | Such Sums As May Be Necessary | --- |
| Rural Interdisciplinary Training (Burdick)<br>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:<br>PHS Act, Section 759, as added by P.L.111-148, Section 4305 and P.L. 115-271, Section 7073 | Such Sums As May Be Necessary for each of the fiscal years 2019 through 2023 (amounts available until expended) | --- | Such Sums As May Be Necessary for each of the fiscal years 2019 through 2023 (amounts available until expended) | --- |
| Advisory Council on Graduate Medical Education:<br>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:<br>PHS Act, Section 807, as amended by P.L. 111-148, Section 5307 | Expired | --- | Expired | --- |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| Minority Faculty Fellowship Program:<br>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:<br>[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:<br>PHS Act, Section 755; as amended by P.L. 116-136, CARES Act, Section 3401 | Not Specified | --- | Not Specified | --- |
| Nurse Managed Health Clinics:<br>PHS Act, Section 330A-1, as added by P.L. 111-148, Section 5208 | Expired | --- | Expired | --- |
| Patient Navigator:<br>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:<br>PHS Act, Section 371A, as added by P.L. 108-216, Section 7 | Not Specified | --- | Not Specified | --- |
| Congenital Disabilities:<br>PHS Act, Section 399T, as added by P.L. 110-374, Section 3, as renumbered by P.L. 111-148, Section 4003 | Not Specified | --- | Not Specified | --- |
| Pediatric Loan Repayment:<br>PHS Act, Section 775, as added by P.L. 111-148, Section. 5203; as amended by P.L. 116-136, CARES Act, Section 3401 | Such Sums As May Be Necessary | --- | Such Sums As May Be Necessary | --- |
| Clinical Training in Interprofessional Practice:<br>PHS Act, Sections 755, 765, 831 | Not Specified (Section 755)<br><br>Expired (Sections 765 and 831) | --- | Not Specified (Section 755)<br><br>Expired (Sections 765 and 831) | --- |
| Rural Access to Emergency Devices:<br>PHS Act, Section 313, as added by P.L. 107-188, Section 159 (Public Access Defibrillation Demo), and P.L. 106-505, Section 413 (Rural Access to Emergency Devices) | Expired | --- | Expired | --- |
| Rural Emergency Medical Services Training and Equipment Assistance Program:<br>PHS Act Section 330J, as amended by P.L. 115-334, Section12608 | Such Sums As May Be Necessary (each of fiscal years 2021 through 2023) | --- | Such Sums As May Be Necessary (each of fiscal years 2021 through 2023) | |

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 President's Budget |
|---|---|---|---|---|
| Training Demonstration Program:<br>PHS Act, Section 760, as added by P.L. 114-255, Section 9022 | $10,000,000 (each of FY 2021 – FY 2022) | --- | $10,000,000 (each of FY 2021 – FY 2022) | --- |
| Liability Protections for Health Professional Volunteers at Community Health Centers:<br>PHS Act, Section 224(q), as added by P.L. 114-255, Section 9025 | Not Specified | --- | Not Specified | --- |

## SUMMARY OF CHANGES

| | |
|---|---|
| 2022 Continuing Resolution | $7,207,234,000 |
| (Obligations) | ($7,207,234,000) |
| 2023 Estimate | $8,485,044,000 |
| (Obligations) | ($8,485,044,000) |
| 2022 Mandatory | $4,699,826,000 |
| (Obligations) | ($4,699,826,000) |
| 2023 Mandatory | $4,789,626,000 |
| (Obligations) | ($4,789,626,000) |
| **Net Change** | **+$1,367,610,000** |

| No. | Program | FY 2022 Continuing Resolution | | FY 2023 President's Budget | FY 2023+/- FY 2022 | |
|---|---|---|---|---|---|---|
| | | FTE | Budget Authority | Budget Authority | FTE | Budget Authority |
| | | **2,096** | $ 375,591,951 | $ 455,407,215 | **+399** | +$79,815,264 |
| | **Increases:** | | | | | |
| | **A. Built in:** | | | | | |
| 1 | January 2023 Civilian Pay Raise | | $ 6,833,260 | $ 11,902,550 | | +$5,069,290 |
| 2 | January 2023 Military Pay Raise | | 665,610 | 1,046,934 | | +$381,324 |
| 3 | Civilian Annualization of Jan. 2023 | | 843,612 | 2,328,760 | | + 1,485,148 |
| 4 | Military Annualization of Jan. 2023 | | 221,870 | 227,594 | | + 5,724 |
| | **Subtotal, built-in increases** | | **$ 8,564,352** | **$ 15,505,838** | | **+$6,941,486** |
| | **Discretionary Increases** | | | | | |
| 1 | Health Centers | 299 | 1,562,772,000 | 1,718,022,000 | + 46 | +$155,250,000 |
| 2 | National Health Service Corps | 16 | 120,000,000 | 210,000,000 | + 3 | +$90,000,000 |
| 3 | Loan Repayment/Faculty Fellowships | - | 1,190,000 | 2,310,000 | + 1 | +$1,120,000 |
| 4 | Centers of Excellence | 1 | 23,711,000 | 36,711,000 | + 3 | +$13,000,000 |
| 5 | Scholarships for Disadvantaged Students | 6 | 51,470,000 | 51,970,000 | + 1 | +$500,000 |
| 6 | Health Careers Opportunity Program | - | 15,000,000 | 18,500,000 | + 3 | +$3,500,000 |
| 7 | Health Workforce Assessment | 4 | 5,663,000 | 5,663,000 | + 4 | - |
| 8 | Primary Care Training and Enhancement | 5 | 48,924,000.00 | 53,924,000 | + 1 | +$5,000,000 |
| 9 | Geriatric Programs | 5 | 42,737,000 | 46,537,000 | + 3 | +$3,800,000 |
| 10 | Behavioral Health Workforce Development Program | 12 | 149,916,000 | 397,374,000 | + 17 | +$247,458,000 |
| 11 | Public Health/Preventive Medicine | 4 | 17,000,000 | 18,000,000 | - | +$1,000,000 |
| 12 | Advanced Nursing Education | 9 | 80,581,000 | 105,581,000 | + 1 | +$25,000,000 |
| 13 | Nursing Workforce Diversity | 3 | 19,843,000 | 23,343,000 | + 1 | +$3,500,000 |
| 14 | Nurse Education, Practice and Retention | 5 | 46,913,000.00 | 48,913,000 | - | +$2,000,000 |
| 15 | NURSE Corps Loan Repayment & Scholarship | 27 | 88,635,000.00 | 88,635,000 | + 1 | - |
| 16 | Nurse Faculty Loan Program | 3 | 28,500,000.00 | 28,500,000 | + 1 | - |

| No. | Program | FY 2022 Continuing Resolution | | FY 2023 President's Budget | FY 2023+/- FY 2022 | |
|---|---|---|---|---|---|---|
| | | FTE | Budget Authority | Budget Authority | FTE | Budget Authority |
| 17 | Children's Hospital GME Program | 16 | 350,000,000.00 | 350,000,000 | + 2 | - |
| 18 | Preventing Burnout in the Health Workforce | - | - | 50,000,000 | + 2 | +$50,000,000 |
| 19 | Maternal and Child Health Block Grant | 59 | 712,700,000 | 953,700,000 | + 21 | +$241,000,000 |
| 20 | Autism and Other Developmental Disorders | 8 | 53,344,000 | 57,344,000 | - | +$4,000,000 |
| 21 | Sickle Cell Service Demonstrations | 1 | 7,205,000 | 7,205,000 | + 1 | - |
| 22 | Emergency Medical Services for Children | 6 | 22,334,000 | 28,134,000 | - | +$5,800,000 |
| 23 | Heritable Disorders | 4 | 18,883,000 | 18,883,000 | + 1 | - |
| 24 | Healthy Start | 17 | 128,000,000.00 | 145,000,000 | + 5 | +$17,000,000 |
| 25 | Poison Control Centers | 1 | 24,846,000.00 | 24,846,000 | + 2 | - |
| 26 | Screening/Treatment for Maternal Depression | 1 | 5,000,000 | 10,000,000 | + 1 | +$5,000,000 |
| 27 | Emergency Relief - Part A | 44 | 655,876,000 | 665,876,000 | + 4 | +$10,000,000 |
| 28 | Comprehensive Care - Part B | 52 | 1,315,005,000 | 1,345,005,000 | + 14 | +$30,000,000 |
| 29 | Early Intervention - Part C | 46 | 201,079,000 | 207,079,000 | + 17 | +$6,000,000 |
| 30 | Ryan White - Part D | 10 | 75,088,000 | 75,088,000 | + 2 | - |
| 31 | Special Project of National Significance (SPNS) | 1 | 25,000,000 | 25,000,000 | + 1 | - |
| 32 | Ending HIV/AIDS Epidemic Initiative | 25 | 105,000,000 | 290,000,000 | + 4 | +$185,000,000 |
| 33 | Rural Health Outreach Grants | 10 | 82,500,000 | 90,000,000 | - | +$7,500,000 |
| 34 | Rural Hospital Flexibility Grants | 1 | 55,609,000 | 57,509,000 | + 1 | +$1,900,000 |
| 35 | Radiation Exposure Screening and Education Prog. | 1 | 1,834,000 | 2,734,000 | - | +$900,000 |
| 36 | Black Lung | - | 11,500,000 | 12,190,000 | - | +$690,000 |
| 37 | Rural Communities Opioid Response | 18 | 110,000,000 | 165,000,000 | + 3 | +$55,000,000 |
| 38 | Rural Residency Planning and Development | 2 | 10,500,000 | 12,700,000 | - | +$2,200,000 |
| 39 | Rural Health Clinic Behavioral Health Initiative | - | - | 10,000,000 | + 1 | +$10,000,000 |
| 40 | Program Management | 770 | 155,300,000 | 168,971,000 | + 116 | +$13,671,000 |
| 41 | Family Planning | 22 | 286,479,000 | 400,000,000 | + 22 | +$113,521,000 |
| 42 | 340B Drug Pricing Prog./Office of Pharmacy Affairs | 19 | 10,238,000 | 17,238,000 | + 6 | +$7,000,000 |
| 43 | Telehealth | 8 | 34,000,000 | 44,500,000 | + 1 | +$10,500,000 |
| | **Subtotal Discretionary Program Increases** | **1,541** | **+$6,760,175,000** | **+$8,087,985,000** | **+313** | **+$1,327,810,000** |
| | **Mandatory Increases** | | | | | |
| 1 | Health Centers | 284 | 3,905,348,000 | 3,905,348,000 | + 33 | - |
| 2 | National Health Service Corps | 222 | 292,330,000 | 292,330,000 | + 32 | - |
| 3 | Teaching Health Centers GME | 9 | 119,290,000 | 119,290,000 | + 7 | - |
| 4 | Maternal, Infant and Early Childhood Home Visiting (MIECHV): | 41 | 377,200,000 | 467,000,000 | + 14 | +$89,800,000 |
| | **Subtotal Mandatory Program Increases** | **555** | **377,200,000** | **467,000,000** | **+87** | **+$89,800,000** |
| | **Decreases:** | | | | | |
| | A. Built in: | | | | | |
| 1 | Pay Costs | - | $ - | $ - | - | - |
| | **B. Program:** | | | | | |
| | **Discretionary Decreases** | | | | - | - |
| 1 | Medical Student Education | 1 | 50,000,000 | - | -1 | -50,000,000 |
| | **Subtotal Discretionary Program Decreases** | | **+$50,000,000** | - | **-1** | **-50,000,000** |
| | **Mandatory Decreases** | - | - | - | - | - |

| No. | Program | FY 2022 Continuing Resolution | | FY 2023 President's Budget | FY 2023+/- FY 2022 | |
|---|---|---|---|---|---|---|
| | | FTE | Budget Authority | Budget Authority | FTE | Budget Authority |
| | Net Change Discretionary | 1,541 | +6,810,175,000 | +8,087,985,000 | +312 | +1,277,810,000 |
| | Net Change Mandatory | +555 | +377,200,000 | +467,000,000 | +87 | +89,800,000 |
| | Net Change Discretionary and Mandatory | 2,096 | 7,187,375,000 | 8,554,985,000 | +399 | +1,367,610,000 |
| | Net Change Discretionary and Mandatory | 2,096 | 7,187,375,000 | 8,554,985,000 | +399 | +1,367,610,000 |

## Budget Authority by Activity
(dollars in thousands)

| | FY 2021 | FY 2022 | FY 2023 |
|---|---|---|---|
| | **Final** | **Continuing Resolution** | **President's Budget** |
| **1. PRIMARY CARE:** | | | |
| **Health Centers:** | | | |
| Health Centers | 1,554,203 | 1,562,772 | 1,718,022 |
| Health Centers Mandatory | 4,000,000 | 3,905,348 | 3,905,348 |
| Health Center Tort Claims | 120,000 | 120,000 | 120,000 |
| ***Subtotal, Health Centers*** | ***5,674,203*** | ***5,588,120*** | ***5,743,370*** |
| Free Clinics Medical Malpractice | 1,000 | 1,000 | 1,000 |
| **Subtotal, Bureau of Primary Health Care** | **5,675,203** | **5,589,120** | **5,744,370** |
| **2. HEALTH WORKFORCE:** | | | |
| **National Health Service Corps (NHSC):** | | | |
| NHSC | 119,526 | 120,000 | 210,000 |
| NHSC Mandatory | 310,000 | 292,330 | 292,330 |
| ***Subtotal, NHSC*** | ***429,526*** | ***412,330*** | ***502,330*** |
| Loan Repayment/Faculty Fellowships | 1,186 | 1,190 | 2,310 |
| **Health Professions Training for Diversity:** | | | |
| Centers of Excellence | 23,510 | 23,711 | 36,711 |
| Scholarships for Disadvantaged Students | 51,390 | 51,470 | 51,970 |
| Health Careers Opportunity Program | 14,449 | 15,000 | 18,500 |
| ***Subtotal, Health Professions Training for Diversity*** | ***89,349*** | ***90,181*** | ***107,181*** |
| Health Care Workforce Assessment | 5,646 | 5,663 | 5,663 |
| Primary Care Training and Enhancement | 48,777 | 48,924 | 53,924 |
| Oral Health Training Programs | 40,673 | 40,673 | 40,673 |
| Medical Student Education | 49,850 | 50,000 | - |
| **Interdisciplinary, Community-Based Linkages:** | | | |
| Area Health Education Centers | 43,250 | 43,250 | 43,250 |
| Geriatric Programs | 42,859 | 42,737 | 46,537 |
| Behavioral Health Workforce Development Programs | 149,207 | 149,916 | 397,374 |
| ***Subtotal, Interdisciplinary, Community-Based Linkages*** | ***235,316*** | ***235,903*** | ***487,161*** |
| **Public Health Workforce Development:** | | | |
| Public Health/Preventive Medicine | 17,000 | 17,000 | 18,000 |
| **Nursing Workforce Development:** | | | |
| Advanced Nursing Education | 80,581 | 80,581 | 105,581 |

| | FY 2021 | FY 2022 | FY 2023 |
|---|---|---|---|
| | **Final** | **Continuing Resolution** | **President's Budget** |
| Nursing Workforce Diversity | 19,843 | 19,843 | 23,343 |
| Nurse Education, Practice and Retention | 46,757 | 46,913 | 48,913 |
| Nurse Faculty Loan Program | 28,414 | 28,500 | 28,500 |
| NURSE Corps Scholarship and Loan Repayment Program | 88,116 | 88,635 | 88,635 |
| ***Subtotal, Nursing Workforce Development*** | ***263,711*** | ***264,472*** | ***269,972*** |
| Children's Hospital Graduate Medical Education | 349,297 | 350,000 | 350,000 |
| Teaching Health Center Graduate Medical Education Mandatory | 126,500 | 119,290 | 119,290 |
| *National Practitioner Data Bank (User Fees)* | *18,814* | *18,814* | *18,814* |
| Preventing Burnout in the Health Workforce | - | - | 50,000 |
| **Subtotal, Bureau of Health Workforce** | **1,675,645** | **1,654,440** | **2,055,318** |
| **3. MATERNAL & CHILD HEALTH:** | | | |
| Maternal and Child Health Block Grant | 710,545 | 712,700 | 953,700 |
| Autism and Other Developmental Disorders | 53,184 | 53,344 | 57,344 |
| Sickle Cell Service Demonstrations | 7,183 | 7,205 | 7,205 |
| Early Hearing Detection and Intervention | 17,765 | 17,818 | 17,818 |
| Emergency Medical Services for Children | 22,267 | 22,334 | 28,134 |
| Healthy Start | 127,616 | 128,000 | 145,000 |
| Heritable Disorders | 18,826 | 18,883 | 18,883 |
| Pediatric Mental Health Care Access Grants | 9,970 | 10,000 | 10,000 |
| Screening and Treatment for Maternal Depression | 5,000 | 5,000 | 10,000 |
| Poison Control Centers | 24,846 | 24,846 | 24,846 |
| Family-to-Family Health Information Centers Mandatory | 5,658 | 5,658 | 5,658 |
| **Maternal, Infant and Early Childhood Home Visiting (MIECHV):** | | | |
| MIECHV Mandatory | 377,200 | 377,200 | - |
| MIECHV Mandatory Proposed | - | - | 467,000 |
| ***Subtotal, MIECHV*** | ***377,200*** | ***377,200*** | ***467,000*** |
| **Subtotal, Maternal and Child Health Bureau** | **1,380,060** | **1,382,988** | **1,745,588** |
| **4. HIV/AIDS:** | | | |
| Emergency Relief - Part A | 655,706 | 655,876 | 665,876 |
| Comprehensive Care - Part B | 1,314,622 | 1,315,005 | 1,345,005 |
| Early Intervention - Part C | 201,079 | 201,079 | 207,079 |
| Children, Youth, Women & Families - Part D | 72,888 | 75,088 | 75,088 |
| AIDS Education and Training Centers - Part F | 33,510 | 33,611 | 33,611 |
| Dental Reimbursement Program - Part F | 13,083 | 13,122 | 13,122 |

| | FY 2021 | FY 2022 | FY 2023 |
|---|---|---|---|
| | **Final** | **Continuing Resolution** | **President's Budget** |
| Special Projects of National Significance (SPNS) | 25,000 | 25,000 | 25,000 |
| Ending HIV Epidemic Initiative | 105,000 | 105,000 | 290,000 |
| **Subtotal, HIV/AIDS Bureau** | **2,420,888** | **2,423,781** | **2,654,781** |
| **5. HEALTH SYSTEMS:** | | | |
| Organ Transplantation | 29,549 | 29,049 | 29,049 |
| Cell Transplantation Program and Cord Blood Stem Cell Bank | 48,063 | 49,275 | 49,275 |
| Hansen's Disease Center | 13,165 | 13,706 | 13,706 |
| Payment to Hawaii | 1,851 | 1,857 | 1,857 |
| National Hansen's Disease Program - Buildings and Facilities | 122 | 122 | 122 |
| **Subtotal, Health Systems Bureau** | **92,750** | **94,009** | **94,009** |
| **6. RURAL HEALTH:** | | | |
| Rural Health Policy Development | 11,043 | 11,076 | 11,076 |
| Rural Health Outreach Grants | 82,153 | 82,500 | 90,000 |
| Rural Hospital Flexibility Grants | 55,442 | 55,609 | 57,509 |
| State Offices of Rural Health | 12,462 | 12,500 | 12,500 |
| Radiation Exposure Screening and Education Program | 1,828 | 1,834 | 2,734 |
| Black Lung | 11,565 | 11,500 | 12,190 |
| Rural Communities Opioid Response | 109,670 | 110,000 | 165,000 |
| Rural Residency Planning and Development | 10,468 | 10,500 | 12,700 |
| Rural Health Clinic Behavioral Health Initiative | | | 10,000 |
| **Subtotal, Federal Office of Rural Health Policy** | **294,631** | **295,519** | **373,709** |
| **7. PROGRAM MANAGEMENT** | 154,834 | 155,300 | 168,971 |
| **8. FAMILY PLANNING** | 285,619 | 286,479 | 400,000 |
| **9. 340B DRUG PRICING PROGRAM/OFFICE OF PHARMACY AFFAIRS** | 10,207 | 10,238 | 17,238 |
| **10. TELEHEALTH** | 33,898 | 34,000 | 44,500 |
| **Total, HRSA Discretionary Budget Authority** | **7,196,763** | **7,218,434** | **8,526,244** |
| **FTE** (excludes VICP and CICP) | 2,293 | 2,293 | 2,846 |

# Appropriations History Table

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| **FY 2014** | | | | |
| General Fund Appropriation: | | | | |
| Base | 6,015,039,000 | | 6,309,896,000 | 6,054,378,000 |
| Advance | | | | |
| Supplemental | | | | |
| Rescissions | | | | |
| Transfers | | | | -15,198,000 |
| Subtotal | 6,015,039,000 | | 6,309,896,000 | 6,039,180,000 |
| **FY 2015** | | | | |
| General Fund Appropriation: | | | | |
| Base | 5,292,739,000 | | 6,093,916,000 | 6,104,784,000 |
| Advance | | | | |
| Supplemental | | | | |
| Rescissions | | | | |
| Transfers | | | | |
| Subtotal | 5,292,739,000 | | 6,093,916,000 | 6,104,784,000 |
| **FY 2016** | | | | |
| General Fund Appropriation: | | | | |
| Base | 6,217,677,000 | 5,804,254,000 | 5,987,562,000 | 6,139,558,000 |
| Advance | | | | |
| Supplemental | | | | |
| Rescissions | | | | |
| Transfers | | | | |
| Subtotal | 6,217,677,000 | 5,804,254,000 | 5,987,562,000 | 6,139,558,000 |
| **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 |

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

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| **FY 2022** | | | | |
| General Fund Appropriation: | | | | |
| Base | 7,813,294,000 | 8,740,422,000 | | |
| Advance | | | | |
| Supplemental | | | | |
| Rescissions | | | | |
| Transfers | | | | |
| Subtotal | 7,813,294,000 | 8,740,422,000 | | |
| **FY 2023** | | | | |
| General Fund Appropriation: | | | | |
| Base | 8,485,044,000 | | | |
| Advance | | | | |
| Supplemental | | | | |
| Rescissions | | | | |
| Transfers | | | | |
| Subtotal | 8,485,044,000 | | | |

# Appropriations Not Authorized by Law[19]

| HRSA Program | Last Fiscal Year of Authorization | Last Authorization Level | Appropriations in Last Year of Authorization | Appropriations in FY 2022 |
|---|---|---|---|---|
| School-Based Health Centers (Facilities Construction) –P.L. 111-148, Section 4101(a) School Based Health Centers - Operations PHS Act, Section 399Z-1, as added by P.L. 111-148, Section 4101(b) | 2013 | $50,000,000 | $47,450,000 | --- |
| NHSC – PHS Act, Sections 331-338 Authorization of appropriations ("Field"): Section 338(a) | 2012 | Such Sums As May Be Necessary | --- | --- |
| Nursing Workforce Development<br>• Comprehensive Geriatric Education – PHS Act, Section 865 | 2014 | Such Sums As May Be Necessary | $4,350,000 | --- |
| Emergency Relief - Part A –<br>PHS Act, Sections 2601-10, as amended by P.L. 106-345; as amended by P.L. 109-415; as amended by P.L. 111-87 | 2013 | $789,471,000 | $649,373,000 | $655,876,000 |
| Comprehensive Care - Part B –<br>PHS Act, Sections 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87 | 2013 | $1,562,169,000 | $1,314,446,000 | $1,315,005,000 |
| Early Intervention Services – Part C –<br>PHS Act, Sections 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87 | 2013 | $285,766,000 | $205,544,000 | $201,079,000 |
| Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D –<br>PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87 | 2013 | $87,273,000 | $72,395,000 | $75,088,000 |
| Special Projects of National Significance - Part F –<br>PHS Act, Section 2691, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87 | 2013 | $25,000,000 | $25,000,000 | $25,000,000 |
| AIDS Education and Training Centers - Part F – PHS Act, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87 | 2013 | $42,178,000 | $33,275,000 | $33,611,000 |
| Dental Reimbursement Program - Part F – PHS Act, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415, as amended by P.L.111-87 | 2013 | $15,802,000 | $12,991,000 | $13,122,000 |
| Minority AIDS Initiative – Part F – PHS Act section 2693 | 2013 | -- | Varies by Part | -- |

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

| HRSA Program | Last Fiscal Year of Authorization | Last Authorization Level | Appropriations in Last Year of Authorization | Appropriations in FY 2022 |
|---|---|---|---|---|
| Early Hearing Detection and Intervention:<br>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 | 2022 | $19,522,758 | $17,818,000 | $17,818,000 |
| Heritable Disorders:<br>PHS Act, Section 1109-1112 and 1114, as amended by P.L. 106-310, Section 2601; as amended by P.L. 110-204, Section 2; as amended by P.L. 110-237, Section 1; as amended by P.L. 113-240, Section 10 (see PHS Act, Section 1117- relating to authorization levels for FY 2015 through 2019) | 2019 | $11,900,000 (Sections 1109-1112); $8,000,000 (Section 1113) (through FY 2019) | $18,883,000 | $18,883,000 |
| Pediatric Mental Health Care Access Grants:<br>PHS Act, Section 330M, as added by P.L. 114-255, Section 10002 | 2022 | $9,000,000 (each of FY 2021 through FY 2022) | $10,000,000 | $10,000,000 |
| Screening and Treatment for Maternal Depression:<br>PHS Act, Section 317L-1, as added by P.L. 114-255, Section 10005 | 2022 | $5,000,000 (each of FY 2021 through FY 2022) | $5,000,000 | $5,000,000 |
| Maternal, Infant and Early Childhood Visiting (MIECHV) Program:<br>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) | 2022 | $400,000,000 (each of FY 2021 through FY 2022) | $377,200,000[20] | $377,200,000[21] |
| Organ Transplantation –<br>42 U.S.C. 273-274g, PHS Act, Sections 371-378, as amended by P.L. 108-216, P.L. 109-129, P.L. 110-144, P.L. 110-413, and P.L. 113-51 | Annual appropriations constitute authorizations (Section-specific appropriations for sections 377, 377A, and 377B expired September 30, 2009) | Section 377— $5,000,000<br>Section 377A— Such Sums As May Be Necessary<br>Section 377B— Such Sums As May Be Necessary | $2,767,000 | $29,049,000 |

[20] Post-sequestration funding level.
[21] Post-sequestration funding level.

| HRSA Program | Last Fiscal Year of Authorization | Last Authorization Level | Appropriations in Last Year of Authorization | Appropriations in FY 2022 |
|---|---|---|---|---|
| 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 | $55,609,000 |
| 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 | $286,479,000 |

# PRIMARY HEALTH CARE

# TAB

# PRIMARY HEALTH CARE

## Health Centers

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $1,554,203,000 | $1,562,772,000 | $1,718,022,000 | +$155,250,000 |
| **Current Law Mandatory Funding** | $4,000,000,000 | $3,905,348,000 | $3,905,348,000[22] | --- |
| **FTCA Program** | $120,000,000 | $120,000,000 | $120,000,000 | --- |
| **Total** | **$5,674,203,000** | **$5,588,120,000** | **$5,743,370,000** | **+$155,250,000** |
| **FTE** | 584 | 584 | 662 | +78 |

Authorizing Legislation: Public Health Service Act, Section 330, as amended by Public Law 111-148, Section 5601; Public Law 111-148, Section 10503, as amended by Public Law 114-10, Section 221; Public Health Service Act, Section 224, as added by Public Law 102-501 and amended by Public Law 104-73; Public Law 114-22; Public Law 116-260.

FY 2023 Authorization: FY 2022 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 2023 Community Health Center Fund Authorization.....$4 billion

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

**Program Description and Accomplishments**

For more than 50 years, health centers have delivered affordable, accessible, quality, and cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become an essential primary care provider for millions of people across the country. Health centers advance a model of coordinated, comprehensive, and patient-centered primary health care, integrating a wide range of medical, dental, behavioral health, and patient support/enabling services. Today, approximately 1,400 health centers operate over 14,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

In 2020, health centers served 28.6 million patients, a reduction of approximately 1.2 million patients, or 4 percent, due to the impact of the COVID-19 pandemic on the operations of health centers nationwide. Even through these challenges, health centers served one in every eleven

[22] FY 2022 and FY 2023 levels reflect the post-sequestration funding amount.

people living in the United States, providing approximately 114 million patient visits (a 7% decrease), at an average cost of $1,157 per patient (including Federal and non-Federal sources of funding). In 2020, about 42 percent of all health centers served rural areas providing care to nearly 9 million patients, about one in 5 people living in rural areas. Patient services are supported through Federal Health Center grants, Medicaid, Medicare, Children's Health Insurance Program (CHIP), other third party payments, self-pay collections, other Federal grants, and State/local/other resources.

Health centers 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, treatment and vaccinations. In 2020, health centers reported a nearly 6,000 percent growth in virtual visits from the previous year, from 478,000 to 28.5 million, with more than 99 percent of health centers offering virtual primary health care services.

Not all primary care services were impacted equally by COVID-19. While health centers reported an increase of 1.8 million mental health patient visits which was 15 percent over 2019 levels, decreases were reported in medical visits (3.8 percent), enabling services (9.6 percent), vision care (27.9 percent), and oral health (34.4 percent).

Through the American Rescue Plan Act, HRSA is providing one-time funding to support health centers in responding to and mitigating the spread of COVID-19, and enhancing health care services and infrastructure. Improvements made with these funds will help health centers to continue meeting the needs of their patient population through the pandemic by providing equitable access to COVID-19 vaccination, testing, and treatment, and supporting critical preventive and primary health care services, as well as health center construction, renovation, modernization and other facility improvements.

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

In addition, HRSA provided at-home self-tests, point of care testing equipment and supplies, and NIOSH-approved N95 respirator masks for health center patients and individuals in their communities. HRSA, in partnership with HHS partners, also launched 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. 77 percent of health centers are currently recognized by national accrediting organizations as Patient Centered Medical Homes– an advanced model of patient-centered primary care that emphasizes quality and care

coordination through a team-based approach to care. Despite treating a sicker, poorer, and more diverse population than other health care providers, health centers exceeded numerous national averages and benchmarks in 2020 including the Healthy People 2020 goal for dental sealant services. Overall, 90 percent of health centers met or exceeded Healthy People 2020 goals for at least one clinical measure in 2020[23]. Health centers also reduce costs to health systems; the health center model of care has been shown to reduce the use of costlier providers of care, such as emergency departments and hospitals[24].

*Populations served:* Health centers serve a diverse patient population. In 2020:

- People of all ages: Approximately 28 percent of patients were children (age 17 and younger), a 14.5 percent decrease from 2019; over 10 percent were 65 or older, an increase of 2.3 percent. Adult patients (18-64) remained relatively steady.

- People in poverty: Approximately 91 percent of health center patients are individuals or families living at or below 200 percent of the Federal Poverty Guidelines as compared to approximately 26 percent of the U.S. population as a whole.

- People without and with health insurance: About 22 percent were without health insurance. Those patients that are insured are covered by Medicaid, Medicare, other public insurance, or private insurance.

- Special Populations: Some health centers receive specific funding to provide primary care services for certain special populations including individuals and families experiencing homelessness, agricultural workers, those living in public housing, and Native Hawaiians. Health centers served nearly 1.3 million individuals experiencing homelessness, almost 1 million agricultural workers and their families, approximately 5.2 million people living in or near public housing and over 7,000 Native Hawaiians.

    - Health Care for the Homeless Program: Homelessness continues to affect rural as well as urban and suburban communities in the United States. According to the Department of Housing and Urban Development's 2018 Annual Homeless Assessment Report to Congress, over 1.4 million people experienced sheltered homelessness. In 2020, HRSA-funded health centers provided primary care services for nearly 1.3 million persons in supportive housing and/or experiencing homelessness. 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 on the street, in shelters, or in transitional housing.

    - Migrant Health Center Program: HRSA-funded health centers provided primary care services for nearly 1 million migratory and seasonal agricultural workers and their families. It is estimated that there are approximately 2.8 million migratory

[23] HP2020 objectives: https://www.healthypeople.gov/2020/topics-objectives
[24] 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

and seasonal agricultural workers in the United States (2016 LSC Agricultural Worker Population Estimate Update). The Migrant Health Center Program supports comprehensive, integrated primary care services for agricultural workers and their families with a particular focus on occupational health and safety.

- Public Housing Primary Care Program: The Public Housing Primary Care Program increases access for residents of public housing to comprehensive, integrated primary care services. Health centers deliver care at locations on the premises of public housing developments or immediately accessible to residents. HRSA-funded health centers provided primary care services for nearly 5.2 million people living in or near public housing. The Public Housing Primary Care Program provides services that are responsive to identified needs of the residents and in coordination with public housing authorities.

- Native Hawaiian Health Care Program: The Native Hawaiian Health Care Program, funded within the Health Center appropriation, improves the health of Native Hawaiians by making health education, health promotion, and disease prevention services available through a combination of outreach, referral, and linkage mechanisms. Services provided include nutrition programs, screening and control of hypertension and diabetes, immunizations, and basic primary care services. Native Hawaiian Health Care Systems provided medical and enabling services to over 7,000 people.

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

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

*Patient Care:* The number of health center patients served in 2020 was 28.6 million; an increase of 9.1 million, or 47 percent, above the 19.5 million patients served in 2010. Of the 28.6 million patients served and for those for whom income status is known, approximately 91 percent were at or below 200 percent of the Federal poverty level and approximately 22 percent were uninsured. Success in increasing the number of patients served has been due in large part

to the development of new health centers, new satellite sites, and expanded capacity at existing clinics.

Health centers focus on integrating care for their patients across the full range of services – not just medical but oral health, vision, behavioral health (mental health and substance use disorder services), and pharmacy. Health centers also deliver crucial services such as case management, transportation, and health education, which enable target populations to access care. Nearly 93 percent of health centers provide preventive dental services either directly or via contract. In 2020, health centers provided oral health services to approximately 5.2 million patients, an increase of almost 40 percent since 2010. In 2020, over 2.8 million people received behavioral health services at health centers, an increase of over 100 percent from 2014 to 2020 due to significant Health Center Program investments in behavioral health services.

From FY 2016 through FY 2019, HRSA invested $540 million in targeted, ongoing annual grant funding for the expansion of substance use disorder (SUD) and mental health (MH) services in health centers. An additional $300 million has been invested in one-time health center infrastructure costs that support the expansion of services. These ongoing annual investments remained in health center continuation awards in FY 2021 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. Screening for substance use disorders has increased 93 percent since 2016 with the number of patients receiving screening, brief intervention, referral and treatment (SBIRT) increasing from 716,677 in 2016 to 1,253,127 in 2020. From 2016–2020, the number of health center providers eligible to prescribe MAT increased over 390 percent (from 1,699 in 2016 to 8,362 in 2020) and the number of patients receiving MAT increased 366 percent (from 39,075 in 2016 to 181,896 in 2020).

*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 73.0 percent in 2020, meeting the program

target. Additional maternal health efforts 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 2020. In 2020, the health center rate was 8.18 percent, lower than the 2020 national rate of 8.24 percent, and has consistently been lower than the national rate during the past several years.

Health center patients, including low-income individuals, racial/ethnic minority groups, and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate health disparities. The Health Center Program began reporting data from all grantees on the control of hypertension and diabetes via its Uniform Data System in 2008. In 2020, 58 percent of adult health center patients with diagnosed hypertension had blood pressure under adequate control (less than 140/90), and 64 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 and utilizing telehealth services in 2020.

*Promoting Efficiency:* Health centers provide cost-effective, affordable, quality primary health care services. The Program's efficiency measure tracks the ratio of medical patients per medical physicians in health centers, which focuses on maximizing the overall efficiency and scope of clinical provider teams, recognizing the valuable and cost effective contributions of physician assistants, nurse practitioners, and certified nurse midwives to health center patient access to comprehensive, quality primary care services. In 2018 and 2019, the number of medical patients per physician in health centers was approximately 1,780. In 2020, the number decreased to 1,713, likely due to the impacts of COVID-19 on the total patient number in health centers.

*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.

- 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 has 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 serve as an essential pathway to accessing mental health and maternal health care. Among female patients of reproductive age, 40.8% of patients reported depression; 28.8% reported generalized anxiety; and 15.2% met the criteria for serious psychological distress. Furthermore, patients with depression had two to three times higher odds of experiencing co-occurring physical health conditions. Lin SC, Tyus N, Maloney M, Ohri B, Sripipatana A. Mental health status among women of reproductive age from underserved communities in the United States and the associations between depression and physical health. A cross-sectional study. PLoS One. 2020 Apr

8;15(4):e0231243. doi: 10.1371/journal.pone.0231243. PMID: 32267903; PMCID: PMC7141664.

- Health centers in urban areas were more likely to provide >30% of visits virtually than were those in rural areas. Telehealth is a promising approach to promoting and expanding access to care, especially in the South and rural areas. Demeke HB, Pao LZ, Clark H, et al. Telehealth Practice Among Health Centers During the COVID-19 Pandemic — United States, July 11–17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1902–1905. DOI: http://dx.doi.org/10.15585/mmwr.mm6950a4

- 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:* The Health Center Program administers the FTCA Program, under which participating health centers, their employees and eligible contractors may be deemed to be Federal employees qualified for medical malpractice liability protection under the FTCA. As Federal employees, they are immune from suit for medical malpractice claims while acting within the scope of their employment. The Federal Government assumes responsibility for such claims. In addition, the FTCA Program supports risk mitigation activities, including reviews of risk management plans and sites visits as well as risk management technical assistance and resources to support health centers. The enactment of the 21st Century Cures Act in December of 2016 extended liability protections for volunteers at deemed health centers under the FTCA Program. In accordance with the statute, HRSA implemented FTCA coverage for volunteers in FY 2018. Nearly 300 volunteers were covered under the FTCA Program in FY 2020. Overall, in FY 2018, 110 claims were paid totaling $109.3 million, in FY 2019, 150 claims were paid totaling $135 million, and in FY 2020, 117 claims were paid totaling $93.5 million. As the number of health center patients continues to grow, it is projected that the amount of annual claims paid will increase through FY 2023.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $1,616,720,000 |
| FY 2019 Mandatory | $4,000,000,000 |
| FY 2020 | $1,625,522,000 |
| FY 2020 Mandatory | $4,000,000,000 |
| FY 2021 Final | $1,674,203,000 |
| FY 2021 Mandatory | $4,000,000,000 |
| FY 2022 CR | $1,682,772,000 |
| FY 2022 Mandatory | $3,905,348,000[25] |

[25] FY 2022 reflects the post-sequestration amount of current law mandatory funding.

| FY | Amount |
|---|---|
| FY 2023 President's Budget | $1,838,022,000 |
| FY 2023 President's Budget Mandatory | $3,905,348,000[26] |

**Budget Request**

The FY 2023 Budget request for the Health Center Program is $1.8 billion in discretionary resources and includes $3.9 billion in mandatory funding[27], for a total request of $5.7 billion, which is an increase of $155.3 million above the FY 2022 Continuing Resolution level. The FY2021 Omnibus and COVID Relief and Response Act, provided mandatory resources of $4.0 billion for each fiscal year through FY 2023. The Administration continues to be committed to working with the Congress to advance the President's goal of doubling the Federal investment in community health centers, which would help reduce health disparities by expanding access to care.

In FY 2023, the Health Center Program will provide care for approximately 30.0 million patients. The FY 2023 Budget provides $85.0 million to support the expansion of early childhood screening and development services in 425 health centers. These awards will ensure the placement of early childhood development experts in each recipient health center, who in coordination with the primary care team will identify whether children are reaching development milestones, address parents' questions and concerns regarding child development, and help connect families to additional services when needed. Many children in the U.S., especially children served by health centers, face significant barriers to accessing high quality screening and development services. Expanding early childhood development services provided by health center awardees will increase the likelihood of children succeeding in school once they start kindergarten.

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 also assists with responding quickly to HIV cluster detection efforts.[28] 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 2020, the first year of the Initiative, HRSA provided $54.0 million in resources to 195 health centers that received Health Center/Ryan White Program funding and/or were located in close proximity to a Ryan White Program where no jointly funded health center currently existed in the target jurisdiction. In FY 2021, HRSA awarded approximately $48.0 million to support the participation of 108 additional health centers in the targeted jurisdictions. These health centers have reported that over 151,000 patients received PrEP services in the first year of the EHE Initiative.

[26] FY 2023 reflects the post-sequestration amount of current law mandatory funding.
[27] FY 2023 current law mandatory funding is subject to sequestration.
[28] Details on the PrEP Delivery Program to End the HIV Epidemic are included in Mandatory Proposals section of the Departmental Management Congressional Justification.

In FY 2023, the Budget includes $172 million, an increase of $70.0 million above the FY 2022 Continuing Resolution level, which will support participation of an additional 100 health centers. The Budget will support the total participation of approximately 400 health centers in the 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 Budget will ensure that current health centers can also continue to provide essential primary health care services to their patient populations, including continuation of supplemental awards initiated in FY 2016 through FY 2019 targeting mental health services and substance use disorder services focusing on the treatment, prevention, and/or awareness of opioid abuse. The FY 2023 Budget Request also supports $120.0 million for the FTCA Program, which is equal to the FY 2022 Continuing Resolution 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. In particular, health centers emphasize coordinated primary and preventive services that promote reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities, and other underserved populations. Health centers place emphasis on the coordination and comprehensiveness of care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices, including HIT. The health center model also overcomes geographic, cultural, linguistic, and other barriers through a team-based approach to care that includes physicians, nurse practitioners, physician assistants, nurses, dental providers, midwives, behavioral health care providers, social workers, and health educators.

Health centers also reduce costs to health systems; the health center model of care has been shown to reduce the use of costlier providers of care, such as EDs and hospitals. In 2016, a study published in the American Journal of Public Health evaluated the total annual health care use and total health care spending of Medicaid (fee-for-service) patients seen at health centers versus those seen at non-health center settings.[29] 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.

The FY 2023 Request supports the Health Center Program's achievement of its performance targets, including goals on access to affordable, accessible, quality, and cost-effective primary health care services, and the improvement of health outcomes and quality of care. The Health Center Program has established ambitious targets for FY 2023 and beyond. For low birth

[29] 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

weight, the Program seeks to be below the national rate. This is ambitious because health centers continue to serve a higher risk prenatal population than represented nationally in terms of socio-economic, health status and other factors that predispose health center patients to greater risk for LBW and adverse birth outcomes. The FY 2023 target for the program's hypertension measure is that 64 percent of adult patients with diagnosed hypertension will have blood pressure under adequate control. The FY 2023 target for the program's diabetes management measure is 67 percent of adult patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent).

The Health Center Program will continue to promote efficient, value-based care, and aims to keep the ratio of medical patients per medical physicians at approximately 1,775 patients. The FY 2023 Request also supports efforts to improve the value, quality, and program integrity in all HRSA-funded programs that deliver direct health care. Health centers annually report on a core set of clinical performance measures that are consistent with Healthy People 2020, and include: immunizations; prenatal care; cancer screenings; cardiovascular disease/hypertension; diabetes; weight assessment and counseling for children and adolescents; adult weight screening and follow up; tobacco use assessment and counseling; depression screening and follow-up; dental sealants; asthma treatment; coronary artery disease/cholesterol; ischemic vascular disease/aspirin use; and colorectal cancer screening. In addition to tracking core clinical indicators, health centers report on health outcome measures (low birth weight, diabetes, and hypertension) by race/ethnicity in order to demonstrate progress towards eliminating health disparities in health outcomes.

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

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

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

The Health Center Program will continue to coordinate with CMS to jointly review section 1115 Medicaid Demonstration Waivers. The Program will continue to work closely with the

Department of Justice on the FTCA Program. Additionally, the proposed Budget supports coordination with programs in the Departments of Housing and Urban Development, Education, and Justice.

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

**Outcomes and Outputs Tables**

| Measure | Year and Most Recent Result /Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 Target +/- FY 2022 Target |
|---|---|---|---|---|
| 1010.01: Number of patients served by health centers (Output) | FY 2020: 28.6 million Target: 28.6 million (Target Met) | 29.8 million | 30.0 million | +0.2 million |
| 1010.02: Percentage of grantees that provide the following services either on-site or by paid referral: (b) Preventive Dental Care (Output) | FY 2020: 93% Target: 90% (Target Exceeded) | 90% | 91% | +1 percentage point |
| 1010.03: Percentage of grantees that provide the following services either on-site or by paid referral: (c) Mental Health/Substance Use Disorder (Output) | FY 2020: 97% Target: 88% (Target Exceeded) | 93% | 97% | +4 percentage point |
| 1010.04: Number of HIV tests conducted (Output) | FY 2020: 2.5 million Target: 2.8 million (Target Not Met) | 2.8 million | 3.0 million | +0.2 million |
| 1010.05: Number of medical patients per medical physician in health centers | FY 2020: 1,713 Target: 1,775 (Target Not Met) | 1,775 | 1,775 | Maintain |

| Measure | Year and Most Recent Result /Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 Target +/- FY 2022 Target |
|---|---|---|---|---|
| 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 2020: 8.18% Target: Below national rate (8.24%) (Target Met) | 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 2020: 58% Target: 63% (Target Not Met) | 63% | 64% | +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 2020: 64% Target: 67% (Target Not Met) | 67% | 67% | Maintain |
| 1010.09: Percentage of pregnant health center patients beginning prenatal care in the first trimester (Output) | FY 2020: 73% Target: 73% (Target Met) | 73% | 73% | Maintain |
| 1010.10: Percentage of Health Center patients who are at or below 200 percent of poverty (Output) | FY 2020: 91% Target: 91% (Target Met) | 91% | 91% | Maintain |
| 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 |

**Grants Awards Table**

| | FY 2021<br>Final | FY 2022<br>Continuing Resolution | FY 2023<br>Budget Level |
|---|---|---|---|
| **Number of Awards** | 1,378 | 1,375 | 1,375 |
| **Average Award** | $3.4 million | $3.4 million | $3.4 million |
| **Range of Awards** | $400,000 – $23 million | $400,000 – $23 million | $400,000 – $23 million |

## Free Clinics Medical Malpractice

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $1,000,000 | $1,000,000 | $1,000,000 | --- |
| **FTE** | --- | --- | --- | --- |

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

FY 2023 Authorization: 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.

Allocation Method ..... Other

**Program Description and Accomplishments**

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

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

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

*Increasing Access:* In FY 2020, 11,291 health care providers received Federal malpractice insurance through the Free Clinics Medical Malpractice Program, exceeding the Program target. In FY 2018, 239 clinics operated with FTCA deemed clinicians; in FY 2019, 236 clinics participated; and in FY 2020, 230 clinics participated, exceeding the program target in each year.

*Promoting Efficiency:* The Free Clinics Medical Malpractice Program is committed to improving overall efficiency by controlling the Federal administrative costs necessary to deem each provider. By restraining these annual administrative costs, the Program is able to provide an increasing number of clinicians with malpractice coverage, thus building the free clinic workforce capacity nationwide and increasing access to care for the target populations served by these clinics. In FY 2018 costs were $38 per provider; in FY 2019 costs were $22 per provider, and in FY 2020 costs were $38 per provider. In each year, the Program performance target has been exceeded.

In FY 2020, there were no paid claims under the Free Clinics Medical Malpractice Program. There is 1 claim currently outstanding, and the Program Fund has a current balance of approximately $3.9 million.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $1,000,000 |
| FY 2020 | $1,000,000 |
| FY 2021 Final | $1,000,000 |
| FY 2022 CR | $1,000,000 |
| FY 2023 President's Budget | $1,000,000 |

**Budget Request**

The FY 2023 Budget for the Free Clinics Medical Malpractice Program is $1.0 million, which is equal to the FY 2022 Continuing Resolution level. The request will support the Program's continued achievement of its performance targets addressing its goal of maintaining access and capacity in the health care safety net. The funding request also includes costs associated with information technology and other program support costs.

Targets for FY 2023 focus on maintaining FY 2022 target levels for the number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage at 11,000, while also maintaining the number of free clinics operating with FTCA deemed clinicians at 220. The Program will also continue to promote efficiency by restraining growth in the annual Federal administrative costs necessary to deem each provider, with a target of $75 administrative cost per provider in FY 2023.

The FY 2023 request will also support the Program's continued coordination and collaboration with related Federal programs in order to further leverage and promote efforts to increase the capacity of the health care safety net. Areas of collaboration include coordination with the Health Center FTCA Program, also administered by HRSA, to share program expertise. In

addition, the two programs control costs by sharing a contract to process future claims, and by providing technical support and outreach. The Program will coordinate with non-profit free clinic-related umbrella groups on issues related to program information dissemination and outreach and will continue to collaborate with the Department of Justice (DOJ) and the HHS Office of General Counsel (HHS/OGC) to assist in drafting items including deeming applications and related policies. The Program continues to work with the HHS/OGC to answer legal technical assistance issues raised by free clinics in the Program and clinics interested in joining the Program.

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

**Outcomes and Outputs Tables**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2022 Target +/- FY 2021 Target |
|---|---|---|---|---|
| 1020.01: Number of free clinic health care providers deemed eligible for FTCA malpractice coverage (Output) | FY 2020: 11,291 Target: 11,000 (Target Exceeded) | 11,000 | 11,000 | Maintain |
| 1020.02: Patient visits provided by free clinics sponsoring FTCA deemed clinicians (Output) | FY 2020: 481,228 Target: 475,000 (Target Exceeded) | 500,000 | 500,000 | Maintain |
| 1020.03: Number of free clinics operating with FTCA deemed clinicians (Output) | FY 2020: 230 Target: 220 (Target Exceeded) | 220 | 220 | Maintain |
| 1020.04: Administrative costs of the program per FTCA covered provider (Efficiency) | FY 2020: $38 Target: $75 (Target Exceeded) | $75 | $75 | Maintain |

# Health Workforce TAB

# HEALTH WORKFORCE

## National Health Service Corps (NHSC)

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $119,526,000 | $120,000,000 | $210,000,000 | +$90,000,000 |
| **Mandatory Funding** | $310,000,000 | $292,330,000 | $292,330,000 | --- |
| **Total** | $429,526,000 | $412,330,000 | $502,330,000 | +$90,000,000 |
| **FTE** | 238 | 238 | 273 | +35 |

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

FY 2023 Authorization (discretionary): Authorized for FY 2023 (and each subsequent year), based on previous year's funding, subject to adjustment formula

FY 2023 Authorization (mandatory) .....$310,000,000

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

**Program Description and Accomplishments:**

Since its inception in 1972, the National Health Service Corps (NHSC) has worked to 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). As of September 30, 2021, there were 6,272 primary care HPSAs, 5,678 dental HPSAs, and 5,391 mental health HPSAs.

The National Health Service Corps provides scholarships and loan repayment for clinicians who commit to practice in underserved communities. NHSC-approved sites provide care to individuals regardless of their ability to pay.

As of September 30, 2021, there are nearly 20,000 primary care medical, dental, and mental and behavioral health practitioners – the largest cohort ever – serving in the NHSC across nearly 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 Native Alaska health clinics, rural health clinics, school-based clinics, and community mental health centers.

The American Rescue Plan (ARP) Act in FY 2021 appropriated $800 million to the NHSC, $700 million of which is for the NHSC Scholarship Program (SP), Loan Repayment Programs (LRPs), and Students to Service (S2S) LRP , which are described below. These funds enabled the NHSC

to award all qualified applicants to the NHSC SP, LRPs, and S2S LRP; the remainder of these funds will be fully obligated in FY 2022. The ARP Act provided the remaining $100 million to the State Loan Repayment Program (SLRP) (see below); these funds will support a new four-year grant cycle beginning in FY 2022.

The National Health Service Corps programs include:

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

***NHSC Loan Repayment Program (LRP):*** The NHSC LRP offers fully-trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a HPSA. In exchange for an initial two years of service, loan repayers receive up to $50,000 in loan repayment assistance. The NHSC LRP recruits clinicians as they complete training and are immediately available for service, as well as seasoned professionals seeking an opportunity to serve in the nation's underserved communities.

The NHSC is collaborating with several HRSA funded workforce programs to bolster the primary care and behavioral health workforce in rural and underserved communities.

***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. Providers receive loan repayment assistance to reduce their educational financial debt in exchange for service at SUD treatment facilities.

Eligible SUD providers include:

- Allopathic/Osteopathic physicians, nurse practitioners, physician assistants with Drug Addiction Treatment Act 2000 Waivers;
- Licensed or certified health professionals providing SUD services; and
- Licensed primary care and mental & behavioral health professionals.

***NHSC Rural Community LRP:*** A portion of the 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 within the Federal Office of Rural Health Policy (FORHP) to provide evidence-based substance use treatment, assist in recovery, and to prevent overdose deaths across the nation.

Both the NHSC SUD Workforce LRP and the NHSC Rural Community LRP will continue to make FY 2023 awards to clinicians who are combating the opioid crisis in rural and underserved communities

***NHSC and the Indian Health Service (IHS):*** Funding has been directed to support awards in the aforementioned NHSC LRPs to both fully-trained medical, nursing, and dental clinicians, behavioral/mental health clinicians, and SUD providers, to deliver health care services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (ITUs). Federal Indian Health Service Clinics, Tribal Health Clinics, Urban Indian Health 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.

***NHSC Students to Service (S2S) LRP:*** The NHSC S2S LRP provides loan repayment assistance of up to $120,000 to allopathic and osteopathic medical students, certified nurse midwives, nurse practitioners, physician assistants, and dental students 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. This program was established with the goal of increasing the number of physicians, certified nurse midwives, nurse practitioners, physician assistants and dentists in the NHSC pipeline.

***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 will continue to support SLRP grantees through additional flexibilities authorized by the American Rescue Plan 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 will provide further incentives for states to participate in the program.

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

**NHSC Student Pipeline by Program as of 09/30/2021**

| Programs | Students |
|---|---|
| Scholarship Program | 2,043 |
| Students to Service Program | 480 |
| **Total** | **2,523** |

**NHSC Student Pipeline by Discipline as of 09/30/2021**

| Disciplines | Students |
|---|---|
| Allopathic/Osteopathic Physicians | 1,054 |
| Dentists | 630 |
| Nurse Practitioners | 280 |
| Physician Assistants | 511 |
| Certified Nurse Midwives | 48 |
| **Total** | **2,523** |

**NHSC Field Strength by Program as of 09/30/2021**

| Programs | Clinicians |
|---|---|
| Scholarship Program Clinicians | 671 |
| Loan Repayment Program Clinicians | 12,321 |
| State Loan Repayment Program Clinicians | 2,246 |
| SUD Workforce Loan Repayment Program Clinicians | 3,066 |
| Rural Community Loan Repayment Program Clinicians | 1,226 |
| Students to Service Loan Repayment Program Participants | 454 |
| **Total** | **19,984** |

**NHSC Field Strength by Discipline as of 09/30/2021**

| Disciplines | Clinicians |
|---|---|
| Allopathic/Osteopathic Physicians | 2,622 |
| Dentists | 1,750 |
| Dental Hygienists | 467 |
| Nurse Practitioners | 3,833 |
| Physician Assistants | 1,542 |
| Nurse Midwives | 241 |
| Mental and Behavioral Health Professionals | 9,346 |
| Other State Loan Repayment Program Clinicians | 183 |
| **Total** | **19,984** |

**Average NHSC New Award by Program as of 09/30/2021**

| Program | Average Award Amount |
|---|---|
| Scholarship Program | $245,323 |
| Students to Service Loan Repayment Program | $105,149 |
| Loan Repayment Programs | $40,906 |

The 2-year retention rate among NHSC participants who completed their service obligation in FY 2019 is 82 percent. The 1-year retention rate among NHSC participants who completed their service obligation in FY 2020 is 84 percent. The Health Workforce Clinician Dashboard calculates retention rates for NHSC providers.[30] The Clinician Dashboard uses National Provider Identifier numbers from the Centers for Medicare and Medicaid Services as a baseline, in conjunction with other data sources, to determine the current practice locations of providers who previously served in the NHSC allowing HRSA to calculate and provide a more accurate retention rate that is not dependent on survey response rates.

**Eligible Entities:**

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

For all of the NHSC LRPs, participants must be practicing in a NHSC-eligible discipline with qualified student loan debt for education that led to their degree

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

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

For the NHSC S2S LRP, participants must be enrolled as a full-time student in the final year at a fully accredited medical school located in an eligible allopathic or osteopathic degree program, a certified nurse midwifery, nurse practitioner, physician assistant school or school of dentistry. Medical students must be planning to complete an accredited primary medical care residence in an NHSC-approved specialty.

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

[30] https://data.hrsa.gov/topics/health-workforce/clinician-dashboards.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 Discretionary | $120,000,000 |
| FY 2019 Current Law Mandatory | $310,000,000 |
| FY 2020 Enacted Discretionary | $120,000,000 |
| FY 2020 Current Law Mandatory | $310,000,000 |
| FY 2021 Discretionary Enacted | $119,526,000 |
| FY 2021 Current Law Mandatory | $310,000,000 |
| FY 2022 Discretionary CR | $120,000,000 |
| FY 2022 Current Law CR | $292,330,000[31] |
| FY 2023 Discretionary Request | $210,000,000 |
| FY 2023 Current Law Mandatory | $292,330,000[32] |

**Budget Request**

The FY 2023 Budget Request for the NHSC of $502.3 million is $90.0 million above the FY 2022 Continuing Resolution level. This request will fund approximately 98 new and 51 continuation scholarship awards, and 3,898 new and 3,416 continuation loan repayment awards, with a priority of substance use disorder Workforce LRP awards, and 168 Student to Service loan repayment awards. The request includes an additional $60.0 million for loan repayment for clinicians to provide opioid and substance use disorder treatment, and an increase of $25 million specifically for mental and behavioral health providers, including peer support specialists, providers in crisis centers. The request also includes an additional $5.0 million for Maternity Care Target areas to implement requirements contained in the Improving Access to Maternity Care Act.

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.

[31] FY 2022 reflects the post-sequestration amount.
[32] *Ibid.*

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target[33] | FY 2023 Target +/- FY 2022 Target |
|---|---|---|---|---|
| 2010.01: Default rate of NHSC Scholarship and Loan Repayment Program participants. (Efficiency) | FY 2021: 1.0% Target: < 2.0% (Target Exceeded) | ≤ 2.0% | ≤ 2.0% | --- |
| 2010.02: Number of individuals served by NHSC clinicians (Outcome) | FY 2021: 20.98 Million Target: 14.8 Million (Target Exceeded) | 20.73 million | 15.71 million | -5.02 million |
| 2010.03: Support field strength (participants in service) of the NHSC (Outcome) | FY 2021: 19,984 Target: 14,338 (Target Exceeded) | 19,739 | 14,966 | -4,773 |
| 2010.04: Percentage of NHSC clinicians retained in service to the underserved for at least one year beyond the completion of their NHSC service commitment. (Outcome) | FY 2020: 81% Target: 80% (Target Exceeded) | 80% | 82% | +2 percentage points |
| 2010.05: Number of NHSC sites (Outcome) | FY 2020: 18,548 Target: 18,000 (Target Exceeded) | 18,000 | 18,500 | +500 |

[33] In FY 2023, the majority of funding will provide for the continuation of the significant ARP-funded new placements that were awarded in FY 2021 and 2022, and therefore, will leave less funds available to support new loan repayment awards resulting in a decrease in a reduced Field Strength.

**Loan Repayments/Scholarships Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| Loan Repayments | $311,000,000 | $260,726,525 | $322,821,545 |
| State Loan Repayments | $19,000,000 | ---[34] | ---[35] |
| Scholarships | $37,000,000 | $31,423,881 | $31,502,904 |
| Students to Service Loan Repayment | $19,000,000 | $20,000,000 | $20,000,000 |

**NHSC Awards Table**

| **Program:** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** |
|---|---|---|---|---|---|---|---|---|---|
| Scholarships | 196 | 205 | 181 | 222 | 200 | 251 | 1,192 | 648 | 98 |
| Scholarship Continuation | 11 | 8 | 7 | 7 | 11 | 12 | 7 | 95 | 51 |
| *Scholarships Subtotal* | *207* | *213* | *188* | *229* | *211* | *263* | *1,199* | *743* | *149* |
| Loan Repayment | 2,934 | 3,079 | 2,554 | 3,262 | 4,012 | 5,963 | 6,553[36] | 6,643[37] | 3,898[38] |
| Loan Repayment Continuations | 1,841 | 2,111 | 2,259 | 2,384 | 2,385 | 2,355 | 2,277 | 3,081 | 3,416 |
| *Loan Repayment Subtotal* | *4,775* | *5,190* | *4,813* | *5,646* | *6,397* | *8,318* | *8,830* | *9,724* | *7,314* |
| State Loan Repayment | 620 | 634 | 535 | 625 | 812 | 712 | 1,628 | 611[39] | 611 |
| Students to Service Loan Repayment | 96 | 92 | 175 | 162 | 127 | 148 | 257 | 482 | 168 |
| **Total Awards** | **5,698** | **6,129** | **5,711** | **6,662** | **7,547** | **9,441** | **11,914** | **11,560** | **8,242** |

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

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

[36] Increases in awards over FY 2022 HRSA CJ reflect additional funding authorized and appropriated by the ARP Act, and projected to be expended in FY 2021 and FY 2022.

[37] *Ibid.*

[38] In FY 2023, the majority of funding will provide for the continuation of the significant ARP-funded new placements that were awarded in FY 2021 and 2022, and therefore, will leave less funds available to support new loan repayment awards resulting in a decrease in a reduced Field Strength.

**NHSC Field Strength Table as of 9/30/2021**

| **Program:** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** |
|---|---|---|---|---|---|---|---|---|---|
| Scholars | 458 | 437 | 405 | 463 | 506 | 573 | 671 | 545 | 749 |
| Loan Repayment | 8,062 | 8,593 | 8,362 | 8,849 | 10,221 | 13,122 | 16,613[40] | 16,390[41] | 11,541[42] |
| Students to Service Loan Repayment | 1,136 | 1,378 | 179 | 277 | 369 | 388 | 454 | 464 | 437 |
| State Loan Repayment | 27 | 85 | 1,233 | 1,350 | 1,957 | 2,146 | 2,246 | 2,340 | 2,239 |
| **Total Field Strength** | **9,683** | **10,493** | **10,179** | **10,939** | **13,053** | **16,229** | **19,984** | **19,739** | **14,966** |

[39] SLRP will be funded by the $100 million set aside for the program in the American Rescue Plan. It will be competed in FY 2022; this new competition will allow states to use up to 10 percent of funds on administrative costs, and not require states to provide matching funds.
[40] Increases in awards over FY 2022 HRSA CJ reflect additional funding authorized and appropriated by the ARP Act, and projected to be obligated in FY 2021 and FY 2022.
[41] *Ibid*.
[42] 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, and therefore, will leave less funds available to support new loan repayment awards resulting in a decrease in a reduced Field Strength.

## Faculty Loan Repayment Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $1,186,000 | $1,190,000 | $2,310,000 | +$1,120,000 |
| **FTE** | --- | --- | 1 | +1 |

Authorizing Legislation: Public Health Service Act, Sections 738 and 740, as amended by Public Law No: 116-136.

FY 2023 Authorization ..... $1,190,000

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

**Program Description and Accomplishments:**

The Faculty Loan Repayment Program (FLRP) is intended to support and recruit 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. In FY 2021, the FLRP made 22 new loan repayment awards. In FY 2022, the FLRP anticipates making 22 new loan repayment awards. For FY 2023, the FLRP anticipates supporting 44 new awards.

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $1,184,000 |
| FY 2020 | $1,190,000 |
| FY 2021 Final | $1,186,000 |
| FY 2022 CR | $1,190,000 |
| FY 2023 President's Budget | $2,310,000 |

**Budget Request**

The FY 2023 Budget Request for the FLRP of $2.3 million is $1.1 million above the FY 2022 Continuing Resolution level. This request will fund 40 new awards and 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.

**Loans Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| Number of Awards | 22 | 22 | 40 |

## Health Professions Training for Diversity

## Centers of Excellence

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $23,510,000 | $23,711,000 | $36,711,000 | +$13,000,000 |
| **FTE** | 1 | 1 | 4 | +3 |

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

FY 2023 Authorization .....$23,711,000

Allocation Method .....Competitive Grant

**Program Description and Accomplishments:**

Established in 1988, 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. In FY 2021, the COE Program supported 19 grantees. In FY 2022, the COE Program anticipates supporting approximately 19 grantees. In FY 2023, the COE Program anticipates supporting approximately 34 grantees, which is 15 grantees above the FY 2022 number.

In Academic Year (AY) 2020-2021, the COE Program supported 142 training programs and activities designed to prepare individuals either to apply to a health professions training program or to maintain enrollment in such programs. Award recipients offered programming focused on mentorship and academic support, as well as faculty recruitment and development. These programs provided 1,534 trainees across the country with stipend support. In addition, 69 percent of the trainees were from financially and/or educationally disadvantaged backgrounds. Additional students participated in COE Programs throughout the academic year, increasing total participation to 5,240 students

Awardees partnered with 200 health care delivery sites to provide 3,590 clinical training experiences to health professions trainees. COE clinical experiences are designed to help prepare health professions students to provide quality health care to diverse populations. The training emphasizes the importance of cultural competency and the impact of health disparities on overall health outcomes. Approximately 48 percent of training sites used by COE awardees were primary care settings and 45 percent were in medically underserved communities. Awardees also provided 56 faculty development activities, which provided training to 1,028 faculty members.

From AY 2015-2016 to AY 2019-2020,COE awardees trained over 30,000 students and reported over 16,000 program completers. Over the five-year period, the percentage of students who received academic or career advising services increased from 52 percent in AY 2015-2016 to 83 percent in AY 2019-2020 and the percentage of students who received counseling services increased from 48 percent in AY 2015-2016 to 66 percent in AY 2019-2020. Awardees supported 681 experiential training sites in 36 states or territories. COEs also trained 7,900 faculty through faculty development training programs and activities.

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $23,593,000 |
| FY 2020 | $23,711,000 |
| FY 2021 Final | $23,510,000 |
| FY 2022 CR | $23,711,000 |
| FY 2023 President's Budget | $36,711,000 |

**Budget Request**

The FY 2023 Budget Request for the COE program of $36.7 million is $13.0 million above the FY 2022 Continuing Resolution level. COEs have made significant contributions to health workforce development, more specifically as it relates to diversity in the workforce and providing culturally competent health care. Increasing COE's capacity to serve an increased number of health professions students and faculty will strengthen their ability to recruit, train, and graduate a greater number of underrepresented minority students.

In FY 2023, the additional $13 million will fund 15 more awards, for a total of 34 grant recipients. In FY 2021, the COE program made 19 awards and under the FY 2022 CR Level, the COE program will continue supporting these 19 grantees. The COE program also plans to continue supporting health workforce activities that strengthen the national capacity to produce a high quality, diverse healthcare workforce. These funds support HBCUs and other minority serving intuitions.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[43] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.20 Percent of program participants who completed pre-health professions preparation training and intend to apply to a health professions degree program (Outcome) | FY 2020: 22%<br>Target: 18%<br>(Target Exceeded) | Discontinued | Discontinued | N/A |
| 6.I.C.21 Percent of program participants who received academic retention support and maintained enrollment in a health professions degree program (Outcome) | FY 2020: 32%<br>Target: 40%<br>(Target Not Met) | 40% | 40% | Maintain |

[43] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

**Program Activity Data**

| COE Program Outputs | Year and Most Recent Result | FY 2021 Target | FY 2022 Target | FY 2023 Target |
|---|---|---|---|---|
| Number of health professions students participating in research on minority health-related issues | FY 2020: 719 | 600 | 600 | 935 |
| Number of faculty members participating in research on minority health-related issues | FY 2020: 514 | 500 | 500 | 780 |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 19 | 19 | 34 |
| **Average Award** | $1,173,423 | $1,173,423 | $1,079,735 |
| **Range of Awards** | $615,000 - $3,177,641 | $615,000 - $3,177,641 | $612,245 - $3,177,641 |

## Scholarships for Disadvantaged Students

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $51,390,000 | $51,470,000 | $51,970,000 | +$500,000 |
| **FTE** | 6 | 6 | 7 | +1 |

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

FY 2023Authorization .....$51,470,000

Allocation Method .....Competitive Grant

**Program Description and Accomplishments:**

The Scholarships for Disadvantaged Students (SDS) Program, authorized in 1989, provides grants to eligible health professions and nursing schools for use in awarding scholarships to students from disadvantaged backgrounds who have financial need, many of whom are underrepresented minorities (URMs). The program also connects students to retention services and activities that support their progression through the health professions pipeline program. In FY 2021, the SDS Program awarded 86 grantees. In FY 2022 and FY 2023, HRSA will continue to support the 86 grantees awarded in FY 2021.

In Academic Year (AY) 2020-2021, the SDS Program provided scholarships to 2,664 students from disadvantaged backgrounds. The majority of students were considered URMs in their prospective professions (65 percent). Additionally, 652 students who received SDS-funded scholarships successfully graduated from their degree programs by the end of AY 2020-2021. . In response to the COVID-19 pandemic, 58 percent of training sites offered COVID-19 related services, and 51 percent of students received COVID-19 related training. Forty-five percent of trainees received training on health equity and/or the social determinants of health.

The SDS Program continues to direct funds to educate midwives to address the national shortage of maternity care providers, and specifically to address the lack of diversity in the maternity care workforce. Additionally, in an effort to combat health workforce shortages, approximately 24 percent of funds are designated for graduate programs in behavioral and mental health and 23 percent are designated for programs in allied health.

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $48,726,000 |
| FY 2020 | $51,470,000 |
| FY 2021 Final | $51,390,000 |
| FY 2022 CR | $51,470,000 |
| FY 2023 President's Budget | $51,970,000 |

**Budget Request**

The FY 2023 Budget Request for the SDS Program of $52.0 million is $500,000 above the FY 2022 Continuing Resolution level. This request will continue to fund 86 awards. The increase will allow grantees to have more funding available to provide student scholarships. The SDS program exposes students to primary care and placements in Medically Underserved Communities (MUCs) by improving distribution, diversity, and supply of primary care providers; improving and strengthening the health profession and nursing workforce by

facilitating the entry of individuals from disadvantaged backgrounds into those professions, and improving quality and access to healthcare to individuals in MUCs.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result /Target for Recent Result / (Summary of Result)[44] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.22 Number of disadvantaged students with scholarships (Outcome) | FY 2020: 2,664<br>Target: 2,930<br>(Target Not Met) | 2,390 | 2,600 | + 210 |

**Program Activity Data**

| SDS Program Outputs | Year and Most Recent Result | FY 2021 Target | FY 2022 Target | FY 2023 Target |
|---|---|---|---|---|
| Number of URM students with scholarships | FY 2020: 1,735 | 1,500 | 1,500 | 1,500 |
| Percent of students who are URMs | FY 2020: 65% | 62% | 62% | 62% |

[44] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 86 | 86 | 86 |
| **Average Award** | $558,824 | $558,824 | $565,143 |
| **Range of Awards** | $137,676 - $650,000 | $177,794 - $650,000 | $183,154 - $650,000 |

## Health Careers Opportunity Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $14,449,000 | $15,000,000 | $18,500,000 | +$3,500,000 |
| **FTE** | --- | --- | 3 | +3 |

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

FY 2023 Authorization .....$15,000,000

Allocation Method .....Competitive Grant

**Program Description and Accomplishments**:

The National Health Careers Opportunity Program (HCOP) Academies, authorized in 1972, provides individuals from economically and educationally disadvantaged backgrounds an opportunity to develop the skills needed to successfully compete for, enter, and graduate from schools of health professions or allied health professions. . The National HCOP Academies provide a variety of academic and social supports to individuals from disadvantaged backgrounds through formal academic and research training, programming, and student enhancement or support services. 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 ultimate 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. The current five-year project period ends on August 31, 2023.

In Academic Year (AY) 2020-2021, National HCOP Academies offered 169 curricula-based structured programs and non-curricula-based stand-alone activities to 3,535 students in the health professions pipeline, almost 70 percent of whom self-identified as underrepresented minorities. This figure includes 2,887 disadvantaged trainees that Academies reached through structured programs such as the HCOP National Ambassadors Program. Forty-three percent of students

(1,515) in structured programs and stand-alone activities completed their training during this time period.

HCOP awardees also partnered with 188 sites to provide 2,740 clinical health professional trainings in primary care, emphasizing experiences in rural and underserved communities for HCOP student trainees (e.g., academic institutions, community-based organizations, and hospitals). Approximately 47 percent of these training sites were located in medically underserved communities and/or rural settings. In response to the COVID-19 pandemic, 28 percent of training sites offered COVID-19 related services.

From AY 2015-2016 to AY 2019-2020, HCOP awardees trained approximately 4,000 to 8,500 students per year, reaching a total of 19,984 unique students during the five year period. HCOP awardees distributed over $12.7 million in stipends to post-secondary students, providing stipend support to 88 percent of post-secondary students in structured HCOP programs. Furthermore, 21,000 students gained exposure to health care settings or hands-on experience at HCOP's 519 field placement sites. Overall, HCOP participants accumulated 550,179 training hours in medically underserved communities, 83,582 training hours in primary care settings, and 43,729 training hours in rural areas. For high school-aged disadvantaged students in structured HCOP programs, 1,672 (80 percent) graduated from high school on time, exceeding the national high school graduation rate for students with low incomes (78 percent).[45] For post-secondary disadvantaged students in structured HCOP programs, 2,623 (89 percent) earned their degrees on time. Among those students for whom degree data was available, nearly 100 percent graduated on time, vastly exceeding the national graduation rates for students earning associate's (33 percent), bachelor's (63 percent), master's (61 percent), and professional (77 percent) degrees.[46,47]

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

[45] Note that HCOP participants are economically disadvantaged and/or educationally disadvantaged, so the comparison between state graduation rates for low-income students and HCOP students is not completely equivalent.

[46] Associate's and bachelor's graduation rates are based on completion within 150 percent of normal time to degree. Associate's degree data comes from a cohort that entered their degree program in 2016, and bachelor's degree data comes from a cohort that began their degree in 2013. HCOP uses a similar time frame for "on-time" completion for both degree types. National Center for Education Statistics. 2021. *The Condition of Education 2021*.

[47] Master's and professional degree data comes from the Baccalaureate and Beyond Longitudinal Study, 1993-2003. Participants completed their bachelor's degree in AY 92-93 and were followed until 2003, so "on-time" degree completion in this context means within the ten years that elapsed between college graduation and study follow-up. HCOP defines "on-time" for professional degrees as completion within five years, but it does not define "on-time" for master's degrees. Baum, Sandy, and Patricia Steele. 2017. "Who Goes to Graduate School and Who Succeeds?" Urban Institute.

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $14,118,000 |
| FY 2020 | $15,000,000 |
| FY 2021 Final | $14,449,000 |
| FY 2022 CR | $15,000,000 |
| FY 2023 President's Budget | $18,500,000 |

**Budget Request**

The FY 2023 Budget Request for the HCOP of $18.5 million is $3.5 million above the FY 2022 Continuing Resolution level. The request funds approximately 7 additional grantees for a total of 28 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.

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[48] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.51 Number of HCOP trainees from disadvantaged backgrounds participating in academic programming, clinical training and/or student support services (Outcome) | FY 2020: 3,474 Target: 3,474 (Baseline) | 3,474 | 4,000 | + 526 |

[48] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[48] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.52 Percent of HCOP health professions program completers who intend to work in primary care settings (Outcome) | FY 2020: 7% Target: 7% (Baseline) | Discontinued | Discontinued | N/A |

**Program Activity Data**

| HCOP Outputs | Year and Most Recent Result | FY 2021 Target | FY 2022 Target | FY 2023 Target |
|---|---|---|---|---|
| Total number of URM students participating in all HCOP programs | FY 2020: 2,452 | 3,000 | 3,200 | 3,200 |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 21 | 21 | 28 |
| **Average Award** | $653,957 | $653,957 | $623,579 |
| **Range of Awards** | $572,361 - $665,227 | $572,361 - $665,227 | $577,146 - $670,012 |

## Health Care Workforce Assessment

## The National Center for Health Workforce Analysis

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $5,646,000 | $5,663,000 | $5,663,000 | --- |
| **FTE** | 4 | 4 | 8 | +4 |

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

FY 2023 Authorization .....$5,663,000

Allocation Method .....Competitive Grant/Contract

**Program Description and Accomplishments:**

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 in order to provide national and state policy makers, researchers, and the public with information on health workforce supply and demand. NCHWA also evaluates the effectiveness of HRSA's workforce investments. NCHWA focuses on:

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

In FY 2023, NCHWA will continue to model supply and demand of health professionals across a range of health occupations, and metro and non-metro geographies, making these assessments of

the adequacy of the health workforce available through reports and online tools. NCHWA publicly released a new interactive projection visualization tool in FY 2021 that incorporates recent projection data. The new Primary Care Provider Projections are displayed in that dashboard. In lieu of reports, the projection visualization tool will be the primary means to disseminate workforce projections data. The most recent projection updates include:

- Primary Care Provider Projections, 2018-2030
- Women's Health Service Provider Projections, 2018-2030
- Oral Health Workforce Projections, 2017-2030

In FY 2023, NCHWA will continue to oversee nine Health Workforce Research Centers (HWRC) 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.[49] Together, these nine Centers will examine a broad range of issues related to various sectors of the health care workforce, including (but not limited to) occupations in Oral Health, Long Term Services and Supports, Allied Health, Behavioral Health, emerging health workforce issues, and health equity in health workforce education and training. NCHWA is planning to fund nine centers in the new grant cycle, which includes a new public health workforce research center. Research conducted by these HWRCs aims to strengthen the evidence base for effective education and training programs that can enable and empower a health workforce capable of fostering and ensuring health equity for all populations. Examples of research include:

- Looking across a range of health care professions and providers to develop a comprehensive picture of how current health workforce education and training programs incorporate consideration of health equity, including social needs, social determinants of health, and related elements, into their programs.
- Developing a deeper understanding of the current behavioral health workforce and its readiness related to addressing the current opioid and overdose crisis.
- Investigating in real-time the impact of the COVID-19 pandemic on sectors of the U.S. health workforce, such as long term services and support occupations.
- Evaluating health workforce education and training programs to understand their impact on 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 2023, NCHWA will continue to maintain the Area Health Resources Files (AHRF) dataset. AHRF is updated annually and contains detailed information on health professions, health facilities, and the population from a variety of sources. NCHWA publicly released an AHRF dashboard and is planning to release a diversity module of the dashboard in FY 2022.

In FY 2023, NCHWA will continue to develop a projection model that allows a more sophisticated analysis and projection of health workforce supply and demand, taking into

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

account changing national demographics, the demand for health care services, and the impact those changes have on the delivery of health care.

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $5,635,000 |
| FY 2020 | $5,663,000 |
| FY 2021 Final | $5,646,000 |
| FY 2022 CR | $5,663,000 |
| FY 2023 President's Budget | $5,663,000 |

**Budget Request**

The FY 2023 Budget Request for the NCHWA Program of $5.7 million is equal to the FY 2022 Continuing Resolution level. This request will fund 9 Health Workforce Research Centers.

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

**Grants Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 9 | 9 | 9 |
| **Average Award** | $500,000 | $500,000 | $500,000 |
| **Range of Awards** | $447,164 - $900,000 | $447,164 - $900,000 | $447,164 - $900,000 |

## Primary Care Training and Enhancement Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $48,777,000 | $48,924,000 | $53,924,000 | +$5,000,000 |
| **FTE** | 5 | 5 | 6 | +1 |

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

FY 2023 Authorization .....$48,924,000

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

**Program Description and Accomplishments:**

The Primary Care Training and Enhancement Program aims to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, and faculty and promoting primary care practice, particularly in rural and underserved areas. The focus is to produce primary care providers who will be well prepared to practice in, teach, and lead transforming health care systems aimed at improving access, quality of care, and cost effectiveness. The PCTE program was established in 2014.

The PCTE Program includes nine cohorts:

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

In Academic Year 2020-2021, PCTE awardees trained 1,937 primary care residents and fellows, 5,885 medical students, 1,323 students in physician assistant programs, 1,242 students from collaborating interprofessional disciplines (including pharmacy students, psychology students, dental students, and nursing students), and 64 faculty members, for a total of 10,451 trainees, 2,750 of whom completed their programs by the end of the academic year. PCTE partnered with 807 health care delivery sites (e.g., physician's offices, hospitals, and ambulatory practice sites) to provide clinical training experiences to trainees.

Roughly 65 percent of sites were located in primary care settings, 62 percent in medically underserved communities, and 30 percent in rural areas. Furthermore, 29 percent of last year's graduates who provided one-year follow-up data were employed at Critical Access Hospitals, Rural Health Clinics, or FQHCs or Look-alikes.

PCTE awardees delivered 85 unique continuing education courses to 3,478 faculty members and current practicing providers. These continuing education courses focused on emerging issues in the field of primary care. In addition, PCTE awardees developed or enhanced 1,395 academic courses, clinical rotations, workshops, and other curricular activities that reached 25,514 students and trainees. PCTE awardees also supported 175 different faculty-focused training programs and activities during the academic year, reaching 4,399 faculty-level trainees.

The FY 23 PCTE line will include the Rural Tribal Health Fellowship Program and will issue a new competitive grant.

HRSA retired measure 6.I.C.25 because the PCTE program is no longer funding medical schools.

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

In Academic Year 2020-2021, PCTE-TPCC provided fellowships to 161 physicians and 32 physician assistants. . Among the physicians, 88 specialized in family medicine, 37 specialized in internal medicine, 27 specialized in pediatrics, and 9 specialized in internal medicine/pediatrics. Sixty-three percent of last year's graduates who provided one-year follow-up data were employed at Critical Access Hospitals, Rural Health Clinics, or FQHCs or Look-alikes.

PCTE-TPCC awardees developed or enhanced 314 courses that reached 1,359 health professions students. PCTE-TPCC fellows also participated in 106 different faculty-focused training programs and activities during the academic year. Fellows received training in health equity and social determinants of health (45 percent), opioid use treatment (40 percent), substance use treatment (37 percent), integrated behavioral health in primary care (37 percent), and COVID-19 (24 percent). In addition, 34 percent trained in a setting that offered telehealth.

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

In Academic Year 2020-2021, the Primary Care Medicine and Dentistry Clinician Educator Career Development Award program supported 22 faculty, including 15 individuals from the field of medicine, 5 in dentistry, and 2 physician assistants. In addition, awardees developed or enhanced 196 courses that reached 9,814 individuals. Awardees also sponsored 115 faculty

development activities that reached 2,600 faculty members. Grant-funded faculty taught 83 courses to 2,284 students and advanced trainees.

***Academic Units for Primary Care Training and Enhancement:***
The Academic Units for Primary Care Training and Enhancements strengthens the primary workforce by establishing, maintaining or improving academic units or programs that improve clinical teaching and research in the fields of family medicine, general internal medicine, or general pediatrics. The primary care workforce is an essential component of any high functioning health care system. The overarching goal of the program is to improve primary care clinical teaching and research to strengthen the primary care workforce. Academic Units achieve this goal through: 1) systems-level research to inform primary care training; 2) dissemination of best practices and resources; and 3) community of practice activities to promote the widespread enhancement of primary care training to produce a diverse, high quality primary care workforce. Each of the AUs completed two research projects and two research policy briefs in FY 2021. Each grantee has either submitted publications or had them published in a peer reviewed journal during FY 2021. Selected research was published in a supplemental issue of the Journal Health Care for the Poor and Underserved in November 2020 entitled *National Academic Units for Primary Care Training and Enhancement, HRSA Academic Units*.

***Primary Care Training and Enhancement (PCTE): Integrating Behavioral Health and Primary Care (IBHPC) Program:*** In FY 2021, HRSA supported 9 PCTE-IBHPC Programs to fund innovative training programs that integrate behavioral health care into primary care, particularly in rural and underserved settings with a special emphasis on mental health and the treatment of opioid use disorder. In FY 2023, HRSA will continue to support 9 grants. In addition, HRSA will hold a new competition to support 10 grants that will support mental health training for primary care professionals.

In Academic Year 2020-2021, PCTE-IBHPC provided training to 1,849 individuals. Nearly 70 percent of individuals received training in opioid use treatment, and 23 percent received training in health equity/the social determinants of health. 74 percent of last year's graduates who provided one-year follow-up data were employed or pursuing further training in a primary care setting, 32 percent were currently employed or pursuing further training in a medically underserved community, and 16 percent were employed at an FQHC or Look-alike.

***Primary Care Training and Enhancement (PCTE) - Physician Assistant (PA) Program:*** In FY 2020, HRSA supported 11 PCTE-PA programs to increase the number of primary care physician assistants, particularly in rural and underserved settings, and improve primary care training in order to strengthen access to and delivery of primary care services nationally. An additional 7 grants were funded in FY 2021. In FY 2023, HRSA will continue to support 18 grants.

In Academic Year 2020-2021, the PCTE-PA program trained 953 physician assistants (PAs), 52 percent of whom were underrepresented minorities or from disadvantaged backgrounds. PAs received training in integrated behavioral health in primary care (83 percent), substance use treatment (81 percent), health equity/the social determinants of health (80 percent), opioid use treatment (70 percent), and COVID-19 (49 percent). Awardees developed or enhanced 158

courses and training activities, which reached 7,100 trainees. Awardees also partnered with 243 sites to offer clinical training experiences. Forty-nine percent of sites were in primary care settings, 30 percent were in rural settings, and 39 percent were in medically underserved communities. A total of 178 individuals completed the PCTE-PA program.

***Primary Care Training and Enhancement (PCTE) – Residency Training in Primary Care:*** In FY 2020, HRSA established the PCTE-Residency Training in Primary Care to enhance accredited residency training programs in family medicine, general internal medicine, general pediatrics or combined internal medicine and pediatrics (med-peds) with a curriculum focus on practice in rural and/or underserved areas, and encourage program graduates to choose primary care careers in these areas. In FY 2023, HRSA will continue to support 21 grants.

In Academic Year 2020-2021, the PCTE-RTPC program trained 428 individuals, including residents in family medicine (85 percent), pediatrics (11 percent), and internal medicine/pediatrics (4 percent). Thirty-one percent of PCTE-RTPC residents were from disadvantaged and/or rural backgrounds. Individuals trained in primary care settings (100 percent), settings that offered telehealth (97 percent), medically underserved areas (91 percent), and rural areas (48 percent). Participants received training on priority topics such as substance use treatment (99 percent), COVID-19 (94 percent), integrated behavioral health in primary care (92 percent), and health equity/the social determinants of health (92 percent).

Of the 140 individuals who completed the program, 71 percent intended to practice in primary care settings, 52 percent intended to practice in medically underserved areas, and 29 percent intended to practice in rural areas. Program completers also planned to teach (36 percent), seek further training such as a fellowship (28 percent), and apply for the National Health Service Corps Loan Repayment Program (7 percent).

In addition, awardees reached 8,296 health professions students through 344 courses, as well as 1,121 faculty members through 87 faculty development trainings. Awardees also oversaw training at 102 sites, which included hospitals (22 percent), Federally Qualified Health Centers or Look-alikes (21 percent), and Critical Access Hospitals (12 percent).

***Primary Care Training and Enhancement (PCTE) – Community Prevention and Maternal Health:*** In FY 2021, HRSA established the PCTE – Community Prevention and Maternal Health to train primary care physicians in maternal health care clinical services or population health in order to improve maternal health outcomes. The program goal is to increase the number of primary care physicians trained in public health and general preventive medicine with maternal health care expertise and the number of primary care physicians trained in enhanced obstetrical care practicing in rural and/or underserved areas. The program issued awards to 31 applicants for a 5-year project period starting July 1, 2021. In FY 2023, HRSA will continue to support 31 grants.

***Primary Care Training and Enhancement – Physician Assistant Rural Training Program (PCTE-PAR):*** In FY 2022, HRSA established the ***Primary Care Training and Enhancement – Physician Assistant Rural Training Program (PCTE-PAR).*** The program seeks to develop and implement longitudinal clinical rotations in primary care in rural areas. The program also

supports the training and development of preceptors in rural areas and plans to fund approximately eight grantees. In FY 2023, this program will continue to support the approximately eight grantees.

***Primary Care Training and Enhancement – Rural and Tribal Health Fellowship Program (PCTE-RTHF):*** In FY 2023, HRSA will establish the ***Primary Care Training and Enhancement – Rural and Tribal Health Fellowship Program (PCTE-RTHF).*** The program will provide grants to train primary care physicians in clinical, or community and population health practice in rural and/or tribal areas; and increase the distribution of primary care physicians who are ready to practice in and lead the transformation of health care systems aimed at improving access, quality of care, and cost effectiveness in rural or tribal areas.

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $48,680,000 |
| FY 2020 | $48,924,000 |
| FY 2021 Final | $48,777,000 |
| FY 2022 CR | $48,924,000 |
| FY 2023 President's Budget | $53,924,000 |

**Budget Request**

The FY 2023 Budget Request for the PCTE program of $53.9 million is $5.0 million above the FY 2022 Continuing Resolution level. This request will fund 10 grants to support mental health training for primary care professionals in support of the Administration's goal to integrate behavioral health care into primary care, particularly in rural and underserved settings. The

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

**Outcomes and Outputs Table**[50]

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[51] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.24 Number of physicians completing a Bureau of Health Workforce-funded residency or fellowship (Outcome) | FY 2020: 730<br>Target:<br>700<br>(Target Exceeded) | 200 | 700 | + 500 |
| 6.I.C.25 Number of physicians graduating from a Bureau of Health Workforce-funded medical school (Outcome) | FY 2020: 1,295<br>Target:<br>1,000<br>(Target Exceeded) | Discontinued | Discontinued | N/A |
| 6.I.C.26 Number of physician assistants graduating from a Bureau of Health Workforce-funded program (Outcome) | FY 2020: 566<br>Target:<br>300<br>(Target Exceeded) | 100 | 900 | + 800 |

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

[51] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

**Program Activity Data**

| PCTE Program Outputs | Year and Most Recent Result | FY 2021 Target | FY 2022 Target[52] | FY 2023 Target |
|---|---|---|---|---|
| Percent of physician and physician assistant trainees receiving at least a portion of their clinical training in an underserved area | FY 2020: 32% | 50% | 50% | 50% |
| Percent of physician and physician assistant graduates and program completers who are minority and/or from disadvantaged backgrounds | FY 2020: 39% | 30% | 30% | 30% |
| Number of physicians training in a Bureau of Health Workforce-funded residency or fellowship | FY 2020: 1,937 | 2,000 | 400 | 400 |
| Number of medical students training in a Bureau of Health Workforce-funded medical school | FY 2020: 5,885 | 4,000 | N/A | N/A |
| Number of physician assistant students training in a Bureau of Health Workforce-funded program | FY 2020: 1,323 | 1,000 | 400 | 900 |

[52] 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-PAT programs. Targets were adjusted accordingly.

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 115 | 98 | 117 |
| **Average Award** | $425,426 | $499,339 | $555,918 |
| **Range of Awards** | $185,849 - $600,000 | $299,000 - $600,000 | $299,000 - $1,000,000 |

## Oral Health Training Programs

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $40,673,000 | $40,673,000 | $40,673,000 | --- |
| **FTE** | 6 | 6 | 6 | --- |

Authorizing Legislation: Public Health Service Act, Sections 748 and 340G,[53] as amended by Public Law No: 116-136.

FY 2023 Authorizations:.....$28,531,000

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

**Program Description and Accomplishments:**

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

| Program | FY 2021 Final | FY 2022 President's Budget | FY 2023 Target Level |
|---|---|---|---|
| Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene[54] and Dental Faculty Loan Repayment | $26,675,000 | $26,675,000 | $26,675,000 |
| State Oral Health Workforce Improvement Grant | $13,998,000 | $13,998,000 | $13,998,000 |

***Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program:*** The purpose of the Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program is to improve access to, and the delivery of, oral health care services for all individuals, particularly underserved, and vulnerable populations by increasing the supply of qualified oral health care workforce caring for these populations and enhancing oral health care workforce education and training. The Program accomplishes this through pre and postdoctoral oral health educational training programs, which integrate oral health and primary care, through

[53] Public Law No: 115-302 extended the authorization for Section 340G until FY 2023.
[54] FY17 the Primary Care Medicine and Dentistry Clinician Educator Career Development Awards were jointly funded by PCTE and Oral Health Programs. The total funding was approximately $4.0 million, $2.9 million from PCTE and $1.1 million from Oral Health Programs. In FY21 the program received $1.4 million from Oral Health Programs. In FY22, the program is funded from Oral Health Programs in amount of $1.5 million.

interprofessional health care teams, and educating the workforce to provide patient-centered care addressing the social determinants of health, incorporating age-friendly health care, and caring for individuals with complex medical conditions. This Program also supports the Primary Care Medicine and Dentistry Clinician Educator Career Development Awards and the Primary Care Dental Faculty Career Development Awards, which support the development of future clinician educator faculty and leaders in primary care medicine and dentistry while also supporting innovative projects that involve the transformation of health care delivery systems.

In FY 2022, the Primary Care Medicine and Dentistry Clinician Educator Career Program became the Dental Clinician Educator Career Development Program to focus on addressing the well-documented need to develop primary care dental faculty.

The FY 2021 Primary Care Dental Faculty Development Program created a national Center to serve as a resource and training hub to support the development of primary care dental faculty within academic institutions as well as faculty teaching in community-based clinical primary care settings. Most dental school faculty did not have access to a formal faculty development program. This new program improved the competence of full-time, part-time and community-based faculty to develop/enhance training focused on improving care for vulnerable and underserved populations. Additionally, this programmatic change incorporated feedback from listening sessions with dental directors/dentists working at community health centers.

In FY 2022, HRSA will continue to support the Postdoctoral Oral Health Training Program, the Primary Care Dental Faculty Development Program, and the Dental Faculty Loan Repayment Program, compete the Dental Clinician Educator Career Development Program and will re-compete the Predoctoral Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene, Dental Clinician Educator Career Development Program, and the Dental Faculty Loan Repayment Program. In FY 2023, HRSA will continue to support previously awarded 748 section programs as well as award competing funds for the Dental Faculty Loan Repayment Program.

In Academic Year (AY) 2020-2021, awardees of the Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program trained 9,562 dental and dental hygiene students in pre-doctoral training degree programs; 736 dental residents and fellows in advanced primary care dental residency and fellowship training programs; and 847 dental faculty members in faculty development activities and programs. Of the dental residents and fellows, 89 percent received training on COVID-19, and 79 percent received training on health equity or the social determinants of health. Awardees offered experiential training opportunities at 483 sites. Over 60 percent of these sites were in medically underserved communities and over 60 percent were in primary care settings. Almost 40 percent of the sites offered COVID-19 related services.

From AY 2015-2016 to AY 2019-2020, PD-sponsored programs trained over 40,000 predoctoral dental students, dental hygiene students, and dental hygienists. In addition, the total percentage of U.S. dental students enrolled in a PD-sponsored predoctoral dental program grew from 15 percent to 41 percent. On average, over 90 percent of the training sites used by students in PD-sponsored programs provided services to children and approximately half of all training sites served the uninsured or underinsured over the five year period. PD-sponsored programs also

trained 65,455 participants in 1,013 courses they developed or enhanced. This included 672 academic courses, 146 clinical rotations, 99 field placements and/or practicums, 92 faculty development activities, and four grand rounds.

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

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

***Dental Faculty Development and Loan Repayment Program:*** The purpose of this program is to increase the number of dental and dental hygiene faculty in the workforce by assisting dental and dental hygiene training programs attract and retain faculty through loan repayment.

In Academic Year 2020-2021, the Dental Faculty Development and Loan Repayment Program provided financial support to 38 dental faculty with a median direct financial support award of $29,228. Thirty-nine percent were from a disadvantaged background, 39 percent were underrepresented minorities, and 18 percent were from a rural background. Almost 70 percent received training on COVID-19 and 40 percent received training on opioid use treatment.

Dental Faculty developed or enhanced 101 curricula that were offered to 2,951 individuals. Sixty two percent of these courses focused on oral health. In addition, awardees sponsored 46 faculty development programs for 227 dental faculty. Faculty funded through the Dental Faculty

Development and Loan Repayment Program offered 105 courses to 2,165 advanced trainees with specialties in general dentistry and pediatric dentistry.

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

In Academic Year 2020-2021, the Dental Faculty Loan Repayment Program provided financial support to 66 dental faculty, with a median direct financial support award of $22,788. Fifty-seven of the faculty were newly recruited or retained because of the program. Thirty-eight percent were underrepresented minorities, 23 percent were from a disadvantaged background, and 12 percent were from a rural background. Awardees sponsored 33 faculty development programs for 180 dental faculty. Faculty funded through the Dental Faculty Loan Repayment Program taught 108 courses, 43 percent of which were on oral health, to 3,410 trainees.

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

| Designated Health Professions | Targeted Educational Levels | Grantee Activities |
|---|---|---|
| • General dentists<br>• Pediatric dentists<br>• Public health dentists<br>• Dental hygienists<br>• Other approved primary care dental trainees | • Dental Hygiene Training Programs<br>• Graduate Schools (dental schools)<br>• Predoctoral Dental Programs<br>• Dental Residency Programs | • Create and manage a loan repayment program for full-time dentistry faculty supervising students and residents at dental training institutions providing clinical services in dental clinics located in dental schools, hospitals, or community based affiliated sites. |

***State Oral Health Workforce Improvement Grant Program:*** The State Oral Health Workforce Improvement Grant Program 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. The program allows a wide range of activities related to recruitment and retention, provider and practice support, service delivery, teledentistry, education and training, and community-based prevention services.

In Academic Year 2020-2021, the State Oral Health Workforce Improvement Grant Program continued to carry out community-based prevention activities authorized under statute. Grantees established eight new oral health facilities for children with unmet needs in dental HPSAs and expanded nine oral health facilities in dental HPSAs to provide education, prevention, and restoration services to 13,938 patients.

Grantees also supported 158 teledentistry facilities, replaced two water fluoridation systems to provide optimally fluoridated water to 10,153 individuals, provided dental sealants to 7,102

children, provided topical fluoride to 20,248 individuals, provided diagnostic or preventive dental services to 34,957 people, and provided oral health education to 70,539 people. The program provided direct financial support to 16 dental students and 14 dental residents. Of these 30 students and residents, 47 percent were from an underrepresented minority group, 37 percent were from a disadvantaged background, and approximately 30 percent were from a rural background.

In FY 2022, the program will support three continuing state grants and hold a new competition to fund an estimated 32 new awards at a maximum amount of $400,000 each. In FY 2023, the program will provide continued support to grants awarded in the FY 2022 competition. HRSA will continue to include additional activities, as allowed by Sec.340G(b)(13) of the program authority, to focus on HHS and HRSA priorities and other oral health workforce trends at the state level such as activities related to opioids, the impact of COVID-19, and the use of dental therapist to meet the oral health needs of rural, underserved, and tribal populations in accordance with state laws.

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

| Designated Health Professions | Targeted Educational Levels | Grantee Activities |
|---|---|---|
| • Oral Health Service Providers | • Primary and Secondary Education<br>• Pre- and Postdoctoral Programs<br>• Residency Programs<br>• Continuing Education | • Integration of oral and primary care medical delivery systems.<br>• Supporting oral health providers practicing in advanced roles.<br>• Teledentistry.<br>• Expand or establish oral health services and facilities in Dental HPSAs.<br>• Placement of dental trainees.<br>• Partnerships with dental training institutions.<br>• State dental office expansion.<br>• Advancing pain management and improving access to opioid treatment services.<br>• Activities related to emerging oral health workforce needs such as opioids, workforce impacts from COVID-19, and the increasing adoption of dental therapy models by States to meet the needs of their underserved populations.<br>• Develop or improve dental therapy programs, including dental health aid therapist programs, in accordance with State laws and policies. |

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $40,471,000 |
| FY 2020 | $40,673,000 |
| FY 2021 Final | $40,673,000 |
| FY 2022 CR | $40,673,000 |
| FY 2023 President's Budget | $40,673,000 |

**Budget Request**

The FY 2023 Budget Request for the Oral Health Training Programs of $40.7 million is equal to the FY 2022 Continuing Resolution level. In FY 2023, 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 intends to make 108 awards to continue the support of dental faculty development, support of innovative oral health programs, and to enhance clinical predoctoral dental and dental hygiene trainees' ability to care for populations and individuals with medically complex conditions.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[55] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.27 Number of dental students trained (Outcome) | FY 2020: 9,562 Target: 5,000 (Target Exceeded) | 4,000 | 6,000 | + 2,000 |
| 6.I.C.28 Number of dental residents trained (Outcome) | FY 2020: 736 Target: 650 (Target Exceeded) | 520 | 650 | + 130 |
| 6.I.C.29 Number of faculty trained (Outcome) | FY 2020: 227 Target: 200 (Target Exceeded) | 160 | 200 | + 40 |

[55] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

**Program Activity Data**

| Oral Health Training and Workforce Program Outputs | Year and Most Recent Result | FY 2021 Target | FY 2022 Target | FY 2023 Target |
|---|---|---|---|---|
| Percent of students and residents trained who are URMs | FY 2020: 27% | 20% | 20% | 20% |
| Number of dentists completing a Bureau of Health Workforce-funded dental residency or fellowship | FY 2020: 574 | 300 | 300 | 550 |
| Number of dentists graduating from a Bureau of Health Workforce-funded dental school | FY 2020: 2,529 | 1,000 | 1,000 | 2,500 |

**Grant Awards Table – Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene**[56]

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 47 | 51 | 51 |
| **Average Award** | $378,189 | $378,189 | $401,599 |
| **Range of Awards** | $142,144 - $650,000 | $142,144 - $650,000 | $187,500 - $699,946 |

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

**Grant Awards Table – Dental Faculty Loan Repayment Programs**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 30 | 28 | 25 |
| **Average Award** | $200,000 | $230,739 | $230,739 |
| **Range of Awards** | $81,000 - $300,000 | $81,000 - $350,00 | $50,438 - $350,000 |

**Grant Awards Table – State Oral Health Workforce Improvement Grant Program**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 35 | 35 | 32 |
| **Average Award** | $340,103 | $340,103 | $376,626 |
| **Range of Awards** | $91,533 - $400,000 | $91,533 - $400,000 | $332,495 - $400,000 |

## Medical Student Education Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $49,850,000 | $50,000,000 | --- | -$50,000,000 |
| **FTE** | 1 | 1 | --- | -1 |

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

FY 2023 Authorization .....…$50,000,000

Allocation Method .....Grants

**Program Description and Accomplishments:**

The purpose of the Medical Student Education (MSE) Program is to provide grants to public institutions of higher education to expand or support graduate education for medical students preparing to become physicians in the top quintile of states with a projected primary care provider shortage in 2025.[57] The program was established in FY 2019. The program is designed to prepare and encourage medical students who are training in the most underserved states to choose residencies and careers in primary care that serve tribal communities, rural communities, and/or medically underserved communities (MUCs) after they graduate. The MSE Program supports the development of medical school curricula, clinical training site partnerships, and faculty training programs, with the goal of educating medical students who are likely to choose career paths in primary care, especially for tribal communities, rural communities, and/or MUCs.

In FY 2020, HRSA made five awards. These grants are fully-funded for their four-year project period. Remaining funds from the FY 2020 appropriation were used to supplement the initial five FY 2019 awardees, who were in their second year of a four-year, fully-funded project period. In FY 2021, HRSA awarded supplements totaling nearly $50 million to each of the 10 MSE grantees, including the five awards from the FY 2019 cohort and the five awards from the FY 2020 cohort. These supplemental awards enabled HRSA to provide all 10 of the MSE grantees with the same level of award amount over the performance period of their respective grants. In FY 2022, HRSA will continue to fund the original 10 MSE grantees, which includes five awards from the FY 2019 cohort and five awards from the FY 2020 cohort. In FY 2023, the

[57] 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.

FY 2019 grantees will finish their project period; HRSA will continue to support the five grants from the FY 2020 cohort with funds obligated in prior fiscal years.

In Academic Year 2020-2021, MSE awardees trained 1,089 medical students. Thirty-eight percent of these students were from rural or disadvantaged backgrounds. MSE awardees developed or enhanced 96 medical school courses and trainings focused on the skills medical students need to practice primary care in rural, tribal, and other underserved communities. In addition, MSE awardees enhanced community-based partnerships with 246 sites to offer experiential training opportunities in primary care settings (97 percent), MUCs (56 percent), and rural areas (45 percent).

Awardees used telehealth modalities and telemedicine networks to connect clinicians to rural patients and provide care and education through telemedicine. Fifty-six percent of MSE trainees received training in telehealth and 53 percent of sites offered telehealth services. In response to the COVID-19 pandemic, 28 percent of medical students received COVID-19 related training and 38 percent of experiential training sites offered COVID-19 related services. Students also received training in integrated behavioral health in primary care (58 percent), opioid use treatment (51 percent), and health equity/the social determinants of health (28 percent). There were 26 graduates (completing medical school typically requires four years, and this was only the second year of the program), all of whom matched to a medical residency program. Twelve matched to Family Medicine residencies, six to Internal Medicine residencies, three to Emergency Medicine residencies, three to Internal Medicine/Pediatrics or General Pediatrics, and two to other medical residency programs.

**Eligible Entities:**

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $25,000,000 |
| FY 2020 | $50,000,000 |
| FY 2021 Final | $49,850,000 |
| FY 2022 CR | $50,000,000 |
| FY 2023 President's Budget | --- |

**Budget Request**

The FY 2023 Budget Request for the MSE Program of $0 million is $50 million below the FY 2022 Continuing Resolution level. In FY 2023, the FY 2019 grantees will finish their project period. HRSA will continue to support 5 grants from the FY 2020 cohort with funds appropriated in prior fiscal years.

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[58] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.59 Number of medical students trained in underserved states (Output) | FY 2020: 1,089<br>Target:<br>1,089<br>(Baseline) | 1,089 | Discontinued | N/A |
| 6.I.C.60 Number of medical students matched to primary care residencies (Output) | FY 2020: 21<br>Target:<br>21<br>(Baseline) | 21 | Discontinued | N/A |

**Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 10 | 10 | --- |
| **Average Award** | $6,431,357 | $6,452,888 | --- |
| **Range of Awards** | $5,837,869 - $6,943,792 | $6,102,305 - $6,750,000 | --- |

[58] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

## Interdisciplinary, Community-Based Linkages

## Area Health Education Centers Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $43,250,000 | $43,250,000 | $43,250,000 | --- |
| **FTE** | 3 | 3 | 3 | --- |

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

FY 2023 Authorization .....$41,250,000

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

**Program Description and Accomplishments:**

Since its inception in 1971, the purpose of the Area Health Education Centers (AHEC) Program is to develop and enhance education and training networks within communities, academic institutions, and community-based organizations. In turn, these networks develop the health care workforce, broaden the distribution of the health workforce, enhance health care quality, and improve health care delivery to rural and underserved areas and populations. AHECs 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 social determinants of health impacting the populations in the communities they serve and incorporate field placement programs. The AHEC program also provides continuing education and information dissemination to practicing health professionals to increase their effectiveness in providing quality health care. The current project period runs through August 31, 2022, supporting 48 cooperative agreements. A new grant competition in FY 2022 will begin a new five-year project period that runs from September 1, 2022 through August 31, 2026.

In Academic Year 2020-2021, the AHEC Program supported pre-pipeline, pipeline, and continuing education training activities for thousands of trainees across the country. AHEC awardees implemented 1,879 unique continuing education courses that were delivered to 168,338 practicing professionals nationwide, 68,894 of whom (41 percent) were concurrently employed in medically underserved communities (MUC). They also enhanced or developed 2,324 courses and training activities for 39,062 AHEC scholars and other health professionals. AHEC awardees partnered with 4,686 training sites to provide 27,661 clinical training experiences to student trainees (e.g., ambulatory practice sites, physician offices, and hospitals). Approximately 60 percent of these training sites were in primary care settings, 68 percent were

located in medically underserved communities, and 47 percent were in rural areas. Twenty-eight percent of sites offered COVID-19 related services.

In Academic Year (AY) 2020-2021, the AHEC Scholars Program supported 7,522 AHEC Scholars. The AHEC Scholars Program is an interprofessional educational and training program targeted towards health professions students and consists of a specialized curriculum focused on six core topic areas and health care delivery within rural/underserved areas and populations. The six core topic areas include: (a) interprofessional education, (b) social determinants of health, (c) behavioral health integration, (d) cultural competency, (e) practice transformation, and (f) current and emergent health issues.

Approximately 40 percent of AHEC Scholars came from a rural background and 47 percent came from a disadvantaged background. Sixty-three percent of AHEC Scholars received training in a medically underserved community, 54 percent in a primary care setting, and 42 percent in a rural setting. Forty-three percent of AHEC Scholars received training on integrating behavioral health in primary care and 21 percent received training in substance use treatment. Ninety-two percent of AHEC scholars received training on interprofessional education, logging close to 530,000 hours of training on this topic.

The AHEC Scholars program is a two-year commitment. In AY 2020-2021, 2,372 AHEC Scholars completed the program. Thirty percent intend to work or pursue further training in a medically underserved community, 40 percent in a primary care setting, and 35 percent in a rural area. AHEC Scholars mostly followed through on their intentions. One year later, 36 percent were working or pursuing further training in a medically underserved community, 37 percent in a primary care setting, and 22 percent in a rural area.

In response to the COVID-19 pandemic, HRSA provided supplemental funding to a subset of AHEC awardees to support telehealth activities. Awardees offered 282 continuing education courses using these supplemental funds, which reached 13,676 health professionals. Thirty-five percent of these health professionals were employed in medically underserved communities and 21 percent were employed in rural settings. Training topics included emergency response for public health/epidemics (26 percent) infectious disease (24 percent), and clinical public health training (12 percent). Awardees also used these funds to develop 119 courses and training activities for students. These courses and activities reached 6,443 students, with almost a third (31 percent) focusing on emergency response for public health/epidemics.

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $39,055,000 |
| FY 2020 | $41,250,000 |
| FY 2021 Final | $43,250,000 |
| FY 2022 CR | $43,250,000 |
| FY 2023 President's Budget | $43,250,000 |

**Budget Request**

The FY 2023 Budget Request for the AHEC Program of $43.3 million is equal to the FY 2022 Continuing Resolution level. In FY 2023, HRSA will support 55 awards to continue to increase the number of students in the health professions who will pursue careers in primary care and are prepared to practice in rural and underserved areas and populations.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[59] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.49 Number of AHEC scholars trained in medically underserved communities and/or rural areas (Outcome) | FY 2020: 5,060<br>Target: 5,060<br>(Baseline) | 5,060 | 5,060 | Maintain |
| 6.I.C.50 Percent of AHEC program completers practicing in medically underserved communities and/or rural areas. (Outcome) | FY 2020: 48%<br>Target: 48%<br>(Baseline) | 48% | 48% | Maintain |

[59] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

**Program Activity Data**

| AHEC Program Outputs | Year and Most Recent Result | FY 2021 Target | FY 2022 Target | FY 2023 Target |
|---|---|---|---|---|
| Number of medical students who participated in community-based clinical training | FY 2020: 9,836 | 11,500 | 11,500 | 11,500 |
| Number of other health professions trainees who participated in community-based clinical training | FY 2020: 11,620 | 11,000 | 11,000 | 11,000 |
| Number of trainees who received CE on topics including cultural competence, women's health, diabetes, hypertension, obesity, and health disparities | FY 2020: 168,338 | 140,000 | 140,000 | 140,000 |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 48 | 55 | 55 |
| **Average Award** | $809,483 | $786,363 | $786,363 |
| **Range of Awards** | $249,967 - $1,927,055 | $226,847 - $1,903,935 | $226,847 - $1,903,935 |

## Geriatrics Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $42,859,000 | $42,737,000 | $46,537,000 | +$3,800,000 |
| **FTE** | 5 | 5 | 8 | +3 |

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

FY 2023 Authorization .....$40,737,000

Allocation Method ..... Cooperative Agreement

**Program Description and Accomplishments:**

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

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

| Program | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| Geriatrics Workforce Enhancement Program | $40,792,475 | $40,618,144 | $44,433,205 |
| Geriatrics Academic Career Awards (GACA) Program | $2,066,525 | $2,118,856 | $2,103,795 |

In Academic Year 2020-2021, GWEP awardees provided training for 69,518 students and fellows participating in a variety of geriatrics-focused degree programs, field placements, and fellowships. Of these trainees, 61,994 graduated or completed their training during this time frame.

GWEP awardees partnered with 262 health care delivery sites (e.g., hospitals, long-term care facilities, and academic institutions) to provide clinical training experiences to trainees. Approximately 52 percent of these sites were located in medically underserved communities, 48 percent were in primary care settings, and 29 percent were in rural areas. Sixty-three percent of sites offered COVID-19 related services, 61 percent offered telehealth services, and 30 percent provided integrated behavioral health services in a primary care setting.

Awardees also developed or enhanced 5,967 courses, which reached over 720,000 students. Courses covered topics such as Alzheimer's disease/dementia (23 percent), geriatric health (22 percent), and evidence-based practice in a clinical setting (7 percent). In addition, GWEP awardees supported health care professionals by providing over 4,500 hours of training across 1,857 continuing education courses. Nearly 520,000 health care professionals participated in GWEP-sponsored continuing education courses and approximately 16 percent of these professionals were employed in medically underserved communities. Thirty-nine percent of GWEP continuing education courses focused on Alzheimer's disease and related dementia. Furthermore, GWEP awardees supported 483 faculty-focused training programs and activities, reaching 9,912 faculty-level trainees.

GWEP significantly outperformed nearly all of its targets this year, sponsoring 721 Alzheimer's disease and dementia-related educational offerings (6.I.C.12), training 180,938 individuals through Alzheimer's disease and dementia-related educational offerings (6.I.C.13), reaching 519,356 geriatrics professionals through continuing education programs (6.I.C.32), and providing 69,518 students with geriatric-focused training in settings across the care continuum (6.I.C.33). The targets were 150; 10,000; 50,000; and 10,000 respectively. Awardees also reached 721,148 trainees through curricula related to treating health problems in elderly individuals, exceeding the FY 2020 target (not depicted in the program activity table) of 140,000 trainees. This shift occurred because awardees moved to online courses for health care professionals and to telehealth-based training for students unable to access clinical training sites. Awardees also established new relationships with the nation's 15,000+ nursing homes in response to COVID-19's impact on nursing homes and geriatric patients. These awardees leveraged the new delivery modes and relationships to expand their activities, such as offering online continuing education courses on Alzheimer's disease and dementia to nursing home-based health care providers.

In FY 2021, the GWEP program received an additional $2 million in annual appropriations. The funding provided COVID-19 specific education and training to the nursing home workforce in order to improve care to nursing home residents.

GWEP awardees used COVID-19 supplemental funding to offer a variety of courses and continuing education classes to help students and professionals respond to the COVID-19 pandemic. With this supplemental funding, awardees developed or enhanced 979 courses for nearly 470,000 students, including 149 courses on geriatric health and 74 courses on telehealth in clinical settings. GWEP awardees also offered nearly 3,000 hours of continuing education across 668 classes, reaching over 360,000 individuals. Fifty-four percent of these trainings addressed issues related to Alzheimer's disease and dementia. Awardees also reached 4,501 faculty-level trainees through 129 faculty-focused training programs and activities.

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

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

In Academic Year 2020-2021, GACA supported the career development of 25 junior faculty in geriatric medicine (52 percent), family and internal medicine (12 percent), advanced practice nursing in gerontology (8 percent), occupational and physical therapy (8 percent), social work and addiction counseling (8 percent), geriatric psychiatry (4 percent), general dentistry (4 percent) and pharmacy (4 percent). Sixty-four percent of GACA recipients provided clinical services in primary care settings (2,359 contact hours), 52 percent provided services in medically underserved communities (1,975 contact hours), and 24 percent provided services in rural areas (459 contact hours). GACA-supported junior faculty published 37 articles, gave 97 conference presentations, and received 36 research or education grants, including six grants worth $100,000 or more. Approximately 96 percent of GACA awardees received training in a setting that offered telehealth, and 40 percent received training in opioid use treatment. Furthermore, 68 percent of GACA faculty received COVID-19 related training, and 56 percent received training on health equity/the social determinants of health. GACA awardees developed or enhanced 646 different courses for students and 579 courses for faculty members, reaching a total of 30,177 students and 25,019 faculty members.

In FY 2023, the 4th and final year of the current GACA cohort (24), will receive funding. In

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

FY 2023, HRSA anticipates issuing a new Notice of Funding Opportunity to hold a new GACA grant competition.

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

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

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $40,534,000 |
| FY 2020 | $40,737,000 |
| FY 2021 Final | $42,859,000 |
| FY 2022 CR | $42,737,000 |
| FY 2023 President's Budget | $46,537,000 |

**Budget Request**

The FY 2023 Budget Request for the Geriatrics Program of $46.5 million is $3.8 million above the FY 2022 Continuing Resolution level. The request will fund approximately 48 GWEP continuation awards and 26 GACA awards through a new competition. In addition, this request will fund approximately five additional grantees through a new GWEP competition at $750,000 each.

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

**Outcomes and Outputs Measures**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[62] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.12 Number of Bureau of Health Workforce-sponsored educational offerings provided on Alzheimer's disease and related dementias (Outcome) | FY 2020: 721<br>Target:<br>150<br>(Target Exceeded) | 150 | 700 | +550 |
| 6.I.C.13 Number of trainees participating in educational offerings on Alzheimer's disease and related dementias (Outcome) | FY 2020: 180,938<br>Target:<br>10,000<br>(Target Exceeded) | 10,000 | 180,000 | +170,000 |
| 6.I.C.32 Number of continuing education trainees in geriatrics programs (Outcome) | FY 2020: 519,356<br>Target:<br>50,000<br>(Target Exceeded) | 50,000 | 500,000 | +450,000 |
| 6.I.C.33 Number of students who received geriatric-focused training in settings across the care continuum (Outcome) | FY 2020: 69,518<br>Target:<br>10,000<br>(Target Exceeded) | 10,000 | 60,000 | +50,000 |

[62] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

**Program Activity Data**

| Geriatrics Program Outputs | Year and Most Recent Result | FY 2021 Target | FY 2022 Target | FY 2023 Target |
|---|---|---|---|---|
| Number of continuing education offerings delivered by grantees | FY 2020: 1,857 | 1,000 | 2,000 | 2,000 |
| Number of faculty members participating in geriatrics trainings offered by grantees | FY 2020: 9,912 | 8,000 | 10,500 | 10,500 |
| Number of individuals trained in new or enhanced curricula relating to the treatment of health problems of elderly individuals | FY 2020: 721,148 | 130,000 | 200,000 | 700,000 |

**GWEP Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 48 | 48 | 53 |
| **Average Award** | $741,108 | $818,191 | $743,765 |
| **Range of Awards** | $611,584 - $750,000 | $611,584 - $1,086,363 | $552,113 - $750,000 |

**GACA Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 25 | 25 | 26 |
| **Average Award** | $77,191 | $78,195 | $77,191 |
| **Range of Awards** | $77,191 | $78,195 | $77,191 |

## Behavioral Health Workforce Development Programs

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $149,207,000 | $149,916,000 | $397,374,000 | +$247,458,000 |
| **FTE** | 12 | 12 | 35 | +23 |

Authorizing Legislation: Public Health Service Act, Sections 755, 756, 760 and 781

FY 2023 Authorization:
BHWET: $50,000,000
MBHET: 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

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

**Program Description and Accomplishments:**

The purpose of the Behavioral Health Workforce Development Programs is to develop and expand the behavioral health workforce, serving populations across the lifespan, including in rural and medically underserved areas. The behavioral health workforce includes a range of providers who promote mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. The behavioral health workforce functions in a wide range of prevention, health care, and social service settings.

There is a shortage of behavioral health providers; as of December 31st, 2021, over 136 million Americans live in a designated mental Health Professional Shortage Area.[63] HRSA's 2020 Behavioral Health Workforce Projections Report estimated national level health workforce needs for several behavioral health occupations between 2017 and 2030. The report estimated the demand for addiction counselors is expected to increase 15 percent by 2030, with demand exceeding supply and leading to a deficit of addiction counselors of approximately 11,530 FTE. Also, the report estimated that by 2030, the supply of psychiatrists is expected to decrease by approximately 20 percent. The COVID-19 pandemic exacerbates the existing imbalance in supply of and demand for mental and behavioral health providers across the U.S. HRSA uses projections data and other information about the behavioral health workforce to develop and adjust programs to ensure that they are responsive to the Nation's emerging needs.

[63] U.S. Health Resources and Services Administration, "Designated HPSA Quarterly Summary, First Quarter of Fiscal Year 2022." Available at https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.

The COVID-19 pandemic has increased the need for behavioral health providers. A recent Kaiser Family Foundation Issue Brief[64] explored the dual impacts of efforts to reduce the spread of COVID-19 on behavioral health: the economic downturn has increased stress and vulnerability to behavioral health conditions at the same time isolating and quarantining have reduced access to behavioral health services. The Issue Brief noted that:

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

In the context of the COVID-19 pandemic, there were over 104,000 drug overdose deaths in the United States during the12-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.

**Behavioral Health Workforce Development Program Breakout**

| | **FY 2021 Enacted** | **FY 2022 Continuing Resolution** | **FY 2023 President's Budget** | **FY 2023 +/- FY 2022** |
|---|---|---|---|---|
| Behavioral Health Workforce Development | $130,916,000 | $130,916,000 | $372,374,000 | +$241,458,000 |
| Graduate Psychology Education | $19,000,000 | $19,000,000 | $25,000,000 | +$6,000,000 |
| **Total Behavioral Health Workforce Development Programs[65]** | **$149,916,000** | **$149,916,000** | **$397,374,000** | **+$247,458,000** |

[64] Panchal, Nirmita, et al. The Implications of COVID-19 for Mental Health and Substance Use, Kaiser Family Foundation. Published April 21, 2020. Available at: https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

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

The Behavioral Health Workforce Development (BHWD) Programs support a number of activities to expand the behavioral workforce as well as enhance the training of the pipeline and current workforce. In FY 2023, these Programs will support a number of activities, which are described below.

***Behavioral Health Workforce Education and Training (BHWET) Programs:*** In FY 2023, the Budget includes $225.8 million for BHWET, a $172.5 million increase over the FY 2022 CR level. HRSA anticipates making $60.5 million in continuation awards and $165.3 million in new awards for BHWET in FY 2023. BWHET increases the number of behavioral health providers entering and continuing practice, with special emphasis on prevention and clinical intervention and treatment for those at risk of developing mental and substance use disorders, and the involvement of families in the prevention and treatment of behavioral health conditions. BWHET includes the activities described below.

- ***BWHET Program for Professionals:*** The BHWET Program for Professionals aims 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. In FY 2022, HRSA supported 168 BHWET Professional grantees. Further, 56 of the BHWET Professional grantees were funded through the American Rescue Plan Act. These additional BHWET awards will result in increasing the supply of behavioral health professionals throughout the nation.

- ***BHWET Program for Paraprofessionals:*** The BHWET Program for Paraprofessionals develops and expands 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. In FY 2022, HRSA supported 44 Paraprofessional grantees.

- ***Behavioral Health Integration into Community-Based Settings:*** In 2023, the Budget includes $10.0 million to support a new pilot program to promote the healthy social and emotional development and behavioral health needs of families in communities that are traditionally underserved or are part of a Mental Health Professional Shortage Area. Specifically, this pilot will provide grants to community-based organizations or local health departments to train community partners and integrate navigators and community health workers in non-traditional community settings where they live, learn, and play. Award recipients would identify, engage, and provide Mental Health First Aid or similar training to community partners, such as social services providers, after-school care and sports programs, community organizations (e.g., the YMCA), boys and girls clubs, recreation and summer care programs, library systems, independent daycares, and local parent/caregiver groups, among others. Recipients will also integrate navigators and community health workers into these and other community settings to link to local resources, such as medical homes (including HRSA-funded health centers), school-based and other community-based organizations, public health departments, and local community social supports and services. This funding will support 30 grants and complements $40 million in the MCH Block Grant for a total investment of $50 million. The $40 million in the MCHB Block Grant will 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.

Funding for BHWET will increase the supply of behavioral health professionals and paraprofessionals, including community health workers, while also improving distribution of a quality behavioral health workforce and thereby increasing access to behavioral health services. A special focus is placed on the knowledge and understanding of children, adolescents, and transitional-aged youth at risk for a mental health disorder, Serious Emotional Disturbance (SED), and/or substance use disorder. The programs also seeks to establish and expand field placements, internships, and experiential sites, especially among children and youth focused community-based partners able to conduct trainings in school-based settings. HRSA also proposes to increase funding to Historically Black Colleges and Universities and Minority Serving Institutions to train behavioral health providers. HRSA will continue to require grantees to prioritize linguistic competencies to ensure these additional funds expand the supply of behavioral health professionals and paraprofessionals who speak languages other than English.

In Academic Year 2020-2021, the BHWET Programs supported training for 6,454 individuals, 57 percent of whom came from underrepresented minority or disadvantaged backgrounds. Awardees trained 3,356 graduate-level social workers, psychologists, school and clinical counselors, psychiatric nurse practitioners, and marriage and family therapists, as well as 3,098 students preparing to become behavioral health paraprofessionals (e.g., community health workers, outreach workers, social services aides, mental health workers, substance abuse/addictions workers, youth workers, and peer paraprofessionals). By the end of the Academic Year, 4,828 students graduated from degree and certificate-bearing programs and entered the behavioral health workforce, and BHWET has produced 7,493 new community health workers, peer paraprofessionals, and substance use/addictions workers since the program was established in 2014. Forty-eight percent of graduates who provided one-year follow-up data were employed in or pursuing further training in medically underserved communities; 21 percent were providing treatment or wraparound services for individuals with substance use disorders; and 16 percent were employed at Critical Access Hospitals, Rural Health Clinics, or FQHCs or Look-alikes. BHWET awardees partnered with 2,354 training sites to provide 5,402 clinical training experiences for BHWET student trainees. Approximately 72 percent of these training sites were located in medically underserved communities, where trainees provided over 1.3 million hours of behavioral health services to patients and clients. BHWET awardees also developed or enhanced 2,513 behavioral health-related courses and training activities, reaching nearly 57,000 students and advanced trainees (i.e., psychology interns and fellows and psychiatry residents).

In fall 2020, HRSA conducted an evaluation of BHWET by administering surveys to BHWET awardees, trainees, and partner sites. Evaluators found that 75 percent of awardees reported partnering with new sites through social services and referrals to provide training on opioid use disorder (OUD) treatment, indicating that the BHWET Program helped enhance academic and community partnerships. In addition, almost all (89 percent) of trainees sought to work in a rural or underserved community because of the opportunity to apply a diverse skill set and 92 percent said training in an underserved area influenced their decision to work in a rural or underserved community upon program completion.

***Behavioral Health Workforce Education and Training-Community Improvement Program (BHWET-CIP):*** In FY 2023, the Budget includes $52.7 million for a new activity to develop and expand community-based experiential training through internships and field placements to increase the supply of students preparing to become behavioral health professionals and behavioral health-related paraprofessionals including trainees ready to support individuals involved, or at risk of being involved in the criminal justice system. The Program focuses on reducing the stigmatization of persons with mental illness and/or substance use disorders through training behavioral health trainees and relevant community partners to appropriately address the needs of individuals during a behavioral health crisis.

***The Behavioral Health Workforce Development Technical Assistance and Evaluation (BHWD TAE) Program:*** In FY 2023, the Budget includes $2.5 million to support one continuation award to fund the BHWD TAE Program which develops and provides tailored technical assistance to current and future grant recipients in the BHWET-Professionals, BHWET-Paraprofessionals, OWEP- Professionals, OWEP-Paraprofessionals, and GPE Programs.

***Addiction Medicine Fellowship (AMF) Program:*** In FY 2023, the Budget includes $24.0 million, an increase of $4.3 million over the FY 2022 CR level for the AMF Program. This funding will support 43 continuation awards. 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 health care sectors.

In Academic Year 2020-2021, the first year the AMF program provided data, awardees trained 98 fellows in addiction medicine, including 63 graduates. Eighty-four were Addiction Medicine Fellows (of which 53 graduated) and 14 were Addiction Psychiatry Fellows (of which 10 graduated). The fellows represented the following disciplines: internal medicine (27), family medicine (24), psychiatry (20), and other medical disciplines (27) such as preventive medicine and pediatrics. Throughout the year, the fellows recorded over 61,000 hours of training and nearly 80,000 patient encounters in medically underserved communities. Upon graduation, eighty-one percent of AMF fellows indicated that they intend to serve individuals with opioid use disorder or substance use disorder, and 52 percent indicated that they intend to work in a medically underserved community.

AMF awardees also supported 234 experiential training sites. Eighty-nine percent of sites provided interprofessional education, 68 percent of sites were located in medically underserved communities, and 28 percent were located in primary care settings. Lastly, the AMF program offered faculty development training programs and activities to over 840 faculty.

***Integrated Substance Use Disorder Treatment Program (ISTP)***: In 2023, the Budget includes $11.6 million for ISTP, which is equal to the FY 2022 CR level. In FY 2021, HRSA awarded 5 awards totaling $11.6 million for 5 years to expand the number of nurse practitioners, physician

assistants, health service psychologists, and social workers trained to provide mental health and SUD services in underserved community-based settings that integrate primary care and mental health and SUD services. The ISTP Program fosters robust clinical training and augment expertise among clinicians who will see patients at access points of care and provides addiction prevention, treatment, and recovery services. Participants will be practicing professionals from the following disciplines: nurse practitioners, physician assistants, health service psychologists, and/or social workers.

***Opioid-Impacted Family Support Program (OIFSP):*** In FY 2023, the Budget includes $16.8 million for OIFSP, which is equal to the FY 2022 CR level. This funding will support 28 continuation awards. OIFSP trains paraprofessionals to support children and families impacted by OUD and other SUD in underserved areas. The Program also provides professional development opportunities and educational support to increase the number of paraprofessional trainees receiving a certificate upon completion of the Program.

OIFSP awardees also supported a total of 552 paraprofessionals, 88 percent of whom received funding. Thirty-nine percent were underrepresented minorities, 27 percent were from rural backgrounds, and 55 percent were from disadvantaged backgrounds. These paraprofessionals trained on substance use treatment (71 percent) and opioid use treatment (64 percent). Forty-seven percent received training in health equity and/or the social determinants of health. OIFSP awardees supported 132 experiential training sites, which provided training to 388 people. Eighty-four percent of these sites were in medically underserved communities, 30 percent were in rural settings and 28 percent were in primary care settings. Sixty-eight percent of these sites offered substance use treatment services, 58 percent offered opioid use treatment services, and 51 percent offered telehealth services. Awardees also developed or enhanced 111 courses, which were offered to 957 trainees.

***Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR LRP)***: In FY 2023, the Budget includes $28.0 million for STAR LRP, which is $12.0 million above the FY 2022 CR level. The STAR LRP 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 substance use disorder. STAR LRP participants must provide services in either a county (or a municipality, if not contained within any county) where the mean drug overdose death rate per 100,000 people over the past three years exceeds the national average, or in a Health Professional Shortage Area (HPSA) designated for Mental Health. In FY 2023, STAR LRP participants will be fulfilling part of their required SUD treatment service commitments, and HRSA anticipates making 112 awards with approximately $28.0 million in funding. This funding is included in the BWHET funding line.

***The Graduate Psychology Education (GPE) Program:*** The Budget includes $25.0 million for GPE, which is $6.0 million above the FY 2022 CR level. This Program supports innovative doctoral-level health psychology programs that foster an interprofessional approach to providing behavioral health and substance use prevention and treatment services in high need and high demand areas through academic and community partnerships. Through these efforts, the GPE Program transforms clinical training environments and aligns with HRSA's mission to improve

health outcomes and address health disparities through access to quality services, a skilled health workforce, and innovative, high-value programs.

In Academic Year 2020-2021, the GPE Program provided stipend support to 376 students participating in practica, internships, or post-doctoral residency programs in psychology. The majority of students were trained in medically underserved communities (92 percent) and/or primary care settings (74 percent). Ninety-six percent of students received training in substance use treatment, 92 percent received training in opioid use treatment, and 67 percent received training in medication assisted treatment for substance use disorder and opioid use disorder. Additionally, 97 percent of students trained at sites offering telehealth services, and 54 percent received training in health equity/the social determinants of health. Of the 181 students who completed GPE-supported programs during this time period, 70 percent intended to become employed or pursue further training in medically underserved communities, and 46 percent intended to become employed or pursue further training in primary care settings.

In addition, 50 percent of last year's graduates who provided one-year follow-up data were currently employed in or pursuing further training in medically underserved communities; 29 percent were employed at Critical Access Hospitals, Rural Health Clinics, or FQHCs or Look-alikes; and 21 percent were currently providing treatment or wraparound services to individuals with substance use disorders.

GPE awardees partnered with 247 sites (e.g., hospitals, ambulatory practice sites, and academic institutions) to provide 732 clinical training experiences for psychology graduate students, who trained alongside 3,937 interprofessional team-based care trainees. Approximately 87 percent of the sites were located in medically underserved communities, 61 percent were in primary care settings, and 29 percent were in rural areas. In addition, 90 percent of the sites offered telehealth services, 76 percent offered substance use treatment services, and 72 percent offered integrated behavioral health services in primary care settings.

In fall 2020, HRSA conducted an evaluation of GPE by administering surveys to GPE awardees, trainees, and partner sites. Evaluators found that most (88 percent) GPE grant programs involved experiential sites in designing their curriculum and training program, indicating that the GPE program supported academic and community partnerships. These experiential training sites involved trainees in different care team functions, such as screening and assessments (95 percent), referrals to other services (95 percent), care coordination (90 percent), and treatment plan development (83 percent). Nearly half of GPE awardees (47 percent) reported that they educated the public on behavioral health and/or SUD treatment and 56 percent of GPE awardees indicated that they addressed the social determinants of health by linking patients to social services or employment. In addition, almost all trainees (91 percent) sought to work in a rural or underserved community because of the opportunity to apply a diverse skill set and 86 percent said training in an underserved area influenced their decision to work in a rural or underserved community upon completion.

The future targets for the GPE Program take into account the timing of the psychology internship match and GPE funding. Because the annual psychology match for the next academic year occurs in early spring and grant funds are allocated in September, GPE grantees would have

already had interns match prior to funding; therefore, almost a one-year delay occurs between the start of the next academic year and this Program's funding cycle.

**Eligible Entities:**

**BHWET Professionals:** Accredited institutions of higher education or accredited behavioral health professional training programs in psychiatry, behavioral pediatrics, social work, school social work, substance use disorder prevention and treatment, marriage and family therapy, occupational therapy, school counseling, or professional counseling. Accredited schools of masters or doctoral level training in psychiatric nursing programs.

**GPE:** American Psychological Association (APA)-accredited doctoral level schools and programs of health service psychology or school psychology as well as Psychological Clinical Science Accreditation System (PCSAS)-accredited doctoral level schools of psychology.

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

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

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

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

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $111,916,000 |
| FY 2020 | $138,916,000 |
| FY 2021 Final | $149,207,000 |
| FY 2022 CR | $149,916,000 |
| FY 2023 President's Budget | $397,374,000 |

**Budget Request**

The FY 2023 Budget Request for the BHWD Program of $397.4 million is $247.5 million above the FY 2022 Continuing Resolution level. This request will fund more than 716 awards that will train over 3,500 additional behavioral health professionals per year and over 4,000 paraprofessionals as well as support over 100 individuals with loan repayments for substance use disorder related services. The increased funding supports the Administration's priority to expand the mental and behavioral health workforce. This includes expanding the BHWET Professional and BHWET Paraprofessional Programs, by approximately $172.5 million to further increase the supply of behavioral health professionals and paraprofessionals. Of the $172.5 million, $10 million will fund up to 30 Behavioral Health Integration in Community-Based Settings awards for communities that are traditionally underserved or are part of a Mental Health Professional Shortage Area to partner with local academic institutions. The Budget provides $34 million for Mental and Substance Use Disorder Workforce training, an increase of $4.3 million for the AMF Program, which 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 Budget request also includes $25 million for the Graduate Psychology program, an increase of $6 million above the FY 2022 Continuing Resolution level.

The Budget includes $52.7 million in funding for the new BHWET-Community Improvement Program to enhance community-based training partnerships for students preparing to become behavioral health professionals and paraprofessionals focused on improving health equity. Additionally, the request includes $28 million, an increase of $12.0 million, for the STAR Loan Repayment Program to recruit and retain medical, nursing, behavioral/mental health clinicians

and paraprofessionals who provide direct treatment or recovery support of patients with or in recovery from a substance use disorder. All the BHWD Programs will work to expand the behavioral health workforce to address the nation's unmet mental and behavioral health care needs.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[66] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.34 Number of students currently receiving training in behavioral health degree and certificate programs (Outcome) | FY 2020: 6,454<br><br>Target: 4,500<br><br>(Target Exceeded) | 6,000 | 12,000 | + 6,000 |
| 2120.01 Number of graduates completing behavioral health programs and entering the behavioral health workforce (Outcome) | FY 2020: 4,828<br><br>Target: 3,000<br><br>(Target Exceeded) | 5,000 | 10,000 | + 5,000 |
| 6.I.C.36 Number of graduate-level psychology students supported in GPE program (Outcome) | FY 2020: 376<br><br>Target: 200<br><br>(Target Exceeded) | 200 | 350 | + 150 |

[66] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[66] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.37 Number of interprofessional students trained in GPE program (Outcome) | FY 2020: 3,937<br><br>Target: 1,900<br><br>(Target Exceeded) | 1,900 | 3,800 | + 1,900 |
| 6.I.C.53 Number of OWEP trainees currently receiving training in opioid-related behavioral health degree and certificate programs (Outcome)[67] | FY 2020: 3,290<br><br>Target: 3,290 (Baseline) | Discontinued | Discontinued | N/A |
| 6.I.C.54 Number of OWEP graduates completing opioid-related behavioral health programs and entering the behavioral health workforce (Outcome)[68] | FY 2020: 2,255<br><br>Target: 2,255 (Baseline) | Discontinued | Discontinued | N/A |
| 6.I.C.61 Number of new addiction medicine and addiction psychiatry fellowship graduates entering workforce (Outcome and Developmental) | FY 2020: 63<br><br>Target: 63<br><br>(Baseline) | 63 | 63 | Maintain |

[67] FY 2021 was the final year of funding for the Opioid Workforce Enhancement Program (OWEP).
[68] FY 2021 was the final year of funding for the Opioid Workforce Enhancement Program (OWEP).

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[66] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.62 Number of substance use disorder treatment providers receiving loan repayment (Output and Developmental)[69] | FY 2021: 255<br><br>Target: 255<br><br>(Baseline) | 255 | 350 | Maintain |

**Program Activity Data**

| Program Outputs | Year and Most Recent Result | FY 2021 Target | FY 2022 Target | FY 2023 Target |
|---|---|---|---|---|
| Number of GPE clinical training experiences that incorporated interprofessional team-based care training | FY 2020: 732 | 400 | 600 | 600 |

**Behavioral Health Workforce Development Programs Grant Award Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 212 | 212 | 408 |
| **Average Award** | $396,984 | $449,501 | $549,501 |
| **Range of Awards** | $26,560 -$800,000 | $26,560 -$800,000 | $26,560 -$800,000 |

[69] This measure reports the number of providers that received loan repayment in FY 2021 and funded in both FY 2020 and FY 2021.

**Substance Use Disorder Treatment and Recovery Loan Repayment Program Award Table**

| | FY 2021 Final[70] | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 255 | 66 | 112 |
| **Average Award** | $103,603 | $250,000 | $250,000 |
| **Range of Awards** | $1,867 - $269,125 | $50,000 - $250,000 | $50,000 - $250,000 |

**GPE Grant Award Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 49 | 55 | 55 |
| **Average Award** | $361,558 | $361,558 | $361,558 |
| **Range of Awards** | $83,235 - $450,000 | $83,235 - $450,000 | $83,235 - $450,000 |

[70] Funding for FY 2021 included $12.0 Million for FY 2020 and $16.0 million for FY 2021.

## Public Health Workforce Development

## Public Health and Preventive Medicine Training Grant Programs

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $17,000,000 | $17,000,000 | $18,000,000 | +$1,000,000 |
| **FTE** | 4 | 4 | 4 | --- |

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

FY 2023 Authorization .....$17,000,000

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

**Program Description and Accomplishments:**

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

| Program | FY 2021 Final | FY 2022 CR | FY 2023 President's Budget |
|---|---|---|---|
| Public Health Training Centers Program | $9,700,258 | $9,700,258 | $10,000,000 |
| Preventive Medicine Residency Program | $7,299,742 | $7,299,742 | $8,000,000 |

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

and consultation to these public health personnel. The primary targets for education and training through the PHTC Program are frontline public health workers, middle managers, and staff in other parts of the public health system.

HRSA has continued to fund 10 PHTCs, one for each HHS region, to ensure that the United States and its territories and jurisdictions have access to quality public health workforce education and training. Each Regional PHTC encompasses a designated geographic area or medically underserved population that provides specialized technical assistance reflective of that Region's unique needs.

In Academic Year (AY) 2020-2021, Regional PHTCs partnered with 248 sites (e.g., local health departments, academic institutions, and community-based organizations) to provide more than 325 clinical training experiences to student trainees. Approximately 73 percent of these training sites were located in medically underserved communities, 25 percent were located in primary care settings, and 35 percent offered COVID-19-related services. PHTC awardees also delivered 2,901 unique continuing education courses (over 5,600 instructional hours) to 343,887 individuals during the academic year, 26 percent of whom were currently employed in medically underserved communities.

HRSA recently completed a five-year outcome evaluation of PHTC program activities using data from AY 2015-2016 to AY 2019-2020. During this time period, PHTCs trained 1,081,148 individuals—including 361,775 public health professionals—through 12,560 continuing education courses, 53 percent of which were accessible anytime online. These courses primarily reached front line/entry level public health workers (67 percent) and program managers/supervisors (29 percent). In addition, the PHTC program trained 1,107 public health students, 42 percent of whom were underrepresented minorities or from disadvantaged backgrounds. PHTC awardees distributed $2,541,516 in stipends to public health students. Students received one year of stipend support with an average stipend amount of $2,269. Furthermore, 685 faculty and 913 students collaborated on PHTC-supported projects. The most frequently covered topics were the development of evidence-based programs (28 percent) and community health assessments (23 percent). PHTC awardees coordinated field placements for 1,335 students at sites located in 49 states, the District of Columbia, and four jurisdictions. Approximately three quarters of the sites were in medically underserved or rural communities. PHTC students at field placement sites accumulated a total of 155,857 hours training in medically underserved communities, 47,647 hours training in primary care settings, and 46,048 hours training in rural areas. Of the 981 individuals who completed their PHTC faculty-student collaboration projects or field placements, 56 percent intended to work in medically underserved communities, 23 percent intended to work in primary care settings, and 22 percent intended to work in rural settings.

In FY 2022, HRSA made new awards to the Regional Public Health Training Centers to develop and implement training focused on regional needs and that aligns 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. In FY 2023, HRSA will fund 10 Regional PHTC continuation awards.

**Eligible Entities:** Health professions schools, including accredited schools or programs of public health, health administration, preventive medicine, or dental public health or schools providing health management programs; academic health centers; State or local governments; or any other appropriate public or private nonprofit entity.

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

***Preventive Medicine Residency (PMR) Program:*** The purpose of the PMR Program is to increase the number of preventive medicine physicians and promote greater access to preventive medicine. This program provides support for residents in medical training in preventive medicine, including stipends for residents to defray the costs associated with living expenses, tuition, and fees. The Program aims to increase the number and quality of preventive medicine residents and physicians to support access to preventive medicine to improve the health of communities.

In Academic Year 2020-2021, the PMR Program provided financial support to 81 residents, the majority of whom received clinical or experiential training in a primary care setting (80 percent) and/or a medically underserved community (69 percent). Seventy-four percent received training in telehealth, and 56 percent of residents received training in substance use treatment. Furthermore, 100 percent of residents received COVID-19-related training, and 69 percent received training in health equity/the social determinants of health. Of the 58 residents who completed their residency training programs during the academic year, 35 percent intended to become employed in public health/prevention settings, 31 percent intended to pursue employment or further training in primary care settings, and 22 percent intended to pursue employment or further training in medically underserved communities. In addition, 45 of last year's program completers provided one-year follow-up data: 36 percent were currently employed in or pursuing further training in medically underserved communities, 36 percent were employed in public health/prevention settings, and 24 percent were currently employed in or pursuing further training in primary care settings.

PMR awardees partnered with 162 sites (e.g., academic institutions, ambulatory care sites, state and local health departments, and hospitals) to provide 492 clinical training experiences for PMR residents. Forty-one percent of these training sites were located in medically underserved communities and 35 percent were primary care settings. In addition, 34 percent offered

telehealth services, 30 percent offered substance use treatment services, and 28 percent offered integrated behavioral health services in a primary care setting.

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $16,915,000 |
| FY 2020 | $17,000,000 |
| FY 2021 Final | $17,000,000 |
| FY 2022 CR | $17,000,000 |
| FY 2023 President's Budget | $18,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Public Health and Preventive Medicine Training Grant Programs of $18.0 million is $1.0 million above the FY 2022 Continuing Resolution level. This request will fund the current 10 PHTC awards and 20 new PMR 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 needs and that align with agency priorities. Some activities include development of micro learning instructional sessions on real time public health issues, aiding in the formulation of state and local workforce development plans, and expanding regional Public Health Leadership Institutes.

The Preventive Medicine Residency Program will make 20 new awards. The awards 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 FQHCs in rural areas.

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[71] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.9 Number of trainees participating in continuing education sessions delivered by PHTCs. (Outcome) | FY 2020: 343,887 Target: 160,000 (Target Exceeded) | 160,000 | 350,000 | + 190,000 |
| 6.I.C.18 Number of instructional hours offered by PHTCs. (Outcome) | FY 2020: 5,630 Target: 6,000 (Target Not Met) | 6,000 | 6,300 | + 300 |
| 6.I.C.19 Number of PHTC-sponsored public health students that completed field placement practicums in State, Local, and Tribal Health Departments (Outcome) | FY 2020: 283 Target: 180 (Target Exceeded) | 180 | 275 | + 95 |

**Program Activity Data**

| PMR Program Outputs | Year and Most Recent Result | FY 2021 Target | FY 2022 Target | FY 2023 Target |
|---|---|---|---|---|
| Number of preventive medicine residents participating in residencies | FY 2020: 81 | 75 | 80 | 80 |
| Number of preventive medicine residents completing training | FY 2020: 58 | 40 | 50 | 50 |
| Percent of program completers who are URMs | FY 2020: 28% | 20% | 20% | 20% |

[71] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

**Grant Awards Table – Public Health Training Centers Program**

| | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 10 | 10 | 10 |
| **Average Award** | $891,381 | $900,000 | $900,000 |
| **Range of Awards** | $767,470 - $1,087,248 | $780,000 - $1,105,000 | $780,000 - $1,105,000 |

**Grant Awards Table – Preventive Medicine Residency Program**

| | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 17 | 17 | 20 |
| **Average Award** | $391,001 | $391,001 | $391,912 |
| **Range of Awards** | $349,719 - $400,000 | $349,719 - $400,000 | $365,405 - $400,000 |

## Nursing Workforce Development

## Advanced Nursing Education Programs [72]

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $80,581,000 | $80,581,000 | $105,581,000 | +$25,000,000 |
| **FTE** | 9 | 9 | 10 | +1 |

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

FY 2023 Authorization ..... $137,837,000

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

**Program Description and Accomplishments:**

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

***Advanced Nursing Education Workforce (ANEW) Program:*** In FY 2019, HRSA established the ANEW Program to train advanced practice registered nursing (APRN) students to provide primary care in rural and underserved communities. The program aims to do so by supporting innovative academic-practice partnerships that prepare primary care APRNs for the unique challenges of practicing in rural and underserved communities, thereby increasing access to needed primary care for these populations. The partnerships support traineeships as well as academic-practice program infrastructure for schools of nursing and their practice partners to deliver longitudinal primary care clinical training experiences with rural and/or underserved populations. The partnerships also help link program graduates to the HRSA Health Workforce Connector, which helps connect eligible professionals to communities in need, and other existing support resources so they can find employment in rural and underserved community-based settings. The program goal is to increase the number of primary care Nurse Practitioners, clinical nurse specialists and Nurse Midwives serving rural and underserved populations, thereby improving access to care and increasing the distribution of health care providers.

In Academic Year 2020-2021, awardees of the ANEW Program trained 4,379 nursing students, more than one third of whom were underrepresented minorities and/or from disadvantaged backgrounds (38 percent). The ANEW program produced 1,644 graduates who were ready to enter the health care workforce. Of the 1,627 students who were directly funded by ANEW, the

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

majority trained in primary care settings (77 percent), in medically underserved communities (75 percent), and/or in a setting that offered telehealth (62 percent). Forty-eight percent of students received training in opioid use treatment. More than 65 percent of students who were directly funded received COVID-19 related training and 37 percent received health equity training. For individuals for whom one-year post graduation data was available, over half were pursuing additional training in a medically underserved community (53 percent). In addition, 51 percent of the recently graduated individuals were working in a primary care setting.

To provide clinical training experiences to nursing students, awardees partnered with 2,049 clinical training sites in primary care settings (75 percent), medically underserved communities (65 percent), and/or rural areas (33 percent). More than half of the partner sites provided services to individuals with mental health or substance use disorders (51 percent) and uninsured or underinsured individuals and families (52 percent); 21 percent offered services to undocumented immigrants. ANEW awardees developed or enhanced 520 courses for trainees, provided 135 continuing education courses to practicing professionals, and offered 167 faculty and preceptor development programs.

***Advanced Nursing Education-Sexual Assault Nurse Examiners (ANE-SANE) Program***: Established in 2018, the Advanced Nursing Education – Sexual Assault Nurse Examiners (ANE-SANE) program increases the number of RNs, APRNs and forensic nurses trained and certified as sexual assault nurse examiners (SANEs) in communities on a local, regional and/or state level. The purpose of the ANE-SANE program is to fund advanced nursing education to recruit, train and certify nurses to practice as sexual assault nurse examiners (SANEs). The program aims to increase the supply and distribution of qualified working SANEs and expand access to sexual assault forensic examinations. By expanding access to SANEs, the ANE-SANE program aims to provide better physical and mental health care treatment for survivors of sexual assault and domestic violence leading to better evidence collection and potentially higher prosecution rates. Programs are required to form collaborative linkages (partnerships) to support training, participant recruitment, training access, practice experience opportunities, practice retention efforts, and to cultivate environments conducive to SANE training and practice throughout the period of performance.

In Academic Year 2020-2021, awardees from the ANE-SANE Program trained 2,360 students and produced 858 graduates. The majority of trainees were from a rural and/or disadvantaged background (57 percent). More than half of SANE trainees received their training in medically underserved communities (53 percent) and about one in ten received training in rural areas (13 percent). Twenty-one percent of students participated in health equity training and approximately 19 percent participated in COVID-19-related training. The ANE-SANE awardees partnered with 169 clinical training sites in medically underserved communities (81 percent), rural areas (28 percent), and/or primary care settings (21 percent). More than 90 percent of the sites provided services to victims of interpersonal violence, abuse, or trauma. SANE awardees developed and/or enhanced 109 courses, 28 percent of which were focused on evidence-based practice.

In FY 2023, HRSA plans to continue supporting the training of SANEs through partnerships that promote recruitment of trainees, interagency collaboration, and integration of trauma-informed,

evidence-based sexual assault and domestic violence services into training and practice settings. The program will continue its focus on promoting and increasing partnerships with HRSA-supported health centers, other HRSA-funded sites, and critical shortage facilities; and supporting technical assistance to improve processes and address system-level and structural barriers to SANE training and practice. HRSA made 20 new awards in FY 2021. HRSA anticipates $9.0 million in 20 continuation awards for the ANE-SANE Program in FY 2023.

***Nurse Anesthetist Traineeships (NAT) Program:*** In existence for over two decades, the purpose of the NAT Program is to increase the number of Certified Registered Nurse Anesthetists providing care, especially to rural and underserved populations. NAT program aims to achieve this by providing support to full-time nurse anesthetist trainees, through educational institutions. The funds for the NAT Program are distributed among all eligible applicant institutions based on a formula. Accredited institutions that educate Registered Nurses to become Certified Registered Nurse Anesthetists will disburse funds to Student Registered Nurse Anesthetists in the form of traineeship support. Student Registered Nurse Anesthetists may use traineeship funds during the period for which the traineeship is provided for full or partial costs of the tuition and fees, any required books/e-books and reasonable living expenses (stipends). The program supports eligible entities to meet the cost of traineeships for individuals (full-time only) in nurse anesthesia degree programs, lessening the financial barrier to program completion and increasing the number of certified registered nurse anesthetists providing care, especially to rural and underserved populations. The NAT Program intent is to increase the number of Certified Registered Nurse Anesthetists nationally who are well prepared and well positioned to practice independently and deliver evidence-based, high quality, and safe anesthesia and services related to the management and treatment of acute and chronic pain.

In Academic Year 2020-2021, awardees of the NAT Program provided direct financial support to 1,757 nurse anesthetist students. Students received clinical training in medically underserved communities (81 percent), rural areas (33 percent), and/or primary care settings (23 percent). In addition, NAT trainees participated in opioid use treatment (81 percent), COVID-19 related training (73 percent), and/or substance use treatment (65 percent). In total, 1,323 students graduated from their degree programs and entered the workforce. At the time of graduation, 52 percent of graduates intended to pursue employment or further training in medically underserved communities, 18 percent planned to pursue employment or further training in a primary care setting, and 14 percent planned to pursue employment or further training in a rural area. Of prior year graduates for whom one year follow-up data was available, 49 percent were employed in a medically underserved and/or rural community.

***Advanced Nursing Education Nurse Practitioner Residency and Fellowship (ANE-NPRF) Program*:** In FY 2023, HRSA intends to combine the current Advanced Nursing Education Nurse Practitioner Residency Program (ANE-NPR) and Advanced Nursing Education Nurse Practitioner Residency Integration Program (ANE-NPRIP) into one program called the Advanced Nursing Education Nurse Practitioner Residency and Fellowship (ANE-NPRF) Program. In some instances, the same entity is a recipient of funding from both programs. Combining ANE-NPR and ANE-NPRIP into the new ANE-NPRF Program is intended to improve program efficiency while reducing burden for award recipients managing awards in both programs.

The ANE-NPRF Program will prepare new primary care and behavioral health nurse practitioners and maternal health providers, to work in community-based settings with an integration of behavioral health. The program seeks to increase the number of new primary care Nurse Practitioners (adult, family, adult gerontology, pediatric and women's health), behavioral health Nurse Practitioners (psychiatric/mental health) and certified nurse midwives serving in behavioral health integrated community-based settings; and by supporting the expansion and/or enhancement of existing Nurse Practitioners residency programs.

The program will fund accredited Nurse Practitioner Residency programs as well as programs in the accreditation process for practicing postgraduate Nurse Practitioners (Residents or Fellows) in primary care or behavioral health. This proposed new ANE-NPRF program will require merging the Nurse Practitioner Optional Fellowship Program funding line into the Advanced Nursing Education funding line, and combining the funding reserved for ANE-NPR under the ANE funding line with the funding appropriated for ANE-NPRIP (or NPOFP).

In Academic Year (AY) 2020-2021, the ANE-NPR Program trained 319 nurse practitioner (NP) residents and graduated 171 NP residents. Almost all of the NP residents received training in medically underserved communities (99 percent) and/or a primary care setting (99 percent). Moreover, the majority of the NP residents participated in trainings related to COVID-19 (96 percent), opioid use treatment (90 percent), and/or trained in a setting that offered telehealth (90 percent).Sixty-six percent of AY 2020-2021 graduates were employed in a primary care setting, 63 percent were employed in a medically underserved community, and 26 percent were employed in a rural area. Of prior year graduates, 77 percent were working in primary care settings one year after graduation, 77 percent were working in medically underserved communities, and 31 percent were working in a rural area. Fifty-two percent of AY 2020-2021 graduates and 77 percent of prior year graduates were employed in FQHCs or look-alikes and Rural Health Clinics.

The ANE-NPRIP Program trained 49 NP residents during AY 2020-2021, 22 percent of whom were from underrepresented minority and/or disadvantaged backgrounds. One hundred percent of the NP residents received training in primary care settings and medically underserved communities, and 43 percent received training in rural settings. Moreover, all NP residents participated in trainings related to COVID-19 (100 percent), health equity (100 percent), and integrated behavioral health in primary care (100 percent) and trained in a setting that offers telehealth (100 percent). Eighty-eight percent of residents received training in medication assisted treatment (MAT) for substance use disorder/opioid use disorder, leading to 55 percent of residents receiving a waiver from the Substance Abuse and Mental Health Services Administration to prescribe MAT.

***Nursing Workforce Advancing Health Equity (NWAHE) Technical Assistance Center Program:***

In FY 2023, HRSA will establish the Nursing Health Workforce Advancing Health Equity (NWAHE) Technical Assistance (TA) Center. The purpose of the NWAHE program is to advance health equity, including the well-being of patients and communities, by providing training and TA to academic institutions that educate, and health care organizations that employ advanced nurses. This program will develop and provide tailored technical assistance (TA) to

institutions to train, adopt and support practices that assist advanced nurses to address health equity in practice.

***Growing and Diversifying the Nursing Workforce Program:***
HRSA will award $25.0 million in grants, including planning grants, to grow and diversify the maternal and perinatal health nursing workforce by increasing and diversifying the number of Certified Nurse Midwives (CNMs) with a focus on practitioners working in rural and underserved communities. The program will fund accredited nurse midwifery programs or other eligible entities to award scholarships to students and RNs to cover the total cost of tuition for the duration of the nurse midwifery program. And will support the planning/development of new midwife training programs. In addition, the program will also support costs for each project to administer the training. The aim is to increase and expand the supply and distribution of, and access to qualified diverse CNMs through support for new and existing nurse midwifery training programs. This will be accomplished by recruiting a diverse student pool, supporting academic–practice partnerships, providing longitudinal immersion training and creating post-employment opportunities. This funding will help advance equity and address disparities in maternal mortality.

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $74,210,000 |
| FY 2020 | $80,581,000 |
| FY 2021 Final | $80,581,000 |
| FY 2022 CR | $80,581,000 |
| FY 2023 President's Budget | $105,581,000 |

**Budget Request**

The FY 2023 Budget Request for the ANE Program of $105.6 million is $25.0 million above the FY 2022 Continuing Resolution level. The Budget includes an increase of $25.0 million for grants to grow and diversify the maternal and perinatal health nursing workforce by increasing and diversifying the number of Certified Nurse Midwives (CNMs) with a focus on practitioners working in rural and underserved communities. Funding will provide approximately 25 grants to eligible organizations to support the full cost of tuition and other educational expenses per student, and train an estimated 330 trainees over the span of the program.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[73] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.38 Number of students trained in advanced nursing degree programs (Outcome) | FY 2020: 4,379<br>Target: 3,700<br>(Target Exceeded) | 3,700 | 4,800 | + 1,100 |
| 6.I.C.39 Percent of students trained who are URMs and/or from disadvantaged backgrounds (Outcome) | FY 2020: 38%<br>Target: 36%<br>(Target Exceeded) | 36% | 38% | + 2 percentage points |

[73] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[73] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.40 Number of graduates from advanced nursing degree programs (Outcome) | FY 2020: 1,644<br>Target: 1,000<br>(Target Exceeded) | 1,000 | 2,000 | + 1,000 |

**Program Activity Data**

| ANE Program Outputs | Year and Most Recent Result | FY 2021 Target | FY 2022 Target | FY 2023 Target |
|---|---|---|---|---|
| Number of students supported in NAT program | FY 2020: 1,757 | 2,400 | 2,400 | 2,400 |
| Number of graduates from NAT program | FY 2020: 1,323 | 1,050 | 1,200 | 1,200 |
| Percent of NAT graduates who are minority and/or from disadvantaged backgrounds | FY 2020: 26% | 30% | 30% | 30% |
| Percent of graduates from NAT programs employed in underserved areas | FY 2020: 45% | 45% | 50% | 50% |
| Number of graduates from ANE-SANE program | FY 2020: 858 | 300 | 300 | 850 |

**Grant Awards Table**

| | FY 2021 Final Level | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 204 | 204 | 210 |
| **Average Award** | $372,941 | $372,941 | $372,941 |
| **Range of Awards** | $1,000 - $1,000,000 | $1,000 - $1,000,000 | $1,000 - $1,000,000 |

## Nursing Workforce Diversity

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $19,843,000 | $19,843,000 | $23,344,000 | +$3,500,000 |
| **FTE** | 3 | 3 | 4 | +1 |

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

FY 2023 Authorization .....$137,837,000

Allocation Method .....Competitive Grant/Contract

**Program Description and Accomplishments:**

The Nursing Workforce Diversity (NWD) Program increases nursing education opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities who are underrepresented among registered nurses. The overarching goal of the NWD Program is to increase access to high quality, culturally aligned registered nurse providers that reflect the diversity of the communities in which they serve. This goal is accomplished by assisting students from disadvantaged backgrounds to become registered nurses through student stipends, scholarships, pre-entry preparation and retention activities; facilitating diploma or associate degree registered nurses to become baccalaureate-prepared registered nurses; and preparing practicing registered nurses for advanced nursing education. The NWD Eldercare Enhancement (NWD-E2) Program strengthens the eldercare workforce communities where there are health care disparities related to access and delivery of care through the expansion of these opportunities for students from disadvantaged backgrounds. NWD-E2 aims to achieve a sustainable eldercare nursing workforce and equip the nursing students with the competencies necessary to address health care disparities related to access and delivery of care of elderly populations in rural and underserved areas.

In FY 2021, HRSA supported 32 new NWD awards, two NWD-E2 continuation awards, and three new NWD-E2 awards were fully funded. In FY 2022, HRSA will support 32 NWD continuing awards and 2 new awards. In FY 2023, HRSA will support approximately 3 new NWD awards and 34 continuing NWD awards.

In Academic Year 2020-2021, the NWD Program supported 64 college-level degree programs as well as 139 training programs and activities designed to recruit and retain health professions students. These programs trained 10,155 students—5,953 nursing students enrolled in degree programs and 4,202 participants in academic support programs. A total of 4,653 students graduated or completed their programs. Twenty-nine percent of nursing students in NWD programs identified as Hispanic or Latino, almost five times higher than the national nursing

estimates, and 14 percent identified as Black or African American, 50 percent higher than the national nursing estimates.[74] The NWD Program directly funded 1,603 nursing students, 100 percent of whom were underrepresented minorities and/or from disadvantaged backgrounds.

In addition to providing support to students, NWD awardees partnered with 778 training sites during the academic year to provide 9,920 clinical training experiences to trainees across all programs. Forty-seven percent of training sites were located in medically underserved communities, 41 percent were in primary care settings, and 16 percent were in rural areas. Seventy-four percent of the sites served elderly populations and 73 percent served the chronically ill.

In Academic Year 2020-2021, the NWD-E2 Program supported two college-level degree programs and one training program designed to recruit and retain health professions students. These programs trained 63 students—23 nursing students enrolled in degree programs and 40 participants in academic support programs. A total of 12 students graduated or completed their programs. Thirty-nine percent of nursing students in NWD-E2 Programs identified as Black or African American, almost four times higher than the national nursing estimates, and 30 percent identified as Hispanic or Latino, almost five times higher than the national nursing estimates.[75] The NWD-E2 Program directly funded 22 nursing students, 100 percent of whom were underrepresented minorities and/or from disadvantaged backgrounds.

**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.

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

[74] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2017. Sex, Race, and Ethnic Diversity of U.S, Health Occupations (2011-2015), Rockville, Maryland.
[75] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2017. Sex, Race, and Ethnic Diversity of U.S, Health Occupations (2011-2015), Rockville, Maryland.

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $17,257,000 |
| FY 2020 | $18,343,000 |
| FY 2021 Final | $19,843,000 |
| FY 2022 CR | $19,843,000 |
| FY 2023 President's Budget | $23,343,000 |

**Budget Request**

The FY 2023 Budget Request for the NWD Program of $23.3 million is $3.5 million above the FY 2022 Continuing Resolution level. The request will fund 37 awards of which 34 are continuation awards and 3 are new 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.

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[76] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.41 Percent of program participants who are URMs and/or from disadvantaged backgrounds (Outcome) | FY 2020: 100%<br>Target: 98%<br>(Target Exceeded) | 98% | 98% | Maintain |
| 6.I.C.42 Number of program participants who participated in academic support programs during the academic year (Outcome) | FY 2020: 4,242<br>Target: 4,500<br>(Target Not Met) | 4,500 | 5,000 | + 500 |
| 6.I.C.43 Number of program participants who are enrolled in a nursing degree program (Outcome) | FY 2020: 5,976<br>Target: 3,000<br>(Target Exceeded) | 2,500 | 6,000 | + 3,500 |

[76] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

**Program Activity Data**

| NWD Program Outputs | Year and Most Recent Result | FY 2021 Target | FY 2022 Target | FY 2023 Target |
|---|---|---|---|---|
| Percent of URM students | FY 2020: 48% | 60% | 60% | 50% |
| Number of nursing students graduating from nursing programs | FY 2020: 1,620 | 2,500 | 2,500 | 3,570 |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 37 | 34 | 37 |
| **Average Award** | $471,884 | $530,740 | $602,500 |
| **Range of Awards** | $95,679 - $555,000 | $384,822 - $555,000 | $555,000 -$650,000 |

## Nurse Education, Practice, Quality and Retention Programs

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $46,757,000 | $46,913,000 | $48,913,000 | +$2,000,000 |
| **FTE** | 5 | 5 | 5 | --- |

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

FY 2023 Authorizations.....$137,837,000

Allocation Method .....Competitive Grant/Contract

**Program Description and Accomplishments:**

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

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

***Mobile Health Training Program***

The NEPQR-Mobile Health Training Program (MHTP) will launch in FY 2022 to address the need for health equity in rural and underserved communities. The purpose of this program is to improve and strengthen health equity in the nursing workforce with education and training to provide culturally aligned quality care in rural and underserved areas. The program will encourage recruitment and training of nursing students to address and manage social determinants of health (SDOH) and improve health equity of vulnerable populations in rural and underserved areas through nurse-led mobile health training sites. The NEPQR-MHTP will create and expand experiential learning opportunities for nursing students, including the provision of high-quality culturally sensitive care, identification of SDOH in local communities, engagement in critical thinking, and clinical practice highlighting a collaborative team approach to care. HRSA anticipates making $35.0 million in new awards to approximately 35 grantees in FY 2022.

***Interprofessional Collaborative Practice (IPCP): Behavioral Health Integration (BHI) Program:*** The IPCP: BHI Program was initiated in July 2016 to address the significant unmet need for behavioral health services in community-based primary care settings. The purpose of this three-year program is to increase the access to and quality of behavioral health services through team-based care models in interprofessional nurse-led primary care teams in rural or underserved areas. The IPCP: BHI program will increase the training of the current and future nursing workforce and strengthen their ability to provide integrated behavioral health care services in primary care settings through academic-practice partnerships. In FY 2022, HRSA will continue to support the 17 awards made in FY 2020. In FY 2023, HRSA plans allocate an additional $2.0 million to implement new programs to support integrate behavioral health services in primary care settings.

In Academic Year 2020-2021, IPCP: BHI awardees trained 1,895 individuals and produced 1,097 graduates. Awardees partnered with 73 clinical sites to provide inter-professional team-based training to 1,100 individuals. Three-fourths of the clinical training sites were located in medically underserved communities (75 percent), over two-thirds were in primary care settings (67 percent), and almost half were in rural areas (47 percent). Two-thirds of the clinical training sites offered integrated behavioral health services in a primary setting (66 percent), 73 percent offered telehealth services, and 58 percent offered COVID-19 related services.

***Registered Nurses in Primary Care (RNPC) Training Program:*** The RNPC Training Program was initiated in July 2018, to achieve a sustainable primary care nursing workforce equipped with the competencies necessary to address pressing national public health issues, even the distribution of the nursing workforce, improve access to care and improve population health outcomes. The purpose of this four-year training program is to recruit and train nursing students and current registered nurses (RNs) to practice to the full scope of their license in community-based primary care teams to increase access to care, with an emphasis on chronic disease prevention and control, including mental health and substance use conditions.

In Academic Year 2020-2021, the RNPC Training Program trained 2,049 individuals in primary care nursing programs and produced 1,046 graduates. Seven in ten nursing students participated in training related to COVID-19 (70 percent); additionally, 36 percent received training in substance use treatment and 33 percent received training in opioid use treatment. RNPC awardees partnered with 596 training sites to provide experiential training. These training sites were located in primary care settings (74 percent), medically underserved communities (66 percent), and/or rural areas (41 percent). The majority of the clinical training sites offered COVID-19 related services (71 percent). In addition, clinical sites provided telehealth services (63 percent) and integrated behavioral health services in primary care settings (39 percent). RNPC awardees developed or enhanced 483 courses for students—31 percent related to primary care and 11 percent related to chronic disease, including mental health and substance use conditions.

In response to the COVID-19 pandemic, HRSA provided supplemental funding to RNPC awardees to support telehealth activities. Using these funds, awardees enhanced or developed an additional 161 courses, training programs, and activities, which were offered to over 9,500

students, professionals, and faculty. Over one-third of the courses and training programs and activities funded with COVID-19 supplemental funds focused specifically on telehealth (34 percent), and 15 percent focused on providing care in primary care settings.

HRSA awarded approximately $27.0 million in continuation awards to 42 grantees in FY 2021 and FY 2022.

***Veteran Registered Nurses in Primary Care (VNPC) Training Program:*** The VNPC Training Program was initiated in 2019 to achieve a sustainable primary care nursing workforce equipped with the competencies necessary to address pressing veteran public health issues, as well as the distribution of the nursing workforce, improve access to care and improve population health outcomes. The purpose of this three-year training program is to recruit and train veteran nursing students and current RNs to practice to the full scope of their license in community-based primary care teams to increase access to care, with an emphasis on veteran care, chronic disease prevention and control, including mental health and substance use conditions. HRSA awarded approximately $3.5 million in continuation awards to seven grantees in FY 2021 and FY 2022.

In Academic Year 2020-2021, the VNPC Program supported 130 veterans pursuing their Bachelor of Science in Nursing (BSN). A majority of veterans trained in medically underserved communities (75 percent) and/or primary care settings (50 percent). In addition, trainees participated in COVID-19 related training (53 percent), trained in telehealth (52 percent), and/or trained in opioid use treatment (39 percent). The VNPC awardees partnered with 50 clinical training sites to offer experiential training. The majority of training sites in the VNPC program were in primary care settings (82 percent) and/or medically underserved communities (66 percent). Additionally, clinical sites offered services related to COVID-19 (82 percent), integrated behavioral health services in primary care settings (40 percent), opioid use treatment (32 percent), and/or substance use treatment (32 percent). Awardees enhanced or developed a total of 63 courses; 32 percent of the courses focused on primary care and/or community-based collaboration and 30 percent focused on veterans' health.

In response to the COVID-19 pandemic, HRSA provided supplemental funding to VNPC awardees to support telehealth activities. Using these funds, awardees developed or enhanced an additional 15 courses and training activities, which were offered to 373 students, professionals, and faculty. Forty percent of the offered courses and trainings focused specifically on telehealth, and 27 percent focused on infectious disease and/or the COVID-19 pandemic.

***Simulation Education Training (SET) Program****:* The NEPQR-SET Training Program was initiated in FY 2020 to enhance public health nursing education and practice with the use of simulation-based technology to advance the health of patients, families, and communities in rural and medically underserved areas experiencing diseases and conditions. In FY 2021, HRSA awarded over $5.0 million in new awards to 10 grantees.

In Academic Year 2020-2021, NEPQR-SET awardees trained 2,934 individuals, 71 percent of whom were underrepresented minorities and/or from disadvantaged backgrounds. The program produced 1,150 graduates during this time frame. Awardees partnered with 21 clinical sites to

provide training to 460 individuals. Just over three-fourths of the clinical training sites were located in primary care settings (76 percent), 71 percent were in medically underserved communities, and almost one-half were in a rural area (48 percent). Almost all of the sites offered COVID-19 related services (95 percent) and over half offered telehealth services (57 percent). Awardees enhanced or developed 23 courses, 70 percent of which were simulation-based trainings. Thirty percent of the courses focused on health equity or health disparities.

***Nurse Education, Practice, Quality and Retention-Public Health Nurse Residency Program (NEPQR-PHNRP)****:* In FY 2023, HRSA will establish the NEPQR-PHNRP to strengthen nursing workforce capacity, improve access to care and achieve health equity through the development and implementation Public Health Nurse Residency programs. The purpose of this program is to create and implement a nursing workforce pipeline from academic institutions to clinical practice sites that provide direct hands on training and employment to registered nurses and APRNs seeking to become public health nurses.

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $41,704,000 |
| FY 2020 | $43,913,000 |
| FY 2021 Final | $46,757,000 |
| FY 2022 CR | $46,913,000 |
| FY 2023 President's Budget | $48,913,000 |

**Budget Request**

The FY 2023 Budget Request for the NEPQR Program of $48.9 million is $2.0 million above the FY 2022 Continuing Resolution level. The Budget provides an additional $2.0 million for 2 new awards for the Nurse Education Practice and Quality Retention for the Interprofessional Collaborative Practice to trains nurses to provide behavioral health services in primary care practices in rural and underserved settings.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[77] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.57 Number of NEPQR nursing students trained in primary care (Outcome) | FY 2020: 2,179<br>Target: 2,179<br>(Baseline) | 2,179 | 2,400 | + 221 |
| 6.I.C.58 Number of NEPQR trainees and professionals participating in interprofessional team-based care (Outcome) | FY 2020: 4,856<br>Target: 4,856<br>(Baseline) | 4,856 | 5,500 | + 644 |

[77] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 77 | 52 | 45 |
| **Average Award** | $633,358 | $747,062 | $950,000 |
| **Range of Awards** | $392,168 - $750,000 | $494,124 - $1,000,000 | $900,000 - $1,000,000 |

## Nurse Faculty Loan Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $28,414,000 | $28,500,000 | $28,500,000 | --- |
| **FTE** | 3 | 3 | 4 | +1 |

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

FY 2023 Authorization .....$117,135,000

Allocation Method .....Formula Grant

**Program Description and Accomplishments:**

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

In Academic Year (AY) 2020-2021, awardees supported 2,763 nursing students pursuing graduate level degrees with the intent of serving as nurse faculty. Twenty-four percent of trainees were underrepresented minorities and 24 percent came from disadvantaged backgrounds. By the end of the Academic Year, the programs graduated 779 trainees, 92 percent of whom intended to teach nursing. One year after graduation, seventy-four percent of prior year graduates were teaching in faculty appointments. The NFLP program provided loans to 2,763 graduate-level nursing students, exceeding the FY 2020 target for 6.I.C.46 (1,900 loans). This increase occurred because the NLFP program updated the definition of "full-time employment," expanding loan cancelation eligibility to include nurse faculty serving as advanced practice registered nurse preceptors for accredited schools of nursing (within an academic-practice partnership framework). Program staff also increased resource sharing, outreach, and technical assistance to NFLP awardees.

BHW conducted a five-year outcome evaluation of the NFLP program using data from AY 2015-2016 to AY 2019-2020. During this time frame, BHW funded 203 unique awardees that conducted active NFLP programs. NFLP awardees provided $147 million in loan repayment funding to between 1,998 and 2,328 nursing students each year pursuing graduate level degrees

with the intent of serving as nurse faculty. Over 50 percent of NFLP nursing graduate students focused on education and almost 20 percent focused on research. Throughout the five year period, 48 percent of NFLP graduates received Doctorate of Nurse Practitioner degrees and another 26 percent received other types of doctoral degrees. Upon program completion, 91 percent of NFLP graduates intended to teach nursing with 1,969 reporting that they already secured employment as nurse faculty. Within one year of completing NFLP, 81 percent of prior year graduates were teaching in faculty appointments, with 43 percent teaching at the undergraduate level.

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. However, even schools that do not receive new awards may continue making loans from the student loan fund accounts they have already established. NFLP grantees are expected to continue conducting training activity and maintaining the loan fund account throughout the duration of the project. Currently, NFLP has a total 205 awardees maintaining the loan fund account.

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

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $13,433,000 |
| FY 2020 | $28,500,000 |
| FY 2021 Final | $28,414,000 |
| FY 2022 CR | $28,500,000 |
| FY 2023 President's Budget | $28,500,000 |

**Budget Request**

The FY 2023 Budget Request for the NFLP Program of $28.5 million is equal above the FY 2022 Continuing Resolution level. This request will fund 80 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.

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[78] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.46 Number of graduate-level nursing students who received a loan (Outcome) | FY 2020: 2,763<br>Target:<br>1,900<br>(Target Exceeded) | 1,900 | 2,500 | + 600 |
| 6.I.C.47 Number of loan recipients who graduated from an advanced nursing degree program (Outcome) | FY 2020: 779<br>Target:<br>400<br>(Target Exceeded) | 400 | 700 | + 300 |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 79 | 80 | 80 |
| **Average Award** | $329,477 | $329,477 | $329,477 |
| **Range of Awards** | $15,900 - $2,040,607 | $15,900 - $2,040,607 | $15,900 - $2,040,607 |

[78] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

## Nurse Corps

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $88,116,000 | $88,635,000 | $88,635,000 | --- |
| **FTE** | 28 | 28 | 39 | +12 |

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

FY 2023 Authorization .....$117,135,000

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

**Program Description and Accomplishments:**

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

In exchange for 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, 2021, 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 began in 1998 to assist 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.

**Nurse Corps Scholarship Program (SP)**: The Nurse Corps SP began in 2002 to provide 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.

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 2021, 58 percent of Nurse Corps LRP participants extended their service commitment for an additional year, exceeding the 52 percent target; and in FY 2021, 84 percent of Nurse Corps participants were retained in service at a CSF for up to two years beyond the completion of their Nurse Corps service commitment.[79] In addition, in FY 2021, 89 percent of Nurse Corps SP awardees are pursuing their baccalaureate degree or advanced practice degree.

Furthermore, as the Administration seeks to continue to address the opioid epidemic and other substance use disorders across the nation, the Nurse Corps program provides support behavioral health nursing workforce. In FY 2022, 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.

The COVID-19 pandemic has added a new layer of challenges to the preservation and expansion of the nursing workforce. Stress and burnout in the nursing workforce are among the most pressing concerns. The risks of acquiring COVID-19, and concerns about transmitting the virus to family and loved ones can all contribute to burnout and an interest in changing to other careers.[80] Nurses have reported experiencing stress associated with separation from family, sleep deprivation, and heavy workloads created by health system demand and staff shortages.[81] Nurses serving throughout the country, especially those on the front lines battling this pandemic, are seeing an increased demand for their services. The Nurse Corps will initiate collaborative technical assistance efforts to share resources and best practices to reduce stress and provider burnout.

Additionally, the Nurse Corps supports increasing the skilled workforce of women's health nurses who are trained to provide care for women, and practice in rural and underserved communities. Maternal mortality and morbidity are key indicators of women's health worldwide. Each year more than 300,000 women across the globe die from complications associated with pregnancy or childbirth.[82] In 2015, the U.S. ranked 46$^{th}$ among the 181 countries

[79] In FY 2020, HRSA began using the "Clinician Dashboard" to calculate the retention rate. The Clinician Dashboard is a data visualization tool that includes data on clinicians with NPI numbers supported by the National Health Service Corps and Nurse Corps.
[80] Fernandez PR, Lord H, Halcomb PE, et al. Implications for COVID-19: a systematic review of nurses' experiences of working in acute care hospital settings during a respiratory pandemic [published online ahead of print, 2020 May 8]. *Int J Nurs Stud*. 2020;103637. doi:10.1016/j.ijnurstu.2020.103637
[81] Huang, L., Rong Liu, H., 2020. Emotional responses and coping strategies of nurses and nursing college students during COVID-19 outbreak.
[82] "Trends in Maternal Mortality: 1990 to 2015." *World Health Organization*, 24 Jan. 2020, www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en.

with a maternal mortality rate that is among the highest of developed countries.[83] Too often, women cannot initiate prenatal care within the first trimester of their pregnancy due to lack of access to providers or coverage for services.[84] Provider availability, knowledge, training, and preparedness, as well as access to life-saving medication and tools are factors that impact high maternal mortality rates. In FY 2022, 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 (CNM), and certified obstetrics and gynecology RNs.

In FY 2021, the Nurse Corps Program received a historic amount of funding through the American Rescue Plan (ARP) Act, which provided the program with $200 million in additional funding to support the nation's COVID-19 emergency response. The Nurse Corps Program plans to fully expend these funds in FY 2022. In FY 2021, the Nurse Corps made 782 awards to clinicians serving in facilities with a shortage of nurses and 325 awards to scholars pursuing a nursing education. In FY 2022, the Nurse Corps estimates making 1,030 additional awards to clinicians serving in facilities with a shortage of nurses and 300 awards to scholars pursuing a nursing education. Approximately $6 million in ARP Act funds are being used to support nurse faculty members who will train the next generation of nurses. These funds are focused on priority areas including 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.

**Eligible Entities:**

For the Nurse Corps LRP, participants must have a current license to practice as an RN who are employed full-time (at least 32 hours per week) at a public or private CSF or at an accredited public or private school of nursing.

For the 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.

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $86,701,000 |
| FY 2020 | $88,635,000 |
| FY 2021 Final | $88,116,000 |
| FY 2022 CR | $88,635,000 |
| FY 2023 President's Budget | $88,635,000 |

[83] World Health Organization. "Maternal Mortality." *World Health Organization*, 24 Oct. 2019, www.who.int/gho/maternal_health/mortality/maternal/en.
[84] Schlesinger, Mark, and Karl Kronebusch. "The Failure of Prenatal Care Policy for the Poor." *Health Affairs*, 2020, pp. 91–111, doi.org/10.1377/hlthaff.9.4.91.

**Budget Request**

The FY 2023 Budget Request for the Nurse Corps Program of $88.6 million is equal to the FY 2022 Continuing Resolution level. This request will fund an estimated 255 scholarship (new and continuation), awards and 962 loan repayment awards.

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result /Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 Target +/- FY 2022 Target |
|---|---|---|---|---|
| 2180.01: Proportion of Nurse Corps LRP participants who extend their service contracts to commit to work at a critical shortage facility for an additional year. *(Outcome)* | FY 2021: 61%<br>Target: 52%<br>(Target Exceeded) | 52% | 52% | --- |
| 2180.02: Proportion of Nurse Corps LRP/SP participants retained in service at a critical shortage facility for at least one year beyond the completion of their Nurse Corps LRP/SP commitment. | FY 2021: 88%<br>Target: 80%<br>(Target Exceeded) | 80% | 80% | --- |
| 2180.03: Proportion of Nurse Corps SP awardees obtaining their baccalaureate degree or advanced practice degree in nursing. *(Outcome)* | FY 2021: 83%<br>Target: 85%<br>(Target Not Met) | 85% | 85% | --- |
| 2180.04: Default rate of Nurse Corps LRP and SP participants. *(Efficiency)* | FY 2020:<br>LRP: 1.8%<br>SP: 1.4%<br>Target:<br>LRP: 3%<br>SP: 15%<br>(Target Exceeded) | LRP:3%<br>SP: 15% | LRP: 3%<br>SP: 15% | --- |

**Nurse Corps Loans/Scholarships Awards Table**

| | FY 2021 Final[85] | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| Loans | $104,919,353 | $59,090,000 | $59,090,000 |
| Scholarships | $54,793,487 | $29,545,000 | $29,545,000 |

**Nurse Corps Awards**

| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021[86] | 2022[87] | 2023 |
|---|---|---|---|---|---|---|---|---|
| **Scholarships** | | | | | | | | |
| New Awards | 230 | 198 | 215 | 220 | 244 | 529 | 523 | 237 |
| Continuation Awards | 12 | 14 | 4 | 6 | 13 | 15 | 16 | 18 |
| **Loan Repayment** | | | | | | | | |
| New Awards | 518 | 501 | 544 | 561 | 465 | 1,246 | 1,314 | 246 |
| Continuation Awards | 365 | 340 | 279 | 292 | 291 | 341 | 268 | 716[88] |
| **Total** | **1,125** | **1,053** | **1,042** | **1,079** | **1,013** | **2,131** | **2,121** | **1,217** |

**Nurse Corps Field Strength**

| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021[89] | 2022[90] | 2023[91] |
|---|---|---|---|---|---|---|---|---|
| Scholarship | 476 | 496 | 465 | 450 | 415 | 400 | 498 | 770 |
| Loan Repayment | 1,219 | 1,093 | 1,129 | 1,279 | 1,293 | 1,907 | 2,538 | 2,048 |
| Loan Repayment Nurse Faculty | 321 | 346 | 271 | 199 | 135 | 214 | 289 | 228 |
| **Total** | **2,016** | **1,935** | **1,865** | **1,928** | **1,843** | **2,521** | **3,325** | **3,046** |

[85] FY 2021 award amount is updated to include ARPA funding.
[86] FYs 2021, 2022 and 2023 awards and field strength are updated to include ARPA funding.
[87] *Ibid.*
[88] *Ibid.*
[89] *Ibid.*
[90] *Ibid.*
[91] *Ibid.*

## Children's Hospitals Graduate Medical Education Payment Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $349,297,000 | $350,000,000 | $350,000,000 | -- |
| **FTE** | 16 | 16 | 18 | +2 |

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

FY 2023 Authorization.. Direct GME: $105,000,000; Indirect Medical Education: $220,000,000

Allocation Method ..... Formula Based Payment

**Program Description and Accomplishments:**

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

A sufficient and appropriate health workforce, efficient organization of health care teams, and training in value-based models of care are all critical components to supporting new models of care that drive value and quality throughout the entire system. In FY 2022, the CHGME Payment Program is implementing the fourth year of the Quality Bonus System (QBS), authorized by statute to allow the Secretary of HHS to distribute bonus payments to participating CHGME hospitals that meet quality standards specified by the Secretary. The goal of the QBS is to recognize and incentivize awardees with high quality training to meet the pediatric workforce needs of the nation.

In FY 2022, CHGME includes up to an estimated $3 million available for the CHGME QBS. In order to qualify for the QBS payment, awardees must complete individual level documentation for all residents supported by the CHGME Payment Program in the FY 2022 Annual Performance Report (AY 2021-2022).

The CHGME Payment Program supports the training of residents in graduate medical education in freestanding children's teaching hospitals and supports a Full-Time Equivalent (FTE) Assessment conducted annually to verify the number of FTE resident counts reported by eligible awardees. In FY 2021, the CHGME Payment Program distributed more than $330 million to 59 eligible awardees, including nearly $1.8 million in QBS payments to 32 awardees who met the eligibility requirements. For FY 2022, the CHGME Payment Program will award more than

$330 million from the base to the same 59 eligible awardees including a QBS payment for those who meet the QBS eligibility criteria. For FY 2023, the CHGME Payment Program plans on the same level funding as the prior fiscal year and number of eligible awardees. The CHGME Payment Program has an annual project period from October 1, 2022 to September 30, 2023.

In FY 2021, 59 children's hospitals received CHGME funding. During FY 2021 (AY 2020-2021), the most recent year for which FTE information was reported, the CHGME hospitals trained 7,900 resident full-time equivalents (FTEs).[92] Among these FTEs, 42 percent were pediatric residents, 29 percent were pediatric subspecialty residents, and 29 percent were residents training in other primary disciplines such as family medicine.

During Academic Year 2020-2021, the most recent year for which performance information is available, CHGME-funded hospitals served as sponsoring institutions for 42 residency programs and 246 fellowship programs. In addition, they served as major participating rotation sites for 642 additional residency and fellowship programs. CHGME supported the training of 5,628 pediatric residents that included general pediatrics residents, as well as residents from eight types of combined pediatrics programs (e.g., internal medicine/ pediatrics).

Additionally, 2,904 pediatric medical subspecialty residents, 238 pediatric surgical subspecialty residents, and 430 adult and pediatric dentistry residents were trained. CHGME funding was also responsible for the training of 4,572 adult medical and surgical specialty residents, such as family medicine residents, who rotate through children's hospitals for pediatrics training. The total number of funded residents and fellows during Academic Year 2020-2021 was 13,772. During their training, these medical residents and fellows provided care during more than 1.4 million patient encounters in primary care settings, in addition to providing over 5.5 million patient contact hours in medically underserved communities.

Of the full-time residents and fellows who completed their training during Academic Year 2020-2021, over 61 percent of these CHGME-funded physicians chose to remain and practice in the state where they completed their residency training. Among the 330 health care delivery sites utilized for residency training, 46 percent provided telehealth services, 22 percent offered substance use treatment services, and 27 percent offered COVID-19 related services. Approximately 21 percent of residents received training in opioid use treatment, 20 percent received training in telehealth, and 65 percent received COVID-19 related training.

**Eligible Entities:** Freestanding children's teaching hospitals.

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $323,382,000 |
| FY 2020 | $340,000,000 |
| FY 2021 Final | $349,297,000 |
| FY 2022 CR | $350,000,000 |
| FY 2023 President's Budget | $350,000,000 |

**Budget Request**

The FY 2023 Budget Request for the CHGME Program of $350.0 million is equal to the FY 2022 Continuing Resolution level. This request will fund the current number of eligible children's hospitals of approximately 59 awards.

The Budget request enables HRSA to continue to support approximately 7,700 physicians FTEs for direct and indirect medical expenses for graduate medical education. Direct medical education spending includes expenditures related to stipends and fringe benefits for residents, salaries and fringe benefits of supervising faculty, costs associated with providing the GME training programs and institutional overhead costs. Indirect medical education spending includes expenditures associated with the productivity of the hospital staff as they assist in training residents, and the processing of additional diagnostic tests that residents may order during their clinical experience.

The FY 2023 funding request will support the FTE resident verification through an annual FTE Assessment contract to ensure funded FTEs counts are reported correctly and are not funded by other federal programs to avoid an overlap in payments. The funding will also support costs associated with the award process, program performance reviews, QBS eligibility reviews, and information technology and other program support costs. The funding will further support additional information technology enhancements that ensure accurate certification of FTE counts and analysis of QBS data needed to determine payments.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[93] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 7.E Percent of payments made on time. (Efficiency) | FY 2020: 100% Target: 100% (Target Met) | 100% | 100% | Maintain |
| 7.VII.C.1 Percent of hospitals with verified FTE residents counts and caps. (Output) | FY 2020: 90% Target: 90% (Target Met) | 90% | 90% | Maintain |
| 2190.01 Maintain the number of FTE residents training in eligible children's teaching hospitals. (Output) | FY 2020: 7,900 Target: 7,141 (Target Exceeded) | 7,700 | 7,700 | Maintain |

**Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 59 | 59 | 59 |
| **Average Award** | $5,624,196 | $5,604,833 | $5,604,833 |
| **Range of Awards** | $30,502 - $24,637,441 | $31,238 - $24,497,311 | $31,238 - $24,497,311 |

[93] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

## Teaching Health Center Graduate Medical Education Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $126,500,000 | $119,290,000 | $119,290,000 | --- |
| **FTE** | 9 | 9 | 16 | +7 |

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

FY 2023 Authorization .....$126,500,000

Allocation Method .....Formula-Based Payment

**Program Description and Accomplishments:**

As of August 6, 2021, an estimated 81 million people live in primary care Health Professional Shortage Areas (HPSAs), 61 million live in dental HPSAs, and 122 million live in mental health HPSAs.[94] Access to high quality primary care is associated with improved health outcomes and lower costs.[95, 96] A number of strategies are effective in incentivizing providers to choose careers in primary care and to practice in rural and underserved areas, including positive training experiences in rural and underserved communities and rotations in community-based practice locations.[97,98] There is evidence that physicians who receive training in community and underserved settings are more likely to eventually practice in similar settings, such as health centers.[99]

The Teaching Health Center Graduate Medical Education (THCGME) Program, established in 2010, increases the number of primary care physician and dental residents, which, in turn, increases the overall number of these primary care providers. Teaching Health Centers (THCs) specifically have been shown to attract residents from rural and/or disadvantaged

[94] Health Services and Resources Administration. (2021). Fourth Quarter of Fiscal Year 2021 Designated HPSA Quarterly Summary. As of August 6, 2021. Available at https://data.hrsa.gov/topics/health-workforce/shortage-areas.
[95] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Quarterly. 2005; 83(3):457-502.
[96] Chang CH, O'Malley AJ, Goodman DC. Association between Temporal Changes in Primary Care Workforce and Patient Outcomes. Health Services Research 2017; 52:634–55.
[97] Washko, M, Snyder, J, & Zangaro, G. Where do physicians train? Investigating public and private institutional pipelines. Health Affairs. 2015; 34(5): 852-856.
[98] Connelly M, et al. Variation in Predictors of Primary Care Career Choice by Year and Stage of Training. Journal of General Internal Medicine. 2003; 18(3): 159-69.
[99] Chang C, O'Malley A, Goodman D. Association between Temporal Changes in Primary Care Workforce and Patient Outcomes. Health Services Research. 2017; 52:634–55.

backgrounds.[100] 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.[101]

Unlike most federal funding for graduate medical education (GME), THCGME payments support primary training in community-based ambulatory care settings, as opposed to primarily training in-patient care settings in hospitals.

After residency training, evidence demonstrates that physicians who trained in cost-efficient geographic areas continue to provide lower-cost care in their post-residency practice.[102] In addition to increasing the number of primary care residents training in these community-based patient care settings, the THCGME Program meets the Administration's priority by increasing health care quality and expanding Americans' overall access to care.

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

In Academic Year 2021-2022, HRSA provided awards to 59 THCs that are supporting the training of 793 resident FTEs. Currently, 45 of the 59 THCs are in Federally Qualified Health Centers (FQHCs) or FQHC Look-Alikes.

In Academic Years 2022-2023, HRSA anticipates awarding approximately $220 million appropriated by the American Rescue Plan (ARP) Act of 2021 to support more than 100 THCs. These funds will be used to increase the maximum number of approved resident FTE slots to over 1,375. In addition, funds will be used to increase the PRA payment to THCGME awardees by $10,000, resulting in a total payment of $160,000 per resident FTE starting in FY 2021. In Fiscal Year 2022, 47 planning and development awards were made from the ARP Act to support the start-up of new community-based, primary care residency programs in family medicine, internal medicine, pediatrics, psychiatry, obstetrics and gynecology, general dentistry and pediatric dentistry to address the physician workforce shortages and challenges faced by rural and underserved communities.

HRSA is supporting an updated evaluation of the costs of residency training at THCs. Information and data from this evaluation will be available in FY 2023 and will provide HRSA

[100] Talib, Z, Jewers, MM, Strasser, JH, Popiel, DK, Goldberg, DG, Chen, C, Kepley, H, Mullan, Regenstein, M. Primary Care Residents in Teaching Health Centers: Their Intentions to Practice in Underserved Settings After Residency Training. Academic Medicine. 2018; 93(1): 98-103.
[101] 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.
[102] 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.

with information to help determine the appropriate per resident payment (PRA) amount for THCGME residency programs in subsequent years.

In Academic Year 2020-2021, the THCGME Program awarded 769[103] resident FTE slots that provided funding to 912 primary care medical and dental residents. Nearly all residents (98 percent) received training in a primary care setting, providing care during almost half a million patient encounters and accruing over 620,000 contact hours with these primary care patients. Additionally, most THCGME residents (93 percent) spent a significant part of their training in medically underserved and/or rural communities, providing more than 1.1 million hours of patient care to more than 850,000 patients. Approximately 19 percent of residents reported coming from a financially or educationally disadvantaged background, 20 percent reported being an underrepresented minority, and 20 percent reported a rural background. During their residency, approximately 82 percent of residents received training in opioid use treatment, 82 percent received training in telehealth, and 67 percent received COVID-19 related training.

In addition to supporting training of individual residents in Academic Year 20-21, THCGME recipients also used funding to develop or enhance curricula on topics related to primary care. Programs developed or enhanced and implemented 1,547 courses and training activities during the academic year, impacting almost 15,000 health care trainees. Over 6,400 students, residents, and other health care professionals from a variety of professions and disciplines trained alongside THCGME residents while participating in inter-professional team-based care. Among the 562 health care delivery sites utilized for residency training, 51 percent provided telehealth services, 35 percent offered COVID-19 related services, and 33 percent offered substance use treatment services.

Of the 297 residents who completed the program in Academic Year 2020-2021, 63 percent reported intentions to practice in a primary care setting, while 43 percent intended to practice in a medically underserved and/or rural area. Employment status will be assessed for these individuals one year after program completion (during Academic Year 2021-2022). Of the 228 program completers from the prior academic year for whom employment data was available, 64 percent currently practice in a primary care setting and 56 percent currently practice in a medically underserved community and/or rural area.

Since the THCGME Program began, 1,731 new primary care physicians and dentists have graduated and entered the workforce. As the national average of physicians practicing in primary care specialties is approximately 33 percent, [104] the THCGME Program has evidenced much stronger results. Cumulative follow-up data indicates that 65 percent of graduates are currently practicing in a primary setting and approximately 56 percent of the graduating physicians and dentists are currently practicing in a medically underserved community and/or rural setting. THCGME residents have cumulatively provided over 4.2 million hours of patient care in primary care settings during over 3.6 million patient encounters. Residents additionally provided over 6.7 million hours of patient care in medically underserved and rural settings, significantly expanding access to care in these key settings.

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

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

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

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $126,500,000 |
| FY 2020 | $126,500,000 |
| FY 2021 | $126,500,000 |
| FY 2022 | $119,290,000[105] |
| FY 2023 | $119,290,000[106] |

**Budget Request**

The FY 2023 Budget Request for the THCGME Program of $119.3 million is equal to the FY 2022 Continuing Resolution level.[107] This request will fund approximately 52 awards. The request will support up to 801 FTE slots. Supplemental funds under the ARP Act of 2021 will also support this activity through Academic Year 2022-2023.

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.

[105] FY 2022 reflects the post-sequestration amount.
[106] FY 2023 reflects the post-sequestration amount.
[107] Subject to Sequestration thru FY 2023.

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[108] | FY 2022 Target | FY 2023 Target | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 6.I.C.48 Percent of THCGME-supported residents training in rural and/or underserved communities (Outcome) | FY 2020: 93%<br>Target:<br>80%<br>(Target Exceeded) | 80% | 80% | Maintain |
| 2200.01 Number of resident positions supported by Teaching Health Centers. (Cumulative) [109] (Outcome) | FY 2020: 769<br>Target:<br>730<br>(Target Exceeded) | 740 | 740 | Maintain |

**Program Activity Data**

| THCGME Program Outputs | Year and Most Recent Result |
|---|---|
| Number of primary care residents funded by THCGME residencies[110] | FY 2020: 912 |
| Number of primary care residents completing training | FY 2020: 297 |
| Percent of residents who are from a disadvantaged and/or rural background | FY 2020: 33% |
| Percent of primary care resident program completers who intend to practice in primary care settings | FY 2020: 63% |

[108] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.

[109] Measure captures the number FTEs resident slots awarded and not the maximum possible nor the number of individuals receiving direct financial support through the program. Awardees may use 1 FTE slot to fund two residents at 50 percent time, thus the FTE slot is not a one to one correspondence with number of individuals trained. Number of residents also does not equal the number of graduates as primary care residency programs require one year (Dental and Geriatrics), three years (Family Medicine, Internal Medicine, and Pediatrics), or four years (Ob-Gyn and Psychiatry) of training.

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

**Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 59 | 52 | 52 |
| **Average Award** | $2,003,550 | $2,172,203 | $2,172,203 |
| **Range of Awards** | $300,000 - $8,175,000 | $320,000 - $8,720,000 | $320,000 - $8,720,000 |

## National Practitioner Data Bank

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $18,814,000 | $18,814,000 | $18,814,000 | --- |
| **FTE** | 37 | 37 | 38 | +1 |

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

FY 2023 Authorization ..... Indefinite

Allocation Method ..... User Fee Program

**Program Description and Accomplishments:**

The National Practitioner Data Bank (NPDB) is a workforce tool that improves health care quality, promotes patient safety, and deters fraud and abuse in the health care system by providing information about past adverse actions of practitioners, providers, and suppliers to authorized health care entities and agencies. With more than 1.6 million reports 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 then use this information to make informed hiring, credentialing, and privileging decisions to ultimately determine whether, or under what conditions, it is appropriate for health care practitioners, providers, and suppliers to provide health care services.

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

- In FY 2021, the NPDB responded to nearly 10.4 million queries, nearly half a million more queries than in FY 2020, from authorized health care entities, practitioners, providers, and suppliers.
- DPDB has completed the launch of attestation initiatives for HRSA's community health centers, hospitals, health plans, medical malpractice payers, all other health care entities, and authorized agents. To date, the attestation completion rate for selected health centers,

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

- In FY 2020, the NPDB released a publicly available interactive Compliance Results tool[111] that displays the compliance and attestation results for state licensing and certification boards.
- In response to the COVID-19 pandemic, the NPDB temporarily waived query fees. The fee waiver supported health care entities, during this national emergency, to make informed hiring, licensing, and credentialing decisions. As a result, the NPDB waived fees for over 6 million one-time queries, continuous queries, and continuous query renewals between March 1, 2020, and September 30, 2020.
- In FY 2021, the NPDB improved services to health care practitioners by enabling digitally certified self-query responses and allowing report subjects the ability to access multiple reports through a single account.
- In an FY 2021 survey, the NPDB had an over 90% satisfaction rate among entity users and over 94% agreed that the information from the NPDB makes their organization confident about the decisions they make concerning practitioners.
- In FY 2022 and FY 2023, the NPDB intends to continue to improve both the services available to practitioners and the education materials available to entity users.

**Funding History**

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

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $18,730,776 |
| FY 2020 | $11,256,402[112] |
| FY 2021 Final | $18,814,000 |
| FY 2022 CR | $18,814,000 |
| FY 2023 President's Budget | $18,814,000 |

**Budget Request**

The FY 2023 Budget Request for NPDB of $18.8 million in user fees, is equal to the FY 2022 Continuing Resolution level. This is based on HRSA's projections of queries on practitioners and organizations.

As mandated by the Health Care Quality Improvement Act, the NPDB does not receive appropriated funds and is financed by the collection of user fees. Annual Appropriations Act language since FY 1993 requires that user fee collections cover the full cost of NPDB operations; therefore, there is no request for appropriation for operating the NPDB. User fees are

[111] https://www.npdb.hrsa.gov/resources/npdbstats/npdbMap.jsp

[112] 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.

established at a level to cover all program costs to allow the NPDB to meet annual and long-term program performance goals. Fees are established based on forecasts of query volume to result in adequate, but not excessive, revenues to pay all program costs to meet program performance goals.

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result /Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 Target +/- FY 2022 Target |
|---|---|---|---|---|
| 2210.01: Increase the number of practitioners enrolled in Continuous Query (which is a subscription service for Data Bank queries that notifies them of new information on enrolled practitioners within one business day) | FY 2020: 4,538,937 Target: 3,900,000 (Target Exceeded) | 5,300,000 | 6,000,000 | +700,000 |
| 2210.02: Increase annually the number of disclosures of NPDB reports to health care organizations | FY 2020: 2,022,845 Target: 1,980,000 (Target Exceeded) | 2,100,000 | 2,130,000 | +30,000 |

## Preventing Burnout in the Health Workforce

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | --- | --- | $50,000,000 | +$50,000,000 |
| **FTE** | --- | --- | 2 | +2 |

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

FY 2023 Authorizations.....$35,000,000

Allocation Method .....Competitive Grant/Contract

**Program Description and Accomplishments:**

The Preventing Burnout in the Health 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 Workforce Resiliency Training Program (HWRTP):*** In Fiscal Year 2022, HRSA awarded 34 awards in the Health and Public Safety Workforce Resiliency Training Program (HPSWRTP) which 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 are using 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 (PRMPW):*** The PRMHPW 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. In Fiscal Year 2022, HRSA funded 10 awards with American Rescue Plan Act resources.

In FY 2023, HRSA anticipates a new competition and making 43 awards totaling approximately $48 million. The program will align with the new authorities provided under Sec. 764 if the PHS Act, and 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 and resiliency for health care professionals. The goal of the PRMHW program is for health care organizations to adopt, promote, implement, and demonstrate an organizational culture of wellness that includes resilience and mental health for their health professional workforce.

**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

| Designated Health Professions | Targeted Educational Levels | Grantee Activities |
|---|---|---|
| Practicing health care professionals | For practicing health care professionals | • Improving awareness among health care professionals about risk factors for, and signs of, suicide and mental health or substance use disorders, in accordance with evidence-based or evidence-informed;<br>• Establishing new, or enhancing existing, evidence based or evidence-informed programs for preventing suicide and improving mental health and resiliency among health care professionals;<br>• Establishing new, or enhancing existing, peer-support programs among health care professionals; or<br>• Providing mental health care, follow-up services and care, or referral for such services and care, as appropriate. |

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | --- |
| FY 2020 | --- |
| FY 2021 Final | --- |
| FY 2022 CR | --- |
| FY 2023 President's Budget | $50,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Preventing Burnout in the Health Workforce programs of $50.0 million is $50.0 million above the FY 2022 Continuing Resolution level. This request will fund a new competition for 43 PRMHW 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.

**Promoting Resilience and Mental Health Among Health Professional Workforce Grant Awards Table**

| | FY 2021 Final | FY 2022 CR | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | --- | --- | 43 |
| **Award Amount** | --- | --- | $1,126,990 |
| **Range of Awards** | --- | --- | $731,989 - $1,425,000 |

## Health Workforce Cross-Cutting Performance Measures

The Bureau of Health Workforce (BHW) has tracked and reported on four cross-cutting measures for over 30 of its programs that reported performance data during Academic Year 2020-2021. The cross-cutting measures focus specifically on the diversity of individuals completing specific types of health professions training programs;[113] the rate in which individuals participating in specific types of health professions training programs are trained in medically underserved communities;[114] the rate in which individuals who complete specific types of health professions training programs report being employed in a medically underserved community; and the rate in which clinical training sites provide interprofessional team-based care to patients. These measures do not currently include data from the Faculty Loan Repayment Program or the National Practitioner Data Bank.[115]

During Academic Year 2020-2021, results showed that 51 percent of graduates and program completers participating in BHW-supported health professions training and loan programs were underrepresented minorities (URMs) in the health professions and/or from disadvantaged backgrounds.[116] This exceeded the target of 46 percent, which was based on prior performance and reflects BHW's emphasis on diversity and health equity.

[113] BHW currently funds more than 40 health professions training and loan programs that have varying types of data reporting requirements based on the program's authorizing legislation. For the purposes of the cross-cutting measures, only programs that are required to report individual-level data are included in the calculation, as this ensures a higher level of accuracy and data quality, as well as consistency in the types of programs that are included in the calculation. Currently, 37 of the BHW-funded programs are required to report individual-level data and are included in these calculations. These programs are representative of the health professions and include oral health programs, behavioral health programs, medicine programs, nursing programs, geriatrics programs, and physician assistant programs, among others.

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

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

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[117] | FY 2022 Target | FY 2023 Target[118] | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 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 2020: 51% Target: 46% (Target Exceeded) | 46% | 47% | +1 percentage point(s) |
| 2000.02 Percentage of trainees in Bureau of Health Workforce-supported health professions training programs who receive training in medically underserved communities. (Outcome) | FY 2020: 52% Target: 55% (Target Not Met) | 55% | 52%[119] | -3 percentage point(s) |
| 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[120] | FY 2020: 40% Target: 40% (Target Met) | 40% | 40% | Maintain |

[117] Most recent results are for Academic Year 2020-2021 and funded in FY 2020.
[118] Targets are adjusted based on results and expected changes to programs and funding levels.
[119] Target for FY 2023 is reduced to more accurately reflect projected results for this measure after the inclusion of the CHGME program in FY 2020.
[120] Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one-year post program graduation. Results are from Academic Year 2020-2021 based on graduates from Academic Year 2019-2020.

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[117] | FY 2022 Target | FY 2023 Target[118] | FY 2023 Target +/-FY 2022 Target |
|---|---|---|---|---|
| 2000.04 Percentage of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program. (Outcome) | FY 2020: 74%<br>Target:<br>50%<br>(Target Exceeded) | 55% | 65% | +10 percentage point(s) |

# Maternal and Child Health

# TAB

# MATERNAL AND CHILD HEALTH

## Maternal and Child Health Block Grant

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $710,545,000 | $712,700,000 | $953,700,000 | +$241,000,000 |
| **FTE** | 59 | 59 | 80 | +21 |

Authorizing Legislation - Social Security Act, Title V

FY 2023 Authorization ..... $850,000,000

Allocation Methods:

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

**Program Description and Accomplishments**

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

- The **State MCH Block Grant program**, which awards formula grants to 59 states and jurisdictions to address the health needs of mothers, infants, and children, as well as children with special health care needs in their state or jurisdiction;
- **Special Projects of Regional and National Significance (SPRANS)** that address national or regional needs, priorities, or emerging issues (such as opioids, maternal mortality, and COVID-19) and demonstrate methods for improving care and outcomes for mothers and children; and
- **Community Integrated Service Systems (CISS)** grants, which help increase local service delivery capacity and form state and local comprehensive care systems for mothers and children, including children with special health care needs.

The MCH Block Grant program funding, combined with state investments, provides a significant funding source to improve access to and the quality of health services for mothers, children, and their families in all 50 states, the District of Columbia and other jurisdictions. As defined in the Title V legislation, the purpose of the MCH Block Grant program is to enable each state to:

- Assure access to quality maternal and child health care services for mothers and children, especially for those with low incomes or limited availability of care;

- Reduce infant mortality and incidence of preventable diseases, and generally promote the health of children;
- Provide access to prenatal, delivery, and postnatal care to women (especially low-income and at-risk pregnant women);
- Increase the number of low-income children who receive regular health assessments and follow-up diagnostic and treatment services;
- Provide access to preventive and primary care services for low-income children as well as rehabilitative services for children with special health needs;
- Implement family-centered, community-based systems of coordinated care for children with special health care needs; and
- Provide toll-free hotlines and other appropriate methods for pregnant women and parents to access information about services under the MCH Block Grant Program and Title XIX (Medicaid).

**State MCH Block Grant Program**

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

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

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

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

- **Reduce state burden** by streamlining the narrative reporting structure of the Five-Year Needs Assessment and Application/Annual Report, reducing duplication in narrative reporting across multiple sections of the Application/Annual Report, and pre-populating performance and outcome measure data, as available, using national data sources.

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

HRSA works in partnership with the State MCH Block Grant programs to provide technical assistance, as requested by the state, for addressing their MCH priority needs as well as other performance and programmatic requirements of the MCH Block Grant program. HRSA makes key state-reported financial, program, performance, and health indicator data available to the public through the Title V Information System.[121]

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

- An estimated 60 million pregnant women, infants, and children, including children with special health care needs, benefitted from a service supported by the State MCH Block Grant program in FY 2020. Nationwide, the 59 State MCH Block Grant programs reached approximately 93 percent of pregnant women, 98 percent of infants, and 60 percent of children.
- Access to health services for mothers has improved with the support of the State MCH Block Grant program. The percentage of women who received early prenatal care in the first trimester of pregnancy increased from 71.0 percent in 2007 to 77.7 percent in 2020. Recognizing that improving maternal and child health in the United States will require improving women's health before pregnancy, 47 states and jurisdictions are now working to improve access to preventive and primary care for all women of childbearing age.
- The infant mortality rate is a widely used indicator of the nation's health. The State MCH Block Grant program has played a lead role in the 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 2020. Efforts to reduce the overall infant mortality rate and its contributing factors continue.
- States are also working to reduce maternal mortality, which has been rising over the past two decades, through a range of approaches. For example, based on reporting in the FY 2021/FY 2019 Title V Application/Annual Reports, 50 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 appropriate action to reduce such events in the future. States also use Title V funds to more broadly address women's and maternal health to improve maternal and other pregnancy-related outcomes through activities such as promoting well-woman visits, increasing access to prenatal care, and enhancing systems of care around maternal mental health.

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

Select National Outcome and National Performance Measures in effect from 1997 to 2020 illustrate the program's successes:

| National Outcome or Performance Measures | Percent Change (1997 – 2020 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 | 25% 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 | 38% 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 | 3% increase (2011-2017) | National Immunization Survey (NIS) |
| Percentage of children without health insurance | 64% decrease | National Health Interview Survey (NHIS) |
| Percent of infants breastfed exclusively through 6 months of age | 87% increase (2007-2018) | NIS |
| Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester | 9% increase (2007-2020) | NVSS |

**Special Projects of Regional and National Significance (SPRANS)**

HRSA awards SPRANS grants to 1) address critical and emerging issues of regional and national significance in maternal and child health, and 2) support collaborative and innovative learning across states so programs can utilize existing best practices and evidence. Of the $139.1 million for SPRANS in FY 2021, Congress set aside approximately 11 percent to address four specific priorities: oral health, epilepsy, sickle cell disease, and fetal alcohol syndrome. In addition, approximately 32 percent of the total SPRANS budget supports specific directives highlighted in the authorizing language, including genetics, hemophilia, training, and research. The remaining approximately 57 percent addresses critical and emerging issues in maternal and child health, such as maternal mortality and the COVID-19 pandemic, and supports collaborative learning across states.

SPRANS awards also drive innovation and build capacity to improve systems of care for MCH populations and enables the Nation to address emerging issues. Funding provides critical programming that complements and ensures the success of state formula-funded activities by

improving workforce and system capacity and the ability of programs to utilize best practices and evidence (e.g., through research, data collection, quality improvement, and workforce development).

Critical and Emerging Issues in Maternal and Child Health

- *Maternal mortality* – HRSA supports a number of investments with SPRANS funding that are integral to HRSA's efforts to promote maternal health and reduce maternal mortality and morbidity. In FY 2021, HRSA continued support for the State Maternal Health Innovation program (9 states), including a focus on access to care via alternative telehealth platforms to address needs resulting from the COVID-19 public health emergency. HRSA has also increased funding for the Alliance for Innovation on Maternal Health (AIM) program with a goal of expanding implementation of the AIM program's maternal safety bundles across all U.S. States, the District of Columbia, and U.S. territories, as well as tribal entities. To date, 44 states and the District of Columbia are enrolled in AIM, with participation from 1,766 birthing facilities. Additional investments related to maternal health include the newly established Maternal Mental Health Hotline and the Women's Preventive Services Initiative.

- *COVID-19* – SPRANS funding has been instrumental in addressing emerging public health issues that impact the MCH population, including COVID-19 response efforts. For example, HRSA launched the Promoting Pediatric Primary Prevention (P4) Challenge in December 2020 to incentivize innovations in pediatric primary care to increase well-child visits and immunizations within primary care settings in light of the COVID-19 pandemic. Innovations were deployed to address decreases in these services to prevent the spread of vaccine-preventable diseases such as measles and ensure children receive preventative care, crucial to their growth and development. Challenge participants generated more than 52,000 well-child visits and nearly 23,000 immunizations.

**Community Integrated Service Systems (CISS)**

CISS grants are awarded on a competitive basis and support states and communities in building 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 to enhance state-level capacity and infrastructure for integrated maternal and early childhood systems of care that lead to improved children's developmental health, family well-being, and increased family-centered access to care for the prenatal-to-3-year-old population. The program provides direct support and technical assistance to 20 states to build leadership capacity in early childhood systems, improve cross-sector service coordination and alignment, improve policies and practices across sectors, and advance health equity and health system improvements in early childhood so that more children are thriving at age three and school-ready by age five. The program was re-competed in FY 2021.

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

| MCH Activities | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| State MCH Block Grant Awards | $561,617 | $563,308 | $592,308 |
| SPRANS | $138,755 | $139,116 | $351,116 |
| CISS | $10,173 | $10,276 | $10,276 |
| **Total** | **$710,545** | **$712,700** | **$953,700** |

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

| MCH SPRANS Set-Aside Programs | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| SPRANS – Other | $123,878 | $124,224 | $336,224 |
| SPRANS - Oral Health | $5,250 | $5,250 | $5,250 |
| SPRANS – Epilepsy | $3,642 | $3,642 | $3,642 |
| SPRANS - Sickle Cell | $4,985 | $5,000 | $5,000 |
| SPRANS - Fetal Alcohol Syndrome Demo | $1,000 | $1,000 | $1,000 |
| **Total SPRANS** | **$138,755** | **$139,116** | **$351,116** |

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $674,723,000 |
| FY 2020 | $687,700,000 |
| FY 2021 Final | $710,545,000 |
| FY 2022 CR | $712,700,000 |
| FY 2023 President's Budget | $953,700,000 |

**Budget Request**

The FY 2023 Budget Request for the Maternal and Child Health (MCH) Block Grant program of $953.7 million is $241.0 million above the FY 2022 Continuing Resolution level. The Budget includes $592.3 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 Budget includes $351.1 million in SPRANS funding, of which $193.3 million will support HRSA's efforts to improve maternal and child health, including reducing maternal

mortality and severe maternal morbidity. This is an increase of $158 million over the FY2022 Continuing Resolution.

Building on the Improving Maternal Health Initiative investments, the FY 2023 Budget provides funding for investments 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 new activities and continues support for existing activities:

- *Addressing Emerging Issues and Social Determinants of Maternal Health*: $55.0 million in new funding for a SPRANS innovation fund for community-based organizations to support priority tracks focused on reducing 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 including:
    - *Maternal mental health equity*: Projects will address maternal mental health conditions and substance use disorders with a focus on activities that expand access to services in areas with high rates of adverse maternal health outcomes and/or significant racial or ethnic disparities in maternal mental health access. .
    - *Addressing social determinants of maternal health*: Projects will provide community resources and programming, and support consultation and engagement with pregnant and postpartum individuals in developing a community needs assessment, among other resources, technical assistance, and support strategies.
    - *Promoting equity in maternal health outcomes through digital tools*: Projects will focus on reducing racial and ethnic disparities in maternal health outcomes by increasing access to effective digital tools related to expanding or enhancing maternal health care.
    - *Expanding the use of technology-enabled collaborative learning and capacity building models for pregnant and postpartum individuals*: Projects will focus on models that train maternal health care providers and students on methods to address implicit bias and racism; screen for social determinants of health; address behavioral health needs; and support remote patient monitoring, among other tools focused on improving maternal outcomes.
- *Growing and Diversifying the Doula Workforce*: $20.0 million in new funding to provide grants to community-based organizations to develop and/or expand programs to recruit doula candidates, support their training/certification, and then employ them as doulas to support improved birth outcomes in the community;
- *Funding for Minority-Serving Institutions:* $10.0 million in new funding for awarding funds through a research network to support minority-serving institutions to study health disparities in maternal health outcomes; and develop curricula for training health professionals on identifying and addressing the risks associated with climate change for vulnerable individuals and individuals with the intent to become pregnant.
- *State Maternal Health Innovation Awards*: $55.0 million, an increase of $32.0 million, to continue to support innovation among states to improve maternal health outcomes and address disparities in maternal health;
- *Alliance for Innovation on Maternal Health*: $15.3 million, an increase of $6.3 million, to continue to expand the reach of evidence-based models of maternity care to a broader

array of providers and health care settings, support increasing AIM penetration in currently enrolled States, and improve systems that track, report, and improve upon maternity care services at the state, regional and national levels;
- *Pregnancy Medical Home Demonstration*: $25.0 million to continue to reduce adverse maternal health outcomes and maternal deaths by incentivizing maternal health care providers to provide integral health care services to pregnant women and new mothers;
- *Maternal Mental Health Hotline*: $7.0 million, an increase of $4.0 million, to continue support for a maternal mental health hotline, staffed by qualified counselors 24 hours a day;
- *Implicit Bias Training Grants for Health Providers*: $5.0 million to continue to support to train providers on implicit bias with the goal of reducing racial disparities; and
- *National Academy of Medicine Study*: $1.0 million to continue to support a partnership with the National Academy of Medicine study and make recommendations for incorporating bias recognition in clinical skills testing for accredited schools of allopathic medicine and accredited schools of osteopathic medicine.

The Budget also provides $40.0 million 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 partners to identify the mental and behavioral health needs of mothers and children, and to support children's social and emotional development within their families. 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. This program will partner with HRSA's Behavioral Health Workforce Education and Training (BHWET) for Paraprofessional program to support partnerships with local academic institutions that support training and placement of navigators in community settings in order to expand workforce capacity and strengthen the behavioral health workforce pipeline.

Additional SPRANS funding supports programs that aim to drive innovation and improve systems of care for MCH populations. These programs address emerging issues relating to disparities in maternal and child health outcomes and gaps in care related to the ongoing impacts of the COVID-19 pandemic on maternal and child health. The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

**Outcomes and Outputs Tables**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3010.01**:** The percentage of children served by the Maternal and Child Health Block Grant[122] *(Outcome)* | FY 2020: 62% 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 2020: 93% 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 2020: 2.3 to 1[123,124] Target: 2 to 1 (Target Not Met) | 2 to 1 | 2 to 1 | Maintain |
| 3010.04: Reduce the infant mortality rate *(Outcome)* | FY 2020: 5.4 per 1,000 Target: 5.5 per 1,000 (Target Met) | 5.4 per 1,000 | 5.3 per 1,000 | Decrease by 0.1 |
| 3010.05: Reduce the incidence of low birth weight births *(Outcome)* | FY 2020: 8.2% Target: 7.8% (Target Not Met but Improved) | 8% | 8% | Maintain |

[122] The term "children" includes both infants and children (0-21) years of age.
[123] Numerator data for infant deaths by race: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2020 on CDC WONDER Online Database. https://wonder.cdc.gov/controller/saved/D158/D268F643
[124] Denominator data for live births by race: Centers for Disease Control and Prevention, National Center for Health Statistics. Natality public-use data 2007-2020 on CDC WONDER Online Database. https://wonder.cdc.gov/controller/saved/D66/D268F641

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3010.06**:** Increase percentage of pregnant women who received prenatal care in the first trimester. *(Outcome)* | FY 2020: 77.7% Target: 80% (Target Not Met but Improved) | 80% | 80% | Maintain |

**Grant Awards Table – Maternal and Child Health Block Grant**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 59 | 59 | 59 |
| **Average Award** | $9,302,887 | $9,317,912 | $9,805,601 |
| **Range of Awards** | $148,196-$39,255,586 | $148,435-$38,836,115 | $156,205-$42,106,132 |

**Grant Awards Table – SPRANS**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 286 | 262 | 437 |
| **Average Award** | $419,961 | $455,261 | $679,933 |
| **Range of Awards** | $13,685-$9,690,281 | $40,000-$9,644,486 | $27,562-$9,644,486 |

**Grant Awards Table – CISS**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 21 | 26 | 26 |
| **Average Award** | $319,135 | $320,654 | $320,654 |
| **Range of Awards** | $240,524-$830,000 | $240,524-$700,000 | $240,524-$700,000 |

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**Health Resources and Services Administration**
**FY 2022 Mandatory (or Discretionary) State/Formula Grants**

| CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant | | | | |
|---|---|---|---|---|
| **STATE/TERRITORY** | **FY 2021 Final[125]** | **FY 2022 Continuing Resolution[126]** | **FY 2023 President's Budget[127]** | **FY 2023 +/- FY 2022** |
| Alabama | 11,523,951 | 11,552,111 | 12,093,322 | 541,211 |
| Alaska | 1,113,786 | 1,118,858 | 1,173,157 | 54,299 |
| Arizona | 7,432,377 | 7,402,255 | 8,100,118 | 697,863 |
| Arkansas | 7,002,733 | 7,051,885 | 7,397,892 | 346,007 |
| California | 39,255,586 | 38,836,115 | 42,106,132 | 3,270,017 |
| Colorado | 7,337,336 | 7,326,269 | 7,639,956 | 313,687 |
| Connecticut | 4,696,032 | 4,768,921 | 4,982,824 | 213,903 |
| Delaware | 2,042,781 | 2,054,626 | 2,131,480 | 76,854 |
| District of Columbia | 6,960,711 | 6,956,695 | 7,017,849 | 61,154 |
| Florida | 19,978,309 | 20,064,608 | 21,797,267 | 1,732,659 |
| Georgia | 17,133,015 | 17,097,767 | 18,171,476 | 1,073,709 |
| Hawaii | 2,138,833 | 2,176,877 | 2,253,698 | 76,821 |
| Idaho | 3,298,645 | 3,279,590 | 3,415,630 | 136,040 |

[125] The poverty-based allocation for FY 21 uses 3-year poverty data from the American Community Survey, 2016-2018
[126] The poverty-based allocation for FY 22 uses 3-year poverty data from the American Community Survey, 2017-2019
[127] The poverty-based allocation for FY 23 uses 3-year poverty data from the American Community Survey, 2017-2019

| CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant | | | | |
|---|---|---|---|---|
| STATE/TERRITORY | FY 2021 Final[125] | FY 2022 Continuing Resolution[126] | FY 2023 President's Budget[127] | FY 2023 +/- FY 2022 |
| Illinois | 21,148,308 | 21,181,237 | 22,178,427 | 997,190 |
| Indiana | 12,334,500 | 12,270,705 | 12,840,693 | 569,988 |
| Iowa | 6,549,015 | 6,562,079 | 6,762,544 | 200,465 |
| Kansas | 4,735,781 | 4,799,283 | 5,021,928 | 222,645 |
| Kentucky | 11,257,105 | 11,274,216 | 11,751,863 | 477,647 |
| Louisiana | 12,634,200 | 12,723,992 | 13,359,025 | 635,033 |
| Maine | 3,299,766 | 3,288,467 | 3,360,894 | 72,427 |
| Maryland | 11,872,645 | 11,925,533 | 12,264,652 | 339,119 |
| Massachusetts | 11,137,523 | 11,140,614 | 11,502,576 | 361,962 |
| Michigan | 18,917,629 | 18,918,990 | 19,788,743 | 869,753 |
| Minnesota | 9,146,460 | 9,176,793 | 9,496,624 | 319,831 |
| Mississippi | 9,297,570 | 9,348,589 | 9,764,183 | 415,594 |
| Missouri | 12,299,305 | 12,340,195 | 12,866,883 | 526,688 |
| Montana | 2,281,009 | 2,297,412 | 2,370,961 | 73,549 |
| Nebraska | 4,013,886 | 4,002,691 | 4,130,488 | 127,797 |
| Nevada | 2,159,962 | 2,191,641 | 2,451,514 | 259,873 |
| New Hampshire | 1,967,356 | 1,972,993 | 2,023,847 | 50,854 |
| New Jersey | 11,703,856 | 11,698,610 | 12,256,662 | 558,052 |
| New Mexico | 4,212,264 | 4,193,789 | 4,461,637 | 267,848 |
| New York | 38,366,219 | 38,383,080 | 40,015,280 | 1,632,200 |
| North Carolina | 17,561,399 | 17,672,594 | 18,668,517 | 995,923 |
| North Dakota | 1,750,204 | 1,750,076 | 1,788,741 | 38,665 |
| Ohio | 22,331,382 | 22,433,267 | 23,499,546 | 1,066,279 |
| Oklahoma | 7,310,479 | 7,330,671 | 7,758,510 | 427,839 |
| Oregon | 6,180,579 | 6,150,653 | 6,429,586 | 278,933 |
| Pennsylvania | 23,954,647 | 24,048,398 | 24,998,367 | 949,969 |
| Rhode Island | 1,642,594 | 1,639,669 | 1,710,513 | 70,844 |
| South Carolina | 11,614,985 | 11,646,085 | 12,156,168 | 510,083 |
| South Dakota | 2,205,134 | 2,211,844 | 2,284,182 | 72,338 |
| Tennessee | 11,982,692 | 12,028,416 | 12,705,471 | 677,055 |

| CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant | | | | |
|---|---|---|---|---|
| **STATE/TERRITORY** | **FY 2021 Final[125]** | **FY 2022 Continuing Resolution[126]** | **FY 2023 President's Budget[127]** | **FY 2023 +/- FY 2022** |
| Texas | 35,734,420 | 35,920,017 | 39,152,053 | 3,232,036 |
| Utah | 6,101,483 | 6,125,443 | 6,325,474 | 200,031 |
| Vermont | 1,656,553 | 1,646,635 | 1,676,257 | 29,622 |
| Virginia | 12,457,398 | 12,549,137 | 13,095,325 | 546,188 |
| Washington | 8,811,411 | 8,861,117 | 9,319,026 | 457,909 |
| West Virginia | 6,205,535 | 6,197,335 | 6,378,380 | 181,045 |
| Wisconsin | 10,878,234 | 10,884,071 | 11,263,354 | 379,283 |
| Wyoming | 1,214,451 | 1,223,255 | 1,260,185 | 36,930 |
| **Subtotal** | **528,842,034** | **529,696,169** | **557,419,880** | **27,723,711** |
| American Samoa | 493,983 | 494,781 | 520,677 | 25,896 |
| Guam | 762,930 | 764,163 | 804,158 | 39,995 |
| Marshall Islands | 230,524 | 230,897 | 242,981 | 12,084 |
| Micronesia | 521,427 | 522,270 | 549,605 | 27,335 |
| Northern Mariana Islands | 466,540 | 467,294 | 491,752 | 24,458 |
| Palau | 148,196 | 148,435 | 156,205 | 7,770 |
| Puerto Rico | 15,906,262 | 15,931,952 | 16,765,813 | 833,861 |
| Virgin Islands | 1,498,417 | 1,500,837 | 1,579,389 | 78,552 |
| **Subtotal** | **20,028,279** | **20,060,629** | **21,110,580** | **1,049,951** |
| **TOTAL RESOURCES** | **548,870,313** | **549,756,798** | **578,530,460** | **28,773,662** |

## Autism and Other Developmental Disabilities

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $53,184,000 | $53,344,000 | $57,344,000 | +$4,000,000 |
| **FTE** | 8 | 8 | 8 | --- |

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

FY 2023 Authorization .....$50,599,000

Allocation Methods:

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

**Program Description and Accomplishments**

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

According to the Centers for Disease Control and Prevention (CDC), approximately 1 in 44 children have ASD,[128] while parent-reported data from the 2019-2020 National Survey of Children's Health documented that 1 in 35 children aged 3–17 years have a diagnosis of ASD.[129] Even though children can be diagnosed as early as two, on average, children identified with ASD are not diagnosed until after age four.[130] There is also wide variability in the age of diagnosis of ASD by state and in many rural communities, children and families face disparities due to distance to subspecialists and a lack of available services. According to the CDC's 2018 Autism and Developmental Disabilities Monitoring Network data, black children with ASD were first

[128] Maenner MJ, Shaw KA, Bakian AV, et al. Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2018. MMWR Surveill Summ 2021;70(No. SS-11):1–16. DOI: http://dx.doi.org/10.15585/mmwr.ss7011a1.
[129] Child and Adolescent Health Measurement Initiative. 2019-2020 National Survey of Children's Health (NSCH) data query. Retrieved 02/22/2022 from https://www.childhealthdata.org/.
[130] National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention. (2019) Spotlight On: Delay Between First Concern to Accessing Services

evaluated at older ages than White children with ASD, and the overall ASD prevalence among Hispanic children was lower than among Black and White children.[131] These findings suggest disparities in access to identification of and services for ASD across groups or communities.

The Autism and Other Developmental Disabilities program supports training programs, research, and state systems grants to:

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

Training Programs

The program has two main training components, the Leadership Education in Neurodevelopmental and Other Related Disabilities (LEND) Training program and the Developmental-Behavioral Pediatrics (DBP) Training program. LEND programs provide interdisciplinary training to enhance the clinical expertise and leadership skills of professionals dedicated to caring for children with neurodevelopmental and other related disabilities including autism. DBP trains the next generation of leaders in developmental-behavioral pediatrics and provides pediatric practitioners, residents, and medical students with essential biopsychosocial knowledge and clinical expertise. Data from FY 2020 showed that the LEND and DBP programs collectively:

- Provided diagnostic services to confirm or rule out ASD and other DDs to over 115,000 children;
- Provided training to over 59,000 trainees in the fields of pediatrics, developmental-behavioral pediatrics, other health professions, and people with lived experience; and
- Provided over 1,700 continuing education events on early screening, diagnosis, and intervention that reached over 128,000 pediatricians and other health professionals.

The training programs have an explicit focus on training professionals to provide culturally and linguistically relevant care and to recruit diverse students and professionals into the programs. In FY 2020, 24% of long-term trainees were from underrepresented racial groups and 13% were Hispanic or Latino. The training programs include self-advocates and family members as trainees and faculty to enhance exposure to lived experiences and increase the leadership skills of self-advocates and family members as part of an interdisciplinary care team.

[131] Maenner MJ, Shaw KA, Baio J, et al. Prevalence of autism spectrum disorder among children aged 8 years—Autism and Developmental Disabilities Monitoring Network, 11 sites, United States, 2016. MMWR Surveill Summ 2020;69(No. SS-4). https://doi.org/10.15585/mmwr.ss6904a1external icon PMID:32214087

Research

To improve the health and well-being of children and adolescents with ASD and other DDs, HRSA supports research networks, single investigator-led autism innovation projects, field-initiated research, and secondary data analysis projects. HRSA supports research and development of reliable screening tools and guidelines for ASD and other DD and the implementation of interventions to improve the physical and behavioral health of individuals with ASD and other DDs across the life course. HRSA also funds research to address barriers to diagnosis, access to care, and social determinants of health and health disparities with an explicit focus on recruiting participants from underserved populations. For example, the two largest Research Networks, the Autism Intervention Research Network on Physical Health (AIR-P) and the Autism Intervention Research Network on Behavioral Health (AIR-B), recruit diverse research participants with the target of including at least 60 percent of study participants from underserved populations,[132] a target these networks have met or exceeded.

Collectively, these research investments address the Interagency Autism Coordinating Committee Strategic Plan research questions around improving early identification and advancing effectiveness of interventions and services for children with ASD and other DD. Accomplishments from the Autism Research Networks and Autism Single Investigator Innovation Programs in FY 2020 include:

- Conducted 45 studies on physical and behavioral health issues related to ASD and other DDs, screening and diagnostic measures, early intervention, and transition to adulthood;
- Enrolled 9,496 participants in primary research studies through fifty-two research sites across the country and there were also 67,637 participants included in secondary data analyses; and
- Developed 137 peer-reviewed publications in leading scholarly journals.

State Systems Grants

The Autism and Other Developmental Disabilities program supports state systems grants to improve access to comprehensive, coordinated health care and related services for children and youth with ASD and other DDs and their families in medically underserved areas. State systems grants promote access to more comprehensive coordinated services for ASD/DD by implementing family navigation and provider training. Family navigators perform time-limited case management for children with or at risk for ASD/DD; services may also include providing support to overcome patient-specific barriers to care in a complex system, coordinating services

[132] "Underserved populations" are defined as "[The] populations sharing a particular characteristic, as well as geographic communities that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the definition of 'equity.'" Executive Order 13985, at § 2(b). "Equity" is defined as "[T]he consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality." Executive Order 13988 on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation, 86 FR 2023, at § 1

and appointments, and facilitating communication among families and providers. During 2019-2021 state awardees:

- Partnered with 43 primary care practices, employed 28 family navigators and served 825 families by providing children with/at risk of ASD/DD screening, diagnosis, and referral to early intervention or related services and enrolling them in community-based services before 36 months of age;
- Promoted and facilitated developmental screening services and follow-up. Grantees increased awareness through stakeholder meetings, online learning communities, or one-time trainings that covered autism generally, intervention services, and assistance programs. Grantees engaged family members and family advocates through trainings or training institutes, steering committees, and family support organizations through:
    - 13 webinars for primary care physicians (PCPs) reaching 115 attendees;
    - Six community trainings reaching approximately 6,000 participants;
    - Nine family leadership training participants and 293 parent attendees at various training activities; and
    - Approximately 600 parents participated in various dissemination activities.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $50,377,000 |
| FY 2020 | $52,344,000 |
| FY 2021 Final | $53,184,000 |
| FY 2022 CR | $53,344,000 |
| FY 2023 President's Budget | $57,344,000 |

**Budget Request**

The FY 2023 Budget Request for the Autism and Other Developmental Disabilities program of $57.3 million is $4.0 million above the FY 2022 Continuing Resolution level. This request will support training programs, research, and state systems with a focus on improving access, quality, and systems of care for underserved children, adolescents, and young adults with ASD or other DDs.

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. Funding will allow expansion of the DBP program including increased fellowship opportunities for existing awardees.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3020.01**:** Percentage of long-term trainees (LEND, DBP) working with underserved populations, 5 years post-training. *(Outcome)* | FY 2020 LEND Result: 82% (5 years)<br>Target: Maintain prior year result of 82% (5 years)<br>(Target Met)<br><br>FY 2020 DBP Result: 100% (5 years)<br>Target: Maintain prior year result of 91% (5 years)<br>(Target Met) | LEND: 80%<br>DBP: 85% | LEND: 82%<br>DBP: 87% | LEND: +2 percentage points<br><br>DBP: +2 percentage points |
| 3020.02**:** Percentage of long-term trainees (LEND, DBP) who at 2 and 5 years post-training, have worked in an interdisciplinary manner to serve the MCH population. *(Outcome)* | FY 2020 LEND Result: 93% (2 years); 95% (5 years)<br>Target: Maintain prior year of 96% (2 years); 94% (5 years)<br>(Target Exceeded; Target Not Met)<br><br>FY 2020 DBP Result: 100% (2 years); 93% (5 years)<br>Target: Maintain prior year of 100% (2 years); 100% (5 years): 5 year (Target Not Met) | LEND: 75% (2, 5 years)<br>DBP: 85% (2, 5 years) | LEND: 90% (2, 5 years)<br>DBP: 90% (2, 5 years) | LEND: +15 percentage points<br><br>DBP: +5 percentage points |
| 3020.03**:** Percentage of MCHB Autism research programs with at least two scientific publications in the past year (*Outcome and Developmental*) | FY 2020: 100%[133]<br><br>Target: Not Defined<br>(Target Not in Place) | Not Defined[134] | Not Defined | Not Defined |

[133] RN/SIIPs and Autism FIRST grants are included in the calculation; Autism SDAR grants are excluded as they are one-year grants.
[134] The program will identify trends over a three year period as the measure is developmental. Once the trend is analyzed, appropriate targets will be identified and included in the FY 2024 budget justification.

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| LEND | $35,783,391 | $36,057,457 | $37,807,457 |
| DBP | $2,246,786 | $2,286,935 | $2,848,380 |
| Research | $7,597,706 | $7,425,000 | $7,525,000 |
| State Systems | $1,855,477 | $1,855,720 | $1,800,000 |
| Resource Centers | $896,000 | $896,000 | $896,000 |
| **Number of Awards** | 92 | 90 | 90 |
| **Average Award** | $525,863 | $539,123 | $565,298 |

## Sickle Cell Disease Treatment Demonstration Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $7,183,000 | $7,205,000 | $7,205,000 | --- |
| **FTE** | 1 | 1 | 2 | +1 |

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

FY 2023 Authorization .....$4,455,000

Allocation Methods:

- Competitive co-operative agreement
- Contract

**Program Description and Accomplishments**

The Sickle Cell Disease Treatment Demonstration Program (SCDTDP) improves access to care and health outcomes for individuals with sickle cell disease, a genetic condition that results in abnormal red blood cells that can block blood flow to organs and tissues, causing anemia, periodic pain episodes, damage to tissues and vital organs, and increased susceptibility to infections and early death. Sickle cell disease (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).[135] While life expectancy of individuals with SCD has increased with advances in science and medicine, affected populations have not benefitted equally from therapies. Individuals with SCD have unequal access to comprehensive, quality health care and treatment due to uneven distribution of specialized providers, reduced comfort among primary care providers in treating and caring for individuals with SCD, limited training of primary care providers, and social factors, including racism, income and stigma. SCDTDP awardees work to address these barriers and improve the prevention and treatment of the complications of sickle cell disease by:

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

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

The program works to improve health equity by increasing access to evidence-based care provided in the communities in which SCD patients live, increasing access to the latest treatment options, and continuing telehealth support for access to services. The program also fosters partnerships between clinicians and community organizations, partners with communities of practice to improve the quality of care provided to patients with SCD, and educates providers, families, and patients to improve knowledge and capacities, particularly as patient transition into adult health care settings. In the last cycle of funding, August 1, 2017—July 31, 2021, the program annually served over 25,000 individuals in 51 sites, worked with 49 community organizations, and had about 200,000 health care provider touchpoints through telehealth, telementoring, junior faculty coaching, grand rounds, and specialized COVID-19 seminars. Additionally, 77% of those served by the program had a hydroxyurea prescription in the past year (until recent years, the only treatment approved by the U.S. Food and Drug Administration (FDA) for sickle cell).

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

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $4,435,000 |
| FY 2020 | $5,205,000 |
| FY 2021 Final | $7,183,000 |
| FY 2022 CR | $7,205,000 |
| FY 2023 President’s Budget | $7,205,000 |

**Budget Request**

The FY 2023 Budget Request for the Sickle Cell Disease Treatment Demonstration Program of $7.2 million is equal the FY 2022 Continuing Resolution level. This request will continue support for regional SCD infrastructure, which strengthens the sickle cell disease system of care for individuals with sickle cell disease, their families, and clinicians. The program partners with states to develop and support comprehensive SCD care teams for supporting care across the lifespan; implements telehealth technologies for health care delivery, education, and health information services; increases access to evidence-based care and the latest treatment options; and increases collaboration and care coordination within each region. In response to the COVID-19 global pandemic and needs identified by the sickle cell disease community, funding also supports technical assistance around accessing care via telemedicine; and webinars and educational opportunities to raise awareness about vaccination access and safety.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 Target +/- FY 2022 Target |
|---|---|---|---|---|
| 3030.01: Number of sickle cell patients served by Sickle Cell Disease Treatment Demonstration Program (SCDTDP) network providers in the past year *(Developmental)* | FY 2019: 25,712[136]<br><br>Target: Not Defined(Historical Actual) | Not Defined | Not Defined | Not Defined |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 5 | 5 | 5 |
| **Average Award** | $1,000,000 | $1,000,000 | $1,000,000 |
| **Range of Awards** | $900,000-$1,150,000 | $1,000,000 | $1,000,000 |

[136] The data for this measure is collected from provider surveys via the SCDTDP National Coordinating Center. Survey administration was delayed from May until September 2020 due to COVID-19. The next fielding of the survey will occur in May 2022. The program will identify trends over a two year period as the measure is developmental. Once the trend is analyzed, appropriate targets will be identified and included in the FY 2024 budget justification.

## Early Hearing Detection and Intervention

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $17,765,000 | $17,818,000 | $17,818,000 | --- |
| **FTE** | 4 | 4 | 4 | --- |

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

FY 2023 Authorization .....Expired

Allocation Methods:

- Competitive grant/co-operative agreement

**Program Description and Accomplishments**

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

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

The EHDI Program funds 59 competitive grants to states and jurisdictions to develop comprehensive and coordinated statewide EHDI systems of care, as well as two technical resource centers that support these efforts. The program also empowers families to serve as leaders through activities which train families as leaders, increase family engagement, and strengthen family support in EHDI systems of care. To address health equity, awardees are required to develop plans to address diversity and inclusion in the EHDI system by the end of FY 2021 to ensure their activities are inclusive of and address the needs of the populations they serve. Since the program's inception, states and jurisdictions have had significant success in identifying newborns and infants who are deaf or hard of hearing.

Funding also supports supplemental awards to 12 Leadership Education in Neurodevelopmental and Related Disabilities training programs supported by the Autism and Developmental Disabilities program to train future leaders in pediatric audiology.

In 2019, 98.4% of births had hearing screening before one year of age.[137] Additionally, 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 enrollment in early intervention services no later than six months of age (1-3-6 objectives). In 2019, 97.7% of infants were screened before one month of age, 79.1% were diagnosed before three months of age, and 72.5% were enrolled in early intervention before six months of age.[138] 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 have not been reported to the EHDI Program and, therefore, cannot be documented). 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 to ensure that newborns, infants, and young children up to three years of age receive pertinent screenings and follow-up services.

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

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $17,740,000 |
| FY 2020 | $17,818,000 |
| FY 2021 Final | $17,765,000 |
| FY 2022 CR | $17,818,000 |
| FY 2023 President's Budget | $17,818,000 |

**Budget Request**

The FY 2023 Budget Request of $17.8 million for the Early Hearing Detection and Intervention Program is equal to the FY 2022 Continuing Resolution level. The Budget Request will continue to support 59 competitive grants to states and jurisdictions, in addition to two technical resource centers and supplemental awards to 12 Leadership Education in Neurodevelopmental and Related Disabilities training programs to train future leaders in pediatric audiology.

[137] 2019 CDC EHDI Hearing Screening & Follow-up Survey (HSFS) data. https://www.cdc.gov/ncbddd/hearingloss/ehdi-data.html
[138] Ibid

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3040.01**:** Percentage of infants screened for hearing loss prior to one month of age. *(Output)* | FY 2019: 97.7%[139] Target: 95% (Target Exceeded) | 98% | 98% | Maintain |
| 3040.02**:** Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by three months of age.[140] *(Output)* | FY 2019: 79.1%[141] Target: 77% (Target Exceeded) | 77% | 79% | +2 percentage points |
| 3040.03**:** Increase the percentage of infants with hearing loss enrolled in early intervention before six months of age.[142] *(Output)* | FY 2019: 72.5%[143] Target: 72% (Target Exceeded) | 72% | 73% | +1 percentage point |

[139] 2019 CDC EHDI Hearing Screening & Follow-up Survey (HSFS): The CDC has been collecting data annually since 2005. https://www.cdc.gov/ncbddd/hearingloss/ehdi-data2019.html
[140] "Confirmed" diagnosis refers to a "documented" diagnosis which is consistent with newborn hearing screening programs.
[141] 2019 CDC EHDI Hearing Screening & Follow-up Survey (HSFS): The CDC has been collecting data annually since 2005. https://www.cdc.gov/ncbddd/hearingloss/ehdi-data2019.html
[142] This measure is to be tracked annually under Part C of the Individuals with Disabilities Act (IDEA) regulations that mandate collaboration with Title V programs and newborn hearing screening programs.
[143] 2019 CDC EHDI Hearing Screening & Follow-up Survey (HSFS): The CDC has been collecting data annually since 2005. https://www.cdc.gov/ncbddd/hearingloss/ehdi-data2019.html

**Grant Awards Table**[144]

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 59 | 59 | 59 |
| **Average Award** | $211,951 | $235,000 | $235,000 |
| **Range of Awards** | $23,355 -$245,000 | $235,000 | $235,000 |

[144] Does not include EHDI National Technical Resource Center cooperative agreement ($1.05M in FY 2020; $0.85M in FY 2021 and $0.85M in FY 2022), LEND supplements ($0.9M), Family Leadership in Language and Learning Center ($0.45M), and Advancing Systems of Services for Children and Youth with Special Health Care Needs ($154,000) and Cares National Interdisciplinary Training Resources Center ($150,000).

## Emergency Medical Services for Children

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $22,267,000 | $22,334,000 | $28,134,000 | +$5,800,000 |
| **FTE** | 6 | 6 | 6 | --- |

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

FY 2023 Authorization .....$22,334,000

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

**Program Description and Accomplishments**

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

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

In recent years, the EMSC Program has invested in:
- The EMSC State Partnership Program which aims to improve pediatric emergency care across 58 states and jurisdictions;
- The Pediatric Emergency Care Applied Research Network (PECARN) and Targeted Issues grants, which aim to carry out rigorous clinical research to develop evidence-based optimal pediatric emergency care guidelines;

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

Notable accomplishments of the EMSC Program include:

- **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 high level of pediatric readiness were less likely to die than children cared for in a trauma center ED with low pediatric readiness. These findings suggest that if all children in the U.S. were cared for in a trauma center ED with high pediatric readiness, we may be able to save an additional 126 children each year[145];
- **Increased the Institutionalization of Pediatric Guidelines in Hospitals:** Between 2018 and 2021, the proportion of hospitals with written interfacility transfer guidelines covering pediatric patients increased from 58% to 62%[146];
- **Integrated EMSC Priorities into Statutes and Regulations:** As of 2020, seven states required the designation of a pediatric emergency care champion in prehospital EMS agencies; and 12 states required EMS providers to demonstrate the correct use of pediatric-specific equipment;
- **Increased Pediatric Workforce Oversight in Prehospital EMS Agencies:** The proportion of EMS agencies with a pediatric emergency care champion increased from 30% in 2019 to 36% in 2021[147];
- **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 health outcomes[148,149];
- **Advanced Prehospital Emergency Services**: In 2020, HRSA-funded Targeted Issues awardees published their findings about the risk of pediatric dosing errors by paramedics

[145] 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 Jun 7.

[146] Data from interfacility transfer guidelines items from the National Pediatric Readiness Assessment, fielded and reported by the EMSC Data Center Data. The 2020 National Pediatric Readiness Assessment was delayed due to COVID-19 until summer 2021, delaying FY20 reporting.

[147] Data reported by the EMSC Data Center, which were collected through a web-based survey of all EMS agency administrators in 58 states and territories from January to March 2021.

[148] 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):2061–2068 https://doi.org/10.2337/dc20-3113

[149] Nicole S. Glaser, MD, Michael J. Stoner, MD, Aris Garro, MD, MPH, Scott Baird, MD, Sage R. Myers, MD, MSCE, Arleta Rewers, MD, PhD, Kathleen M. Brown, MD, Jennifer L. Trainor, MD, Kimberly S. Quayle, MD, Julie K. McManemy, MD, MPH, Andrew D. DePiero, MD, Lise E. Nigrovic, MD, MPH, Leah Tzimenatos, MD, Jeff E. Schunk, MD, Cody S. Olsen, MS, T. Charles Casper, PhD, Simona Ghetti, PhD, Nathan Kuppermann, MD, Serum Sodium Concentration and Mental Status in Children With Diabetic Ketoacidosis. *Pediatrics* (2021) 148 (3): e2021050243.

and the need for expanded prehospital emergency services education.[150] This work has been included in the American Board of EMS core content for pediatric patient safety continuing medical education; and

- **Advanced EMSC Health Equity Research and Care**: In 2021, PECARN-supported research publications increased our understanding of and approaches to remediating racial inequities in pain management and diagnosing for pediatric emergency patients.[151,152,153] Additionally, State Partners are addressing health equity by expanding virtual educational trainings, focusing on rural and tribal areas, increasing diverse representation on EMSC advisory councils, and increasing EMS education and relationship-building with populations with special health care needs.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $22,236,000 |
| FY 2020 | $22,334,000 |
| FY 2021 Final | $22,267,000 |
| FY 2022 CR | $22,334,000 |
| FY 2023 President's Budget | $28,134,000 |

**Budget Request**

The FY 2023 Budget Request for the Emergency Medical Services for Children (EMSC) Program of $28.1 million is $5.8 million above the FY 2022 Continuing Resolution level. This funding request provides additional support to states to address critical gaps that remain for access to high-quality emergency and trauma care, including pre-hospital and hospital emergency medical services, for children across the country.

EMSC agencies are a critical resource in responding to childhood trauma, youth suicide (now the second leading cause of death for people aged 10-34[154]), and the health and social/emotional

[150] Hoyle JD Jr, Ekblad G, Hover T, Woodwyk A, Brandt R, Fales B, Lammers RL. Dosing Errors Made by Paramedics During Pediatric Patient Simulations After Implementation of a State-Wide Pediatric Drug Dosing Reference. Prehosp Emerg Care. 2020 Mar-Apr;24(2):204-213.

[151] George Lindbeck, Manish I. Shah, Sabina Braithwaite, Jonathan R. Powell, Ashish R. Panchal, Lorin R. Browne, Eddy S. Lang, Brooke Burton, Jeffrey Coughenour, Remle P Crowe, Hannah Degn, Mary Hedges, James Gasper, Kyle Guild, Connie Mattera, Sandra Nasca, Peter Taillac & Mark Warth (2021) Evidence-Based Guidelines for Prehospital Pain Management: Recommendations, Prehospital Emergency Care, DOI: 10.1080/10903127.2021.2018073

[152] 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):949-956. doi: 10.1111/acem.14142. Epub 2020 Oct 21. PMID: 32991770.

[153] 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.

[154] CDC. Web-based Injury Statistics Query and Reporting System (WISQARS). (2020) Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

impact of the COVID-19 pandemic on children. Currently, of the EMS agencies reporting, only 25% require EMS practitioners to demonstrate the effective use of pediatric equipment, 36% have dedicated pediatric emergency care coordinators, and only 62% of hospitals have inter-facility transfer guidelines, all of which are critical for improving pediatric readiness and improving outcomes.[155] Additional funding to states will help to increase readiness in EMS agencies and hospitals across the country through additional personnel, quality improvement initiatives, and pediatric specialized training.

Funding will also support State EMSC programs to build mental health capacity for children in EDs. This growing issue is particularly important from an equity standpoint—Black children have 1.5 times the rate of mental health diagnoses in the ED compared to White children, and the rate of mental health-related ED visits has increased faster for Black children compared to White children.[156] Funding will provide additional support to EMS agencies and EDs for training to appropriately respond to these diagnoses.

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.

**Outcomes and Outputs Tables**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3050.01**:** Percentage of responding EMS agencies nationwide that have a pediatric emergency care coordinator *(Outcome)* | FY 2021: 36%[157] Target: Not Defined (Target Not In Place) | 38% | 39% | +1 percentage point |

[155] Data reported by EMSC State Partnership performance reports.
[156] Abrams M, Goyal M, Badolato G. Racial Disparities in Pediatric Mental Health-Related Emergency Department Visits: A Five-Year Multi-Institutional Study. Pediatrics August 2019, 144 (2 Meeting Abstract) 414. https://pediatrics.aappublications.org/content/144/2_MeetingAbstract/414
[157] The data source for this measure is the EMSC Data Center.

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 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%<br>Target: Not Defined[158]<br>(Historical Actual) | Not Defined[159] | 65% | N/A[160] |
| 3050.03**:** Number of children enrolled in Pediatric Emergency Care Applied Research Network (PECARN) studies. *(Outcome)* | FY 2021: 143,000[161]<br>Target: Not Defined<br>(Target Not In Place) | 135,000 | 144,000 | +9,000 |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 72 | 72 | 73 |
| **Average Award** | $271,638 | $266,921 | $348,421 |
| **Range of Awards** | $130,000-$3,000,000 | $130,000-$3,200,000 | $130,000-$3,200,000 |

[158] Target not defined because FY2021 CJ zeroed out the program.
[159] [159] The FY2022 CJ reported the FY2022 target as 61%. This was reported in error as data for this measure is collected every 2 years for this measure and was most recently collected in FY2021.
[160] FY2023 target reflects a 4% increase over the last target set in FY2020 of 61%.
[161] The data source for this measure is the EMSC Data Center.

## Healthy Start

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $127,616,000 | $128,000,000 | $145,000,000 | +$17,000,000 |
| **FTE** | 17 | 17 | 22 | +3 |

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

FY 2023 Authorization .....$125,500,000

Allocation Method:

- Competitive grant/co-operative agreement

**Program Description**

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

Following a plateau between 2000 and 2005, the U.S. infant mortality rate declined more than 21 percent overall between 2005[162]and 2020[163] to a record low of 5.42 infant deaths per 10,000 live births. However, the non-Hispanic Black infant mortality rate is more than two and a half times that for non-Hispanic Whites.[164,165] In 2020, the five leading causes of infant mortality in the

[162] 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

[163] NCHS Data Brief No. 427, December 2021; Mortality in the United States, 2020 (cdc.gov)

[164] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 2018-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 2018-2020, 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 10, 2022 7:13:06 PM

[165] United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2016-2020, on CDC WONDER Online Database, October 2021. Accessed at http://wonder.cdc.gov/natality-expanded-current.html on Jan 11, 2022 4:49:38 PM

U.S. included birth defects, preterm birth and low birthweight, sudden infant death syndrome, unintentional injuries, and maternal pregnancy complications.[166] There is a potential for reducing each of these causes of death, particularly among low-income families and communities. Preterm birth (defined as birth at less than 37 completed weeks of gestation) is a key risk factor for infant death. Approximately two-thirds of all infant deaths occur among infants born preterm.[167] After declining from 2007 to 2014, the U.S. preterm birth rate increased nearly 6.9 percent from 9.57 percent in 2014 to 10.23 percent in 2019[168]; however, between 2019 and 2020 it dropped to 10.1 percent, a 1% decline.[169] Non-Hispanic Black women continue to be more likely to experience preterm birth than non-Hispanic White women (14.4 and 9.1 percent, respectively, in 2020).[170] Healthy Start aims to reduce these disparities by supporting high-risk women and their families with accessing needed services to improve the health of mothers and children before, during, and after pregnancy.

Healthy Start targets communities with infant mortality rates that are at least 1½ times the U.S. national average and/or with high indicators of poor perinatal outcomes, particularly among non-Hispanic Black and other disproportionately affected populations. In FY 2022, Healthy Start funded 101 competitive grants in 35 States, the District of Columbia, and Puerto Rico.

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

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

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

[166] NCHS Data Brief No. 427, December 2021; Mortality in the United States, 2020 (cdc.gov)
[167] Ely DM, Driscoll AK. Infant mortality in the United States, 2019: Data from the period linked birth/infant death file. National Vital Statistics Reports; vol 70 no 14. Hyattsville, MD: National Center for Health Statistics. 2021. https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-14.pdf
[168] https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-508.pdf
[169] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm. Accessed on Jan 7, 2022.
[170] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm. Accessed on Jan 7, 2022.

families to appropriate services and a medical home. Healthy Start delivers services using a range of approaches, including on-site services, in-home visits, and services provided at community locations/events. Services incorporate:

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

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

Healthy Start projects collaborate with federal, state, and local programs, including but not limited to: the Maternal, Infant, and Early Childhood Home Visiting Program; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Early Head Start; Title V State Maternal and Child Health Services Block Grant; Medicaid; Children's Health Insurance Program; and local perinatal systems such as those in community health centers. These collaborations strengthen the services provided and help reduce risk factors, such as substance use during pregnancy, while promoting healthy behaviors that can lead to improved outcomes for women and their families. Healthy Start may also provide home visiting services, but in communities where there is a home visiting program, programs are expected to collaborate in order to maximize coordination and minimize duplication.

HRSA supports program implementation through technical assistance, training, and education provided to grantees by the Healthy Start EPIC Center (www.healthystartepic.org). EPIC Center services include strengthening staff skills to implement evidence-based practices in maternal and child health; facilitating grantee-to-grantee sharing of expertise and lessons learned from the field; and sharing resources for effective program delivery. The EPIC Center has been instrumental in providing COVID-19-related training to Healthy Start grantees whose programs and program participants have been impacted by the COVID-19 pandemic. Information gathered through grantee listening sessions conducted through the EPIC Center has informed trainings for grantees on how to adapt in-person services to remote or virtual services to protect the health and safety of their clients and staff. During the COVID-19 pandemic, the EPIC Center has worked with Postpartum Support International (PSI) to provide virtual support groups for Healthy Start clients and virtual wellness coaching for Healthy Start staff.

In FY 2019, Healthy Start began supporting a new initiative to reduce maternal mortality through hiring of clinical services providers (e.g., nurse practitioners, certified nurse midwives, physician assistants, and other maternal-child advance practice health professionals) to provide clinical services, such as well-woman care and maternity care services, within program sites nationwide. In FYs 2020 and 2021, HRSA used $15 million to support these activities within existing Healthy Start awards. To date, 93 grantees have received clinician funding.

**Program Accomplishments**

Key program accomplishments highlighted below reflect FY 2020 outcomes among Healthy Start program participants. This is the second year of data reporting for the cohort of grantees initially funded in FY 2019. In FY 2020, the program did not meet any of the three performance measure targets for timely prenatal care utilization, low birthweight, or number of participants served, potentially reflecting the impact of the pandemic on service provision and participation, 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. While the program did not meet these targets, the program saw significant improvements across all three measures in FY 2020, as compared to the previous year's outcomes.

The Healthy Start program served approximately 61,000 women and children in FY 2020, in addition to nearly 5,000 men. During the same period, Healthy Start programs screened 93 percent of women participants for depression with 74 percent of those who screened positive receiving referral for services. 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, 93 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 infant mortality rate in the United States for 2018-2020 (three-year average) was 5.56 per 1,000 live births. The 2018-2020 (three-year average) infant mortality rate among Healthy Start participants was 7.04 per 1,000 live births, which reflects the high-risk populations targeted by the program.[171] The previous three-year (2017-2019) average infant mortality rates were 5.68 per

[171] A multi-year infant mortality rate (IMR) is reported for 2018-2020. 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 2017 to 2020 are as follows:

2017: Healthy Start 9.47 per 1,000 live births, United States 5.79 per 1,000 live births
2018: Healthy Start 6.26 per 1,000 live births, United States 5.67 per 1,000 live births
2019: Healthy Start 8.05 per 1,000 live births, United States 5.58 per 1,000 live births
2020: Healthy Start 6.99 per 1,000 live births, United States 5.42 per 1,000 live births

*Healthy Start Data Source:* Healthy Start Aggregate Reporting Spreadsheet
*U.S. IMR Data Sources:*
2019, 2020: https://www.cdc.gov/nchs/products/databriefs/db427.htm
2018: https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-7-508.pdf
2017: https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_10-508.pdf

1,000 live births in the U.S. and 7.98 per 1,000 live births for Healthy Start participants.[172] Comparing the three-year infant mortality rate averages for the periods of 2018-2020 and 2017-2019, the U.S. three-year infant mortality rate decreased by 2.1 percent, whereas the Healthy Start three-year infant mortality rate decreased by 11.8 percent. This is the third year in which the program is monitoring and reporting a multi-year infant mortality rate among the Healthy Start participants.

Healthy Start is committed to data-driven and evidence-based decision-making. In FY 2020, HRSA invested in a one-year contract to design an evaluation plan for the Healthy Start program with the secondary purpose of assessing grantee data collection and evaluation capacity. The resulting grantee organizational assessment and Healthy Start Evaluation Design Plan informed the development of the Healthy Start Evaluation and Capacity Building Support statement of work, which was competed and awarded at the end of FY 2021 for a four-year period of performance. These efforts continue to build from evaluation work that began in 2017 when Healthy Start initiated a national evaluation to explore associations between program participation, participant-level characteristics (such as race, health insurance coverage, pre-existing conditions, income, age), and program outcomes. Findings from the evaluation showed positive outcomes related to program goals.[173] 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.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $121,962,000 |
| FY 2020 | $125,500,000 |
| FY 2021 Final | $128,000,000 |
| FY 2022 CR | $128,000,000 |
| FY 2023 President’s Budget | $145,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Healthy Start program of $145.0 million is $17.0 million above the FY 2022 Continuing Resolution. This increase will support a new, targeted expansion of an enhanced Healthy Start program model in 12 new communities with the highest rates of perinatal health disparity in the country. This expansion aims to reduce racial disparities in poor maternal and infant health outcomes, such as maternal and infant mortality, low birthweight, preterm birth, and other perinatal health risks. An estimated 9,600 additional women and infants will receive critical direct and enabling services with this additional funding with additional broader individual and community benefits resulting from structural and system improvements.

[172] See footnote on multi-year infant mortality rate (IMR).
[173] Abt Associates (2020). Evaluation of the Implementation and Outcomes of the Maternal & Child Health Bureau's Federal Healthy Start Program.

This investment will include two program components: 1) 12 new awards of approximately $1.2 million each in communities not currently served by a Healthy Start program, and 2) a resource center that will provide technical assistance to new enhanced Healthy Start program model awardees. Technical assistance will include identification and dissemination of evidence-based practices (including community-driven interventions) to address social and environmental factors contributing to perinatal health disparities; scaling of efforts to address systemic and structural factors influencing health disparities in communities served; data collection and reporting; and product development.

New Healthy Start award recipients will build on the program's past success by more precisely targeting expansion to 12 new communities with the highest rates of perinatal health disparity in the country—reaching communities that account for up to 30% of excess Black infant deaths.[174] HRSA will leverage two ongoing analytic efforts to identify and target need and geographic priority for the new Healthy Start awards to communities with high rates of adverse maternal health outcomes (e.g. perinatal health risk) and infant health disparities. Grant 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, justice, and housing—in order to provide enabling services and address social determinants of maternal and infant health. Efforts may include support in accessing health insurance coverage, addressing inadequate or potentially hazardous housing, offering legal aid to assist women, or leveraging existing policies and supports such as the Earned Income Tax Credit (EITC) and Child Tax Credit (CTC), among other community, social and economic support services in order to significantly reduce racial disparities in perinatal health outcomes by 2030.

Heathy Start funding also continues $15.0 million in support for grantees to hire clinical service providers at Healthy Start sites to provide direct access to well woman care and maternity care services. This will reduce barriers to care and better address health disparities among high-risk and underserved women. In FY 2023, the program will continue to serve women and families across the nation through the 101 grants awarded in the FY 2019 funding cycle. At this funding level, Healthy Start expects to serve at least 82,000 participants in FY 2023 with case management services. Recognizing that improving birth outcomes begins with improving women's health before, during, and between pregnancies, funding will continue to improve access to quality healthcare and support services for women and children throughout the prenatal, postpartum, and inter-conception periods. The funding request also includes costs associated with the Healthy Start Monitoring and Evaluation Data (HSMED), as well as grant review and award process, follow-up performance reviews, information technology, and other program support costs.

[174] I.e., Deaths that occur due to higher mortality rates relative to non-Hispanic White infants and can be referred to as deaths attributable to disparity or deaths that need to be prevented to achieve equity in infant mortality rates.

**Outcomes and Outputs Tables**[175]

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3060.01**:** The percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester. *(Outcome)* | FY 2020: 78%<br>Target: 80%<br>(Target Not Met) | 80% | 84% | +4 percentage points |
| 3060.02**:** Percentage of singleton births weighing less than 2,500 grams (low birthweight) *(Outcome)* | FY 2020: 10.3%<br>Target: 9.6%<br>(Target Not Met) | 9.6% | 9.6% | Maintain |
| 3060.03**:** The number of persons case managed in the Healthy Start Program. *(Efficiency and Developmental)* | FY 2020: 65,942[176]<br>Target: 70,000<br>(Target Not Met) | 80,000 | 82,000 | +2,000 |

**Grant Awards Table**[177]

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 101 | 101 | 113 |
| **Average Award** | $1,078,527[178] | $1,125,185 | $1,132,236 |
| **Range of Awards** | $695,786-$1,144,121 | $623,477-$1,144,121 | $623,477-$1,200,000 |

[175] Fiscal year targets reflect calendar year data. Awards are made annually in April, thus the bulk of the data coincides with the fiscal year.
[176] The Healthy Start Program most likely served fewer participants than anticipated in CY 2020 due to effects of the COVID-19 pandemic.
[177] FY 2022 and FY 2023 reflect before -offset awards. .
[178] FY 2021 does not include executed supplements of $1.6M for Action Plans for Infant Health Equity and $3.12M for Community-Based Doulas.

## Heritable Disorders in Newborns and Children

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $18,826,000 | $18,883,000 | $18,883,000 | --- |
| **FTE** | 4 | 4 | 5 | +1 |

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

FY 2023 Authorization……Expired

Allocation Methods:

- Contract
- Competitive grant/co-operative agreement

**Program Description and Accomplishments**

The Heritable Disorders in Newborns and Children program focuses on reducing the morbidity and mortality caused by heritable disorders in newborns and children by supporting state and local public health agencies' ability to provide screening, counseling, and health care services. Four million newborns each year are screened for at least 30 of the 35 core conditions on the Recommended Uniform Screening Panel (RUSP), a list of conditions recommended by the Secretary of Health and Human Services (HHS) for state newborn screening programs. Babies testing positive for one of these conditions receive early intervention and treatment to prevent serious problems such as brain damage, organ damage, and even death. Newborn screening saves or improves the lives of nearly 13,000 babies in the United States each year.

The program is composed of the following:

- The **Newborn Screening Family Education Program** seeks to increase awareness, knowledge, and understanding of newborn screening for parents, families, patient advocacy and support groups, as well as the public at large. The program develops and delivers educational programs about newborn screening, counseling, testing, follow-up, treatment, and specialty services. In 2020 the program launched a free online training for families, and developed resources that highlighted newborn screening resources and access to services during the COVID-19 pandemic.
- The **Regional Genetics Networks** enhance, improve, or expand access to screening, counseling, and health care services for newborns and children having or at risk for genetic disorders. The networks link patients to genetic services and provide resources to genetic service providers, public health officials, and families. During FY 2021, the program served 18,697 individuals and families through education and training,

facilitating connections to genetic services, and facilitating telehealth services. Of those, 5,977 were from medically underserved populations. In FY 2021 the program provided education and training to 6,789 professionals, including genetics providers and primary care providers, through webinars and in-person sessions.

- **Long-Term Follow-Up for Severe Combined Immunodeficiency (SCID) Implementation and Other Newborn Screening Conditions Program** supports comprehensive, collaborative models of long-term follow-up between clinicians, public health agencies, and families. The program expands the ability of state public health agencies to provide screening, counseling, and services to children identified through newborn screening. The program also supports collaboration with clinicians, public health agencies, and families to create a system of care that can assess and coordinate follow-up and treatment of SCID and/or other newborn screening conditions.
- The **Advancing, Improving, and Measuring Newborn Screening System Programs** will support and strengthen state public health agencies and newborn screening system partners to provide screening, counseling, or health care services to newborns and children with, or at risk for, heritable disorders. In FY2023, these new programs, including up to 22 awards to states and a national coordinating center, will collectively work to improve identification of newborns and children with heritable disorders, including increased NBS timeliness and implementation of new conditions added to the recommended uniform screening panel (RUSP), to improve short-term and long-term follow-up outcomes for infants and families identified through NBS, and to increase access to follow-up for individuals and families with conditions identified through NBS.

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

Since 2009, the program also supports the Clearinghouse of Newborn Screening Information as a central source of current educational and family support information, materials, resources, research, and data on newborn screening. The Newborn Screening Information Center (NBSIC) is interactive and contains links to various resources including government-sponsored, non-profit organizations, laboratories, and other organizations with expertise in newborn screening; research-based information on newborn screening tests currently available throughout the United States; and information about newborn conditions and screening services available in each state. From September 2020 to August 2021, the NBSIC had over 100,000 page views.

In response to the COVID-19 global pandemic and needs expressed by newborn screening programs across the nation, NewSTEPs, the Newborn Screening Family Education Program, and the Regional Genetics Networks provided technical assistance to states around laboratory supply and support needs; emergency and contingency planning tools and resources, including information about access to care through telehealth; and educational materials to their constituents and stakeholders.

The program addresses health equity through the Regional Genetics Networks and the Newborn Screening Education program, which aim to increase access to genetic services and information for underserved populations. Additionally, The Western States Regional Genetics Network has developed a national minority genetics professional network to support and encourage increased diversity across all genetics professions.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $16,311,000 |
| FY 2020 | $17,883,000 |
| FY 2021 Final | $18,826,000 |
| FY 2022 CR | $18,883,000 |
| FY 2023 President's Budget | $18,883,000 |

**Budget Request**

The FY 2023 Budget Request for the Heritable Disorders in Newborns and Children program of $18.9 million is equal to the FY 2022 Continuing Resolution. This request will invest $18.9 million to 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 newborn screening and enhance, improve, or expand access to screening, counseling, and health care services for newborns and children having or at risk for genetic disorders.

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

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 19 | 19 | 37 |
| **Average Award** | $760.063 | $729,177 | $402,811 |
| **Range of Awards** | $199,758 -$3,300,000 | $133,333-$3,300,000 | $250,000-$2000,000 |

## Pediatric Mental Health Care Access

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $9,970,000 | $10,000,000 | $10,000,000 | --- |
| **FTE** | 4 | 4 | 4 | --- |

Authorizing Legislation – Public Health Service Act, Section 330M, as added by Public Law 114-255

FY 2023 Authorization……..Expired

Allocation Method

- Competitive co-operative agreement

**Program Description and Accomplishments**

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

In 2019, over 1 in 5 children ages of 3 to 17 had some type of mental, emotional, developmental, or behavioral condition or problem.[179] While the need for and receipt of treatment varies by condition, some analyses indicate that children with behavioral/conduct problems are less likely to receive care than those with anxiety problems or depression. Significant disparities exist in access to behavioral health care. Studies have generally found lower behavioral health service utilization among Black/African American and Hispanic/Latino children, compared with White children.[180] 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 children in rural areas are significantly less likely to receive

[179] Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health. 2018-2019 National Survey of Children's Health (NSCH) data query. www.childhealthdata.org. Accessed April 05 2021.

[180] Stacy Hodgkinson, Leandra Godoy, Lee Savio Beers, Amy Lewin; Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. *Pediatrics* January 2017; 139 (1): e20151175. 10.1542/peds.2015-1175

mental health services than their counterparts in urban areas.[181] These findings remain statistically significant even after income, family composition, and health insurance status are controlled for, and they suggest that there may be other determinants, such as communication, bias and discrimination, and practical barriers that may affect access to behavioral health services. Often, pediatric primary care providers are the first responders in behavioral disorder identification and service provision. However, they may not have the knowledge and training to screen, diagnose, and treat behavioral disorders. Patients may also lack access to needed services, leading to conditions severe enough to impair child, adolescent, and family functioning, school performance, and safety.

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

PMHCA program award recipients address increases in behavioral health concerns among children and adolescents related to the COVID-19 pandemic, including increased reports of anxiety, depression, and suicidal ideation and attempts. PMHCA program award recipients also support resilience strategies among families and clinicians. In FY 2020,[182] PMHCA recipients achieved the following:

- Over 4,500 primary care providers in 21 states enrolled in a statewide or regional PMHCA program.
- Over 3,000 tele-consultations were provided and approximately 3,800 providers were trained.
- Approximately 3,000 children and adolescents overall were served by pediatric primary care providers who contacted the pediatric mental health team.
- Approximately 2,000 children and adolescents living in rural and underserved counties were served by pediatric primary care providers who contacted the pediatric mental health team.

Section 2712 of the American Rescue Plan Act of 2021 (P.L. 117-2) (ARP) provides $80 million in funding to support pediatric mental health care access and promote behavioral health integration into pediatric primary care by supporting state or regional networks of pediatric mental health care teams. HRSA awarded 24 additional PMHCA projects in areas without current HRSA-funded programs in FY 2021. This expansion increased the program reach from 21 awards in 21 states to 45 awards in 40 states, as well as the District of Columbia, the U.S. Virgin Islands, and the Republic of Palau. It also provides support to two Tribal areas – the Chickasaw Nation and the Red Lake Band of the Chippewa Indians. HRSA is conducting a second ARP-PMHCA competition in FY 2022 to fund up to 10 additional programs in states, political subdivisions of states, Indian Tribes, and Tribal organizations not currently supported by a HRSA PMHCA program. . ARP funds also will be used to establish a new PMHCA

[181] See footnote 2 on page 2
[182] FY 2020 data covers a 12-month period of work from 7/1/2019-6/30/2020 and 9/30/2020-9/29/2021 (Hae Young Note: this edited date is not correct: it should be changed back to 9/30/2019-9/29/2020).

Innovation Center to provide technical expertise and assistance to state, regional, territorial, and tribal PMHCA programs. An evaluation contractor for PMHCA and the Screening and Treatment for Maternal Depression and Related Behavioral Disorders program will expand evaluation efforts to include newly-funded PMHCA projects in national program evaluation and evaluation capacity-building activities.

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

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $9,956,000 |
| FY 2020 | $10,000,000 |
| FY 2021 Final | $9,970,000 |
| FY 2022 CR | $10,000,000 |
| FY 2023 President's Budget | $10,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Pediatric Mental Health Care Access program of $10.0 million is equal to the FY 2022 Continuing Resolution level. The Budget Request will continue to support 21 statewide or regional pediatric mental health care telehealth access programs providing tele-consultation, training, technical assistance, and care coordination 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.

**Outcomes and Outputs Tables**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3080.01**:** Number of providers participating in the program. (*Output*)[183] | FY 2020: 4,552<br>Target: Not Defined<br>(Target Not in Place) | 4,750 | 5,000 | +250 |
| 3080.02: Percentage of providers using the teleconsultation line (*Output*)[184] | FY 2020: 45.0%<br>Target: Not Defined<br>(Historical Actual) | 45% | 47% | +2 percentage points |
| 3080.03: Number of children served through teleconsultation who were recommended for referral/treatment *(Outcome)* | FY 2020: 1,107[185]Target: Not Defined<br>(Historical Actual) | Set Baseline | TBD | N/A |
| 3080.04: Number of providers trained *(Output)* | FY 2020: 3,873<br>Target- Not Defined[186]<br>(Baseline) | Set Baseline | TBD | N/A |
| 3080.05: Number of children served through teleconsultation *(Output)* | FY 2020: 2,922[187]<br>Target- Not Defined[188]<br>(Historical Actual) | Set Baseline | TBD | N/A |

[183] This measure was previously worded as "Number of primary care providers enrolled in a statewide or regional pediatric mental health care access program." HSRA revised the measure language in the FY 2023 budget to simplify.
[184] This measure was previously worded as "Percentage of primary care providers enrolled in a statewide or regional pediatric mental health care access program who received teleconsultation on behavioral health conditions." HSRA revised the measure language in the FY 2023 budget to simplify.
[185] FY2020 result does not include data from one state. Result will be updated in FY2024 budget justification based on final data reflecting all states.
[186] Target will be set following availability of 3 years of data which includes Fiscal Year 2021 (7/1/2020-6/30/2021 AND 9/30/2020-9/29/2021).
[187] FY2020 result does not include data from one state. Result will be updated in FY2024 budget justification based on final data reflecting all states.
[188] Target will be set following availability of 3 years of data which includes Fiscal Year 2021 (7/1/2020-6/30/2021 AND 9/30/2020-9/29/2021).

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 52.3**:** Number of children and adolescents, 0-21 years of age, seen by primary care providers enrolled in a statewide or regional pediatric mental health care access program, who received at least one screening for a behavioral health condition using a standardized validated tool. *(Intermediate Outcome)* | FY 2020: 1,306[189]<br>Target: Not Defined<br>(Historical Actual) | Discontinued | Discontinued | N/A |
| 52.4**:** Among children and adolescents, 0-21 years of age, seen by primary care providers enrolled in a statewide or regional pediatric mental health care access program and who received at least one screening for a behavioral health condition using a standardized validated tool, the percentage who screened positive for a behavioral health condition. *(Intermediate Outcome)* | FY 2020: 42.5%.<br>Target: Not Defined<br>(Baseline) | Discontinued | Discontinued | N/A |

[189] Ibid.

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 52.5**:** Among children and adolescents, 0-21 years of age, seen by primary care providers enrolled in a statewide or regional pediatric mental health care access program, who screened positive for a behavioral health condition, the percentage who received treatment from the primary care providers or a referral to a behavioral clinician *(Outcome)* | FY 2020: 92.5%<br>Target: Not Defined<br>(Historical Actual) | Discontinued | Discontinued | N/A |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 45 | 55 | 55 |
| **Average Award** | $433,849 | $441,022 | $444,957 |
| **Range of Awards** | $98,514 – $445,000 | $425,000 - $445,000 | $425,000 - $445,000 |

## Screening and Treatment for Maternal Depression and Related Behavioral Disorders

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $5,000,000 | $5,000,000 | $10,000,000 | +$5,000,000 |
| **FTE** | 1 | 1 | 2 | +1 |

Authorizing Legislation – Public Health Service Act, Section 317L-1, as added by Public Law 114-255

FY 2023 Authorization……Expired

Allocation Method

- Competitive co-operative agreement

**Program Description and Accomplishments**

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

The program's long-term goal is to improve the mental health and well-being of pregnant and postpartum women and, in turn, their infants' social and emotional development. The program aims to:

- Increase universal screening among providers participating in the program;
- Support timely detection, assessment, treatment, and referral of maternal mental health conditions by participating providers using evidence-based practices; and
- Improve access to treatment and recovery support services that are affordable, culturally and linguistically appropriate, and community-based or provided via telehealth.

There are approximately 64 million women of childbearing age in the United States (U.S.) and approximately 4 million women give birth each year. Despite advances in medical care and investments in improving access to care, the maternal mortality rate has not improved. In 2020, 861 women died of maternal causes, representing a maternal mortality rate of 23.8 deaths per 100,000 live births.[190,191] Data from 14 U.S. Maternal Mortality Review Committees (MMRCs)

[190] https://wonder.cdc.gov/controller/saved/D158/D98F942
[191] https://wonder.cdc.gov/controller/saved/D149/D98F943

showed that from 2008 to 2017, mental health conditions were a leading underlying cause of pregnancy-related death.[192] These included deaths to suicide, drug overdose or poisoning, and unintentional injuries, during pregnancy and up to one year after childbirth.

Depression is a common complication of pregnancy. In 2018, 13% of women with a recent live birth reported depressive symptoms during the postpartum period.[193] Additional data from the National Inpatient Sample indicate that the rate of depression diagnoses during delivery hospitalizations increased by sevenfold from 2000-2015.[194] Additionally, substance misuse can co-occur with mental disorders and is at least as common as some other medical conditions that are typically screened for during pregnancy.[195] These issues affect not only the mother, but can also affect maternal-infant bonding and the child's cognitive and emotional development. Intervening early and offering integrated services and support can prevent or reverse these effects.

Despite the importance of screening and early intervention, these services are often unavailable due to limited access to behavioral health resources for front-line health care providers. A nationwide shortage of psychiatrists, especially perinatal psychiatrists, compounds this issue. Women in rural and medically underserved areas are especially vulnerable to these shortages and experience poorer health outcomes than urban women.[196]

As awardees ramped up from the first to the second year, the Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program demonstrates improved short and intermediate-term outcomes:

*Training*

- Awardees trained 1,085 providers in FY 2020, an increase from 160 providers trained in FY 2019. Providers received training on a variety of evidence-based practices such as: Screening, Brief Intervention, and Referral to Treatment (SBIRT); Medication Assisted Treatment; use of standardized validated screening tools for perinatal depression and anxiety; behavioral health integration in primary care settings; and training on perinatal mood and anxiety disorders. Providers trained included 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.

[192] Davis NL, Smoots AN, Goodman DG. Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2019.
[193] https://www.cdc.gov/mmwr/volumes/69/wr/mm6919a2.htm?s_cid=mm6919a2_w
[194] Haight SC, Byatt N, Moore Simas TA, Robbins CL, Ko JY. Recorded Diagnoses of Depression During Delivery Hospitalizations in the United States, 2000-2015. Obstet Gynecol. 2019 Jun;133(6):1216-1223. doi: 10.1097/AOG.0000000000003291. PMID: 31135737; PMCID: PMC6842065.
[195] Wright, T.E., Terplan, M., Ondersma, S.J., Boyce, C., Yonkers, K., et al. (2016). The role of screening, brief intervention, and referral to treatment in the perinatal period. American Journal of Obstetrics & Gynecology, 215(5), 539-547.
[196] The American College of Obstetricians and Gynecologists 2014 Committee Opinion (Reaffirmed 2016), Health Disparities in Rural Women. Retrieved 8/2021. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women

*Consultation*[197]

- Providers sought/received expert consultation for 7,448 pregnant and postpartum women in FY 2020, of which 47% lived in rural/underserved areas. This was an increase from 233 pregnant and postpartum women in FY 2019, of which 30% lived in rural/underserved areas.

*Screening*

- The number of pregnant and postpartum women screened for *depression* by participating providers increased from 4,053 in FY 2019 to 24,518 in FY 2020[198]
- The number of pregnant and postpartum women screened for *anxiety* by participating providers increased from 2,554 in FY 2019 to 14,978 in FY 2020[199]
- The number of pregnant and postpartum women screened for *substance use* by participating providers increased from 2,447 in FY 2019 to 12,928 in FY 2020[200]

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $4,978,000 |
| FY 2020 | $5,000,000 |
| FY 2021 Final | $5,000,000 |
| FY 2022 CR | $5,000,000 |
| FY 2023 President's Budget | $10,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Screening and Treatment for Maternal Depression and Related Behavioral Disorders program of $10.0 million is $5.0 million above the FY 2022 Continuing Resolution level. This request builds upon the Improving Maternal Health Initiative investments to expand support for the Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program to increase access for perinatal women to behavioral health care. This effort supports use of telehealth, psychiatric consultation and care coordination support, and training to expand front-line health care provider capacity to screen, assess, treat, and refer pregnant and postpartum women for maternal depression and related behavioral disorders, including in rural and medically underserved areas. This funding will help states address ongoing needs for maternal behavioral health problems as a result of the impact of COVID-19 on pregnant and postpartum women.

[197] "Consultation" refers to psychiatric consultation and/or care coordination support provided either via telehealth or in-person by the program.
[198] Includes data from four of seven awardees reporting FY 2019 data and all seven awardees reporting FY 2020 data.
[199] Includes data from three of seven awardees reporting FY 2019 and six of seven awardees reporting FY 2020 data.
[200] Includes data from three of seven awardees reporting FY 2019 and four of seven awardees reporting FY 2020 data.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3090.01 Number of pregnant or postpartum women about whom providers sought consultation[201] *(Developmental)* | FY 2020: 7,448 Target: Not Defined[202] (Historical Actual) | Not Defined | TBD | N/A |

[201] HRSA is adding this measure as use of provider consultation is a major component of this program; this measure will show use of consultation services.

[202] The program will identify trends over a three year period as the measure is developmental. Once the trend is analyzed, appropriate targets will be identified and included in the FY 2024 budget justification.

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3090.02 Number and percent[203] of pregnant or postpartum women (PPW) screened for:<br>• ***Depression*** *number (percent);*<br>• ***Anxiety*** *number (percent);*<br>• ***Substance use*** *number (percent)*<br>by participating providers *(Output)*[204] | Depression:<br>FY 2020: 24,518 (54%)[205]:<br>Target: Not Defined[206] (Historical Actual)<br><br>Anxiety:<br>FY 2020: 14,978 (33%)[207]<br>Target: Not Defined[208] (Historical Actual)<br><br>Substance use:<br>FY 2020: 12,928 (45%)[209]<br>Target: Not Defined[210] (Historical Actual) | TBD | TBD | N/A |

[203] Number of PPW women screened/ total number of PPW women served by participating providers. Due to new providers joining the program in a given year, it is possible that the number screened may increase while the overall percent decreases.
[204] This new measure combines and expands on the discontinued measures 53.1, 53.2, and 53.3 to add number served as well as percent to more accurately reflect program impact. Note, new providers may the join the program in each year, and it is possible that the number screened may increase while the overall percentage decreases.
[205] For the FY 2022 HRSA CJ, data in the table were reported as FY 2019, when they actually represented FY 2020 data. This has been corrected in the above FY 2023 Outcomes and Outputs table to reflect the data as FY2020.
[206] The program will identify trends over a three year period as the measure is developmental. Once the trend is analyzed, appropriate targets will be identified and included in the FY 2024 budget justification.
[207] FY 2020 data for anxiety screening was reported by six of seven awardees.
[208] The program will identify trends over a three year period as the measure is developmental. Once the trend is analyzed, appropriate targets will be identified and included in the FY 2024 budget justification.
[209] FY 2020 data for substance use screening was reported by four of seven awardees.
[210] The program will identify trends over a three year period as the measure is developmental. Once the trend is analyzed, appropriate targets will be identified and included in the FY 2024 budget justification.

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 53.1**:** Percent of pregnant and postpartum women at participating practices who received at least one screening for *substance use* using a standardized validated tool conducted by participating practices during pregnancy or the first 12 months after delivery *(Developmental)*[211] | FY 2020: 45% Target: Not Defined (Historical Actual) | Discontinued | Discontinued | N/A |
| 53.2**:** Percent of pregnant and postpartum women at participating practices who received at least one screening for *anxiety* using a standardized validated tool conducted by participating practices during pregnancy or the first 12 months after delivery *(Developmental)*[212] | FY 2020: 33% Target: Not Defined (Historical Actual) | Discontinued | Discontinued | N/A |
| 53.3**:** Percent of pregnant and postpartum women at participating practices who received at least one screening for *depression* using a standardized validated tool conducted by participating practices during pregnancy or the first 12 months after delivery *(Developmental)*[213] | FY 2020: 54% Target: Not Defined (Historical Actual) | Discontinued | Discontinued | N/A |

[211] HRSA is discontinuing this measure and replacing with measure 3090.02 above. The discontinued measure only presents the percentage, which does not capture the full reach and effect of the program. New providers may the join the program in each year, changing the denominator for the percentage; it is possible that the number screened may increase while the overall percentage decreases. The new measure expands on the discontinued measure to add number served as well as percent to more accurately reflect program impact.
[212] Ibid.
[213] Ibid.

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 7 | 7 | 12 |
| **Average Award** | $513,220 | $646,466 | $689,605 |
| **Range of Awards** | $285,839-$650,000 | $627,525-$650,000 | $650,000-$750,000 |

## Poison Control Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $24,846,000 | $24,846,000 | $24,846,000 | --- |
| **FTE** | 1 | 1 | 3 | +2 |

Authorizing Legislation: Public Health Service Act, Sections 1271-1274, as amended by Public Law 116-94

FY 2023 Authorization ..... $30,100,000

Allocation Method:

- Contracts
- Competitive Grants/Co-operative Agreements

**Program Description and Accomplishments**

The Poison Control Program (PCP) was established in 2000 and is legislatively mandated to:

- Fund poison control centers (PCCs);
- Establish and maintain a national toll-free number (800-222-1222) to ensure access to poison control center services; and
- Implement a national media campaign to educate and support outreach to the public and health care providers about:
    - Poisoning and toxic exposure prevention, and
    - The availability of poison control center resources in local communities through a toll-free number.

The PCP supports PCCs' efforts to: 1) prevent and provide treatment recommendations for poisonings; 2) comply with operational requirements to sustain accreditation and/or achieve accreditation; and 3) improve and enhance communications and response capability and capacity. Funds may also be used to improve the quality of data uploaded from poison control centers to the National Poison Data System in support of national toxic surveillance activities conducted by the Centers for Disease Control and Prevention (CDC).

The national toll-free Poison Help line was established in 2001. Individuals can call from anywhere in the U.S. and the territories and connect to the PCCs that serve their respective areas. The PCP maintains the number, provides interpretation services in over 150 languages, and offers services for the hearing impaired.

Today, a network of 55 PCCs, supported by 52 grant awards, provides high quality, cost-effective, health care guidance regarding poisoning to the general public and health care

providers across the U.S., including American Samoa, the District of Columbia, the Federated States of Micronesia, Guam, Puerto Rico, and the U.S. Virgin Islands. The PCP ensures that the Poison Help line is operational, calls are routed to the appropriate PCC, and multilingual interpreter services are available. Twenty-four hours a day, seven days a week, health care providers and other specially trained toxicology experts provide assessments, triage, and treatment recommendations at no cost to callers. PCCs are consulted for a range of exposures including, for example, when a child swallows a household product; an adolescent ingests 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 health care professionals regularly consult PCCs for expert consultation in managing poisonings. PCCs are critically important partners in emergency preparedness. A hallmark of PCP case management is the use of follow up calls to monitor case progress and document medical outcomes.

According to the American Association of Poison Control Centers, PCCs managed 3.1 million encounters in 2020, a 28.9 percent increase from 2019. Although the number of human exposure poisonings remained unchanged in 2020 (2.1 million), PCCs experienced an increase in medical information requests, primarily related to COVID-19, with peaks in these requests documented in April 2020, July 2020 and November-December 2020. These peaks generally corresponded to the peaks in COVID-19 cases reported in the United States. Increases in calls regarding COVID-related substances included questions about cleaners/disinfectants (e.g., bleaches) in April, chloroquine/hydroxychloroquine in June, and COVID-19 vaccines in December. As in previous years, PCCs managed about 69 percent at the site of exposure; health care facilities made approximately 22 percent of calls to PCCs. The top 5 substance classes most frequently involved in all human exposures were analgesics (10.3%), household cleaning substances (8.4%), cosmetics/ personal care products (6.6%), antidepressants (5.3%); and sedatives/ hypnotics/ antipsychotics (4.9%).[214] Ninety-three percent of the cases occurred in a residence. Overall, PCCs continue to provide around-the-clock guidance that results in decreasing unnecessary visits to emergency departments, reducing health care costs, improving poison-related health outcomes, and serving as a trusted source of public health information.

Through the nationwide Poison Help media campaign, the PCP has been educating the public about the toll-free number and increasing awareness of poison control center services. In FY 2021, the Poison Help media campaign included an investment of $617,515. This campaign published almost 100 social media posts, resulting in nearly 1,000 engagements. Additionally, the campaign generated over 200 million impressions from public service announcements valued at over $9 million through over 35,000 airings on nearly 500 television and radio stations in over 200 markets.

Another critical function of the PCCs is to collect poison exposure and surveillance data. Multiple Federal agencies, including the CDC, Consumer Product Safety Commission, Environmental Protection Agency, Food and Drug Administration, and Substance Abuse and Mental Health Services Administration, use these data for public health surveillance, including timely identification, characterization, or ongoing tracking of occurrences and other public health

[214] 2020 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 38th Annual Report

threats. Many state health departments collaborate directly with poison control centers within their jurisdictions, using data from poison control centers to monitor exposures to e-cigarette devices and liquid nicotine, synthetic cathinones and cannabinoids, opioids, hand sanitizer, and laundry detergent packets.

According to the CDC, in 2020, there were 87,404 unintentional poisoning deaths at a rate of 26.5 per hundred thousand population.[215] Opioid-involved overdose deaths rose from 21,088 in 2010 to 46,802 in 2018 and remained steady in 2019 with 49,860 deaths.[216] Poison Control Centers play a critical role in combatting opioid drug-related abuse and misuse, from helping to define and trace the problem within a local and national context to responding to calls from health care providers seeking treatment advice for patients.

In addition, PCCs provide public and health care provider education and actively seek to change behaviors to reduce poisonings and promote awareness and use of PCC services. Education efforts include: partnering with health departments, education departments, and other state agencies; promoting safe prescription medication use and storage; messaging at health fairs and community events; and collaborating to develop media campaigns focused on preventing poisonings. Poison Control Centers participate in National Prescription Drug Take-Back events sponsored by the Drug Enforcement Agency to provide a safe, convenient, and responsible means of prescription drug disposal while also educating the public about potential medication abuses.

**Funding History**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $22,746,000 |
| FY 2020 | $22,846,000 |
| FY 2021 Final | $24,846,000 |
| FY 2022 CR | $24,846,000 |
| FY 2022 President's Budget | $24,846,000 |

**Budget Request**

The FY 2023 Budget Request of $ 24.8 million is equal to the FY 2022 Continuing Resolution level. This request will support the 52 Poison Control Center grants to maintain infrastructure and core triage and treatment services. Poison Control Centers predominantly rely on state and local funding, as Federal funding accounts for approximately 13 percent of total Poison Control Center funding. While Poison Control Centers have innovatively secured funding from a variety of local sources, including philanthropic organizations, their financial stability is tenuous. Federal funding helps reinforce the nationwide Poison Control Center infrastructure, enabling Poison Control Centers to sustain their public health and toxic surveillance efforts.

[215] https://www.cdc.gov/nchs/fastats/accidental-injury.htm
[216] Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths – United States 2013-2019 – Morbidity and Mortality Weekly Report (MMWR), February 12, 2021

The FY 2023 Budget Request will also support continued maintenance of the national toll-free Poison Help line and interpretation services for non-English speaking callers. The Nationwide Media Campaign will continue to educate the public and health care providers about poisoning, toxic exposure prevention, and the availability of the national toll-free number.

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

**Outputs and Outcomes**

| Measure | Year and Most Recent Result/ Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 5030.01: Percentage of inbound volume on the toll-free number. (Output) | FY 2020: 78% Target: 85% (Target Not Met) | 73% | 73% | Maintain |
| 25.III.D.4: Percent of national survey respondents who are aware that calls to poison control centers are handled by health care professionals. (Outcome)[217] | FY 2017: 37% Target: 25% (Target Exceeded) | Discontinued | Discontinued | N/A |
| 25.III.D.6: Percent of human exposure calls made to Poison Control Centers that came from health care facilities. (Output) | FY 2021: 24% Target: 24% (Historical Actual) | 15% | 20% | +5 percentage points |

[217] This is a long-term measure based on periodic survey data, reported about every 5 years. The next survey findings are expected in FY 2022, with results in 2023 once a final report is approved by HRSA.

**Grants Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards[218]** | 52 | 52 | 52 |
| **Average Awards** | $413,846 | $421,861 | $421,861 |
| **Range of Award** | $88,478-$2,560,600 | $88,478-$2,560,600 | $88,478-$2,560,600 |

**Contracts Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Contracts** | 2 | 2 | 2 |
| **Average Contract** | $564,172 | $529,836 | $529,836 |
| **Range of Contracts** | $510,829-$617,515 | $510,829-$548,842 | $510,829-$548,842 |

[218] There are 55 Poison Control Centers across the Nation. Fifty-two awards were made in FY 2021 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.

## Family-To-Family Health Information Centers

| | FY 2021 Final[219] | FY 2022 Continuing Resolution[220] | FY 2023 President's Budget [221] | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $5,658,000 | $5,658,000 | $5,658,000 | --- |
| **FTE** | 1 | 1 | 1 | --- |

Authorizing Legislation - Social Security Act, Title V, Section 501(c)(1)(A) of the, as amended by Public Law 116-39, Section 5

FY 2023 Authorization……$6,000,000

Allocation Method:

- Competitive grant/co-operative agreement

**Program Description and Accomplishments**

The Family-to-Family Health Information Centers (F2F HICs) Program assists families of children and youth with special health care needs (CYSHCN) to be partners in health care decision making. Staffed by family members who have first-hand experience using health care services and programs for CYSHCN, F2F HICs promote cost-effective, quality health care by providing patient-centered information, education, technical assistance, and peer support to families of CYSHCN and health professionals. Initially authorized by the Deficit Reduction Act of 2005, the program funded one health information center in each of the 50 states and the District of Columbia. Since then, F2F HICs have been developed in all jurisdictions and also for Indian tribes. Most recently, the Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39) reauthorized the program through FY 2024.

The F2F HICs empower families of CYSHCN to be partners in health care decision making by:

- Helping families gain the knowledge and skills to make informed health care choices that promote good treatment decisions, cost effectiveness, and improved health outcomes;
- Developing models for building working relationships between families and health professionals to assist in providing appropriate services and information;
- Providing training and guidance to health professionals on the care of CYSHCN;
- Conducting outreach activities to families, health professionals, schools, and other appropriate entities to increase their knowledge of F2F HICs and the resources available for CYSHCN and their families; and
- Enlisting families of CYSHCN and health professionals to staff these efforts.

[219] Reflects post-sequestration level
[220] Reflects post-sequestration level
[221] Reflects post-sequestration level

Research supports the effectiveness of the F2F HIC strategy.[222] 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.[223] Documented outcomes include:

- Improved transition from pediatric to adult health care systems;
- Fewer unmet health needs, better community-based systems;
- Fewer problems with specialty referrals;
- Lowered out-of-pocket costs;
- Improved physical and behavioral health; and
- Increased access to preventive health care in a medical home.

Data for FY 2020 shows F2F HICs provided services to 207,815 families, which exceeded the target of 184,250 families. In addition, F2F HICs trained and provided information, resources, and referrals to 97,835 health professionals who serve CYSHCN and their families within community and state public health agencies, managed care and insurance organizations, medical practices, children's hospitals, universities, Federally Qualified Health Centers, and more.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $6,000,000 |
| FY 2020 | $6,000,000 |
| FY 2021 Final | $5,658,000[224] |
| FY 2022 CR | $5,658,000[225] |
| FY 2023 President's Budget | $5,658,000[226] |

**Budget Request**

The Family-to-Family Health Information Centers (F2F HICs) program is funded at $6.0 million for each fiscal year through FY 2024.[227] In FY 2023, F2F HICs will be reduced by $342,000 through sequestration pursuant to the Balanced Budget and Emergency Deficit Control Act (BBEDCA).

FY 2023 funding will support 59 F2F HIC grants to enable families of CYSHCN to partner in health care decision making at all levels to improve health outcomes for CYSHCN and achieve

[222] Perrin JM, Romm D, Bloom SR, Homer CJ, Kuhlthau KA, Cooley C, Duncan P, Roberts R, Sloyer P, Wells N, Newacheck P. A Family-Centered, Community-Based System of Services for Children and Youth With Special Health Care Needs. *Arch Pediatr Adolesc Med.* 2007;161(10):933-936. doi:10.1001/archpedi.161.10.933
[223] Singer, G. H., Marquis, J., Powers, L. K., Blanchard, L., Divenere, N., Santelli, B., et al. (1999). A multi-site evaluation of parent to parent programs for parents of children with disabilities. *Journal of Early Intervention, 22*(3), 217-229 and Rearick, E. M., Sullivan-Bolyai, S., Bova, C., & Knafl, K. A. (2011).
[224] Reflects the post-sequestration amount.
[225] Reflects the post-sequestration amount.
[226] Reflects the post-sequestration amount
[227] Funding is subject to sequestration.

cost-savings for families. The FY 2023 funding will help ensure continued delivery of patient-centered information, education, technical assistance, and peer support to families of CYSHCN. These family-staffed centers will provide other enabling support to families and health professionals serving them, including training and guidance to health professionals on the care of CYSHCN, and building joint working relationships between families and health professionals to improve delivery of appropriate care.

To address health equity, an objective of the F2F program is to increase the number of individuals from underrepresented and diverse communities trained to partner with families at all levels of decision making. The F2Fs are doing this through targeted outreach and leadership development to specific populations. Additionally, F2Fs participated in community forums and town halls led by Family Voices to address the impact of racism on CYSHCN and their families.

To address the impact of COVID-19, in FY 2020, 56 awardees received funding through the CARES Act to help prepare families to access services through telehealth, especially those in underserved communities. Among other things, F2Fs purchased equipment, software, pre-paid phone cards, hot spots or data plans needed by families to access telehealth. The centers also provided training to over 3,000 families on telehealth.

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

**Outcomes and Outputs Table[228]**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3100.01**:** Number of families with CSHCN who have been provided information, education, and/or training from Family-to-Family Health Information Centers (Outcome) | FY 2020: 207,815<br><br>Target: 184,250 (Target Exceeded) | 200,000 | 210,000 | +10,000 |

[228] FY 2021 and 2022 Targets for measures 15.III.C.1 and C.2 incorporate potential modifying effects of COVID-19. Targets will be revisited in future years once additional data is available.

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3100.02**:** Number of professionals who serve CSHCN who have been provided information, education, and/or training from Family-to-Family Health Information Centers *(Output and Developmental)* | FY 2020: 97,835[229] Target: 84,700 (Target Exceeded) | 100,000 | 100,000 | Maintain |
| 3100.03**:** Percentage of families with CSHCN served who report that the information or services received from Family-to-Family Health Information Centers helped prepare them to work with those who serve their children *(Outcome and Developmental)* | FY 2020: 89%[230] Target: Not Defined (Historical Actual) | 90% | 90% | Maintain |
| 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 CSHCN and/or others who serve CSHCN *(Outcome and Developmental)* | FY 2020: 95%[231] Target: Not Defined (Historical Actual) | 96% | 97% | +1 percentage point |

[229] Ibid.
[230] The data for this measure is collected from awardee surveys.
[231] Ibid.

**Grant Awards Table**[232]

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 59 | 59 | 59 |
| **Average Award** | $89,275 | $88,625 | $88,625 |
| **Range of Awards** | $49,000-$96,750 | $49,000-$96,750 | $49,000-$96,750 |

[232] Does not include carryover funding. FY 2021 and FY 2022 reflect post-sequestration funding.

## Maternal, Infant, and Early Childhood Home Visiting Program

| | FY 2021 Final[233] | FY 2022 Continuing Resolution[234] | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **Current Law Mandatory** | $377,200,000 | $377,200,000 | --- | -$377,200,000 |
| **Proposed Mandatory** | --- | --- | $467,000,000 | +$467,000,000 |
| **Total** | **$377,200,000** | **$377,200,000** | **$467,000,000** | **+$89,000,000** |
| **FTE** | 41 | 41 | 55 | +14 |

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

FY 2023 Authorization .....Expired

Allocation Methods:

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

**Program Description**

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry living in at-risk communities. The MIECHV Program builds upon decades of scientific research showing that home visits by a nurse, social worker, 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.

[233] FY2021 reflects the post-sequestration funding amount.
[234] FY2022 reflects the post-sequestration funding amount.

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.[235]

States, jurisdictions, and tribal entities participating in MIECHV direct their home visiting efforts to at-risk communities. The statute defines at-risk communities as those with concentrations of:

- Premature birth, low birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;
- Poverty;
- Crime;
- Domestic violence;
- High rates of high school drop-outs;
- Substance abuse;
- Unemployment; or
- Child maltreatment.[236]

Grantees deliver services by implementing one or more of 20 evidence-based home visiting models, selected by the grantee, which meet HHS-established evidence of effectiveness criteria and MIECHV criteria for implementation. Administered by the Administration for Children and Families (ACF), the Home Visiting Evidence of Effectiveness review (HomVEE) assesses the research literature to determine which home visiting models meet the HHS criteria for evidence of effectiveness. While there is some variation across the 20 evidence-based home visiting models from which grantees may select (e.g., some programs serve pregnant people as well as parents with young children, while others only serve families after the birth of a child), all models share some common characteristics. In these voluntary programs, trained professionals meet regularly with expectant parents or families with young children in their homes, building strong, positive relationships with families who want and need support. Home visitors work with families to determine their specific needs and provide services tailored to those needs, such as:

- Teaching parenting skills and modeling effective parenting techniques;
- Promoting early learning in the home with an emphasis on positive interactions between parents and children and the creation of a language-rich environment that stimulates early language development;
- Providing information and guidance on a wide range of topics including breastfeeding, safe sleep position, injury prevention, and nutrition;
- Conducting screenings and providing referrals to address caregiver depression, substance abuse, and family violence;
- Screening children for developmental delays and facilitating early diagnosis and intervention for autism and other developmental disabilities; and
- Connecting families to other services and resources as appropriate.

MIECHV grantees have the flexibility to tailor the program to serve the specific needs of their states and communities. In order to meet those needs, grantees conducted needs assessments,

[235] 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.
[236] 42 U.S.C. § 711(b)(1)(A).

which were updated by October 1, 2020, as required under the Bipartisan Budget Act of 2018, to identify eligible at-risk communities, determine priority populations, and choose which approved evidence-based models or promising approaches for home visiting will be used.

MIECHV currently distributes funds for delivery of early childhood home visiting services through two types of awards:

1. Formula Grants to states, jurisdictions, and nonprofit organizations.
2. Competitive Cooperative Agreements to Indian tribes (or a consortium of Indian tribes), tribal organizations, and urban Indian organizations, as defined in section 4 of the Indian Health Care Improvement Act.

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

**Formula grants to states, jurisdictions, and nonprofit organizations**

In FY 2021, HRSA awarded $342 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 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. In FY 2020, three states implemented and evaluated three promising approaches to better address the needs of their communities.

**Cooperative agreements to Indian tribes, tribal organizations, and urban Indian organizations**

Statute currently provides that three percent of funding is reserved for grants to Indian tribes, tribal organizations, and urban Indian organizations. As of FY 2020, a total of 30 tribal entities had received funding through the Tribal Home Visiting program, administered by ACF. Currently, there are 23 Tribal Home Visiting program grantees that receive five-year competitive awards. The Tribal Home Visiting Program is designed to:

- Develop and strengthen tribal capacity to support and promote the health and well-being of American Indian and Alaska Native families through home visiting programs;
- Expand the evidence base around home visiting in tribal communities; and
- Support and strengthen cooperation and linkages between programs that serve Native children and their families.

Grantees may choose to implement either Family Spirit, the one evidence-based home visiting model with evidence of effectiveness in tribal communities, or a promising approach for home visiting (which includes any model that meets the evidence of effectiveness criteria for the formula grants but does not have specific evidence of effectiveness in American Indian and Alaska Native populations).

Section 9101 of the American Rescue Plan Act of 2021 (P.L. 117-2) (ARP) appropriated $150 million to enable MIECHV Program recipients to address the needs of expectant parents and families with young children during the COVID-19 public health emergency. HRSA made formula-based awards to all MIECHV recipients to support direct COVID-related costs (e.g., costs associated with shifting to virtual service delivery including the provision of technology-related items; basic supplies such as formula, diapers, and groceries to families; and hazard pay and other supports for staff) and expand services to families in communities at risk for poor maternal and child health outcomes. HRSA will also use ARP funding to make competitive awards to MIECHV awardees to develop, implement, and evaluate data and technology innovations that leverage new technology and/or data collection or sharing strategies to improve MIECHV service delivery and extend the impact of MIECHV-funded voluntary evidence-based home visiting services to respond to the evolving and long-term impacts of the COVID-19 public health emergency. In addition, funds are being used to support current MIECHV recipients serving tribal communities and for administration of the program.

**Program Accomplishments**

MIECHV state and jurisdictional grantees provided over 8 million visits from FY 2012 through FY 2021. In FY 2021 states reported serving more than 140,000 parents and children in 1,065 counties across all 50 states, the District of Columbia, and five territories. This is more than a 300 percent increase in the number of participants served since FY 2012 (see Tables 1 and 2 below). Tribal grantees provided over 142,500 home visits from FY 2012 to FY 2021 and served more than 3,500 parents and children in FY 2021.

**Table 1: Number of State/Jurisdictional Participants (FY 2012 – FY 2021)[237]**

| Fiscal Year | Number of Participants |
|---|---|
| 2012 | 34,180 |
| 2013 | 75,970 |
| 2014 | 115,545 |
| 2015 | 145,561 |
| 2016 | 160,374 |
| 2017[238,239] | 156,297 |
| 2018[240] | 150,291 |
| 2019 | 154,496 |
| 2020[241] | 140,606 |

[237] Data in Tables 1 and 2 represent the number of participants and home visits provided by state and jurisdictional grantees (does not include tribal data).
[238] 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.
[239] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.
[240] Does not include data from the Commonwealth of the Northern Mariana Islands due to reporting delays caused by Super Typhoon Yutu.
[241] 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.

| | |
|---|---|
| 2021[242] | 140,674 |

**Table 2: Number of Home Visits by State/Jurisdictional Grantees (FY 2012 – FY 2021)**

| Fiscal Year | Number of Home Visits |
|---|---|
| 2012 | 174,257 |
| 2013 | 489,363 |
| 2014 | 746,303 |
| 2015 | 894,347 |
| 2016 | 979,521 |
| 2017[243,244] | 942,676 |
| 2018[245] | 930,595 |
| 2019 | 1,015,217 |
| 2020[246] | 928,130 |
| 2021[247] | 921,706 |

MIECHV serves many families living in at-risk communities. In FY 2021:

- 68 percent of participating families had household incomes at or below 100 percent of the federal poverty guidelines[248] ($26,500 for a family of four), and 41 percent were at or below 50 percent of those guidelines;
- 23 percent of adult program participants had less than a high school education, and 37 percent had only a high school degree or equivalent; and
- 10 percent of households included pregnant teens; 20 percent of households reported a history of child abuse and maltreatment; and 14 percent of households reported substance abuse.

Performance data collected to fulfill the statutory requirement of a three-year assessment of improvement[249] were most recently updated following the conclusion of FY 2020. These data indicate that 100 percent of states, jurisdictions, and non-profit grantees demonstrated improvement in at least four of the six benchmark areas as outlined in the legislation:

- Improving maternal and newborn health;
- Preventing child injuries, maltreatment, and emergency department visits;

[242] FY 2021 results were impacted by funding cuts due to sequestration and the impacts of COVID-19 on enrollment and service delivery.
[243] 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.
[244] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.
[245] Does not include data from the Commonwealth of the Northern Mariana Islands due to reporting delays caused by Super Typhoon Yutu.
[246] 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.
[247] FY 2021 results were impacted by funding cuts due to sequestration and the impacts of COVID-19 on enrollment and service delivery.
[248] The HHS Poverty Guidelines are updated annually in February and published in the Federal Register. See https://aspe.hhs.gov/poverty-guidelines
[249] Performance data represent data submitted after three years of program implementation as required under Social Security Act, Title V, § 511(d)(1)(B)

- Improving school readiness and achievement;
- Reducing crime or domestic violence;
- Improving family economic self-sufficiency; and
- Improving service coordination and referrals for other community resources and supports.

Since FY 2017, following a redesign of the MIECHV performance measurement system, grantees have been reporting on 19 standardized performance indicators and systems outcome measures. These performance measures allow grantees to more effectively monitor and understand program performance, and implement continuous quality improvements in home visiting.

The statute requires an evaluation of the MIECHV Program. To fulfill this requirement, the Mother and Infant Home Visiting Program Evaluation (MIHOPE) was initiated in 2011. Released in November 2018,[250] findings from the MIHOPE Implementation Report include: the local programs that participated in MIHOPE served eligible families in disadvantaged communities with high levels of socioeconomic risk as intended by the program; most home visitors were well educated, trained and experienced; local programs focused on improving parenting and child development outcomes; and the tailoring of services to families' needs was especially evident in areas of substance use, mental health, and intimate partner violence. The MIHOPE Impact Report, released in January 2019,[251] presents evidence that MIECHV-funded home visiting services had positive effects for the families that participated in services, including in the quality of the home environment and the frequency of psychological aggression towards the child. The study provides evidence that differences in effects among the evidence-based models included in the study are generally consistent with the models' area of focus.

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

[251] Michalopoulos, Charles, Kristen Faucetta, Carolyn J. Hill, Ximena A. Portilla, Lori Burrell, Helen Lee, Anne Duggan, and Virginia Knox. 2019. *Impacts on Family Outcomes of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation.* OPRE Report 2019-07. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

**Funding History**

| FY | Amount[252] |
|---|---|
| FY 2019 | $400,000,000 |
| FY 2020 | $376,400,000 |
| FY 2021 | $377,200,000 |
| FY 2022 | $377,200,000 |
| FY 2023 proposed mandatory | $467,000,000 |

**Budget Request**

The FY 2023 Budget Request proposes mandatory funding of $467.0 million for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. This is a $67.0 million[253] increase over the FY 2022 current law mandatory funding level. The FY 2023 Budget requests to extend and expand the program for FY 2023 through FY 2027 with an increase of $67.0 million per year over the five years for a total of $3.0 billion. 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 27 tribal entities; and
- Support for research, evaluation, and technical assistance for both corrective action and program improvement for state, jurisdictional, and tribal MIECHV grantees.

The increase in funds will expand the capacity of MIECHV awardees to reach more communities and families. Currently, MIECHV-funded programs serve 71,000 families at $400 million per year reaching approximately 15% of the more than 465,000 families who are likely currently eligible and in need of MIECHV services[254]. Over 5 years, this funding increase will provide comprehensive, coordinated home visiting services to over 600 additional communities, including up to 165,000 additional families through targeted evidence-based home visiting. In FY 2025 – FY 2027, up to 95,000 additional families will be served through universal home visiting approaches, which may be implemented by grantees as part of expansion efforts.

The additional appropriations in FY 2023 and FY 2024 will 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. Awardees may also begin to plan for the use of universal home visiting initiatives and promising approaches responsive to local

[252] Reflects post-sequestration amounts in FY 2020, FY 2021, and FY 2022.
[253] Pre-sequestration funding level.
[254] HRSA internal analysis using 2019 Current Population Survey data

community needs that may be implemented with additional appropriations in FY 2025-FY 2027. Beginning in FY 2025, universal home visiting initiatives, which reach all postpartum women and children within an identified geographic area, may be introduced as part of a continuum of care with the targeted home visiting initiatives, which focus on specific populations within an identified area. Additionally, new awards will be made to tribal entities to expand services to additional tribal communities.

Funds will continue to support the statutory directive for an ongoing portfolio of research and evaluation on home visiting and technical assistance to ensure families have access to quality evidence-based and promising home visiting service delivery models.

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

**Outcomes and Outputs Tables[255]**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3110.01**:** Number of home visits to families receiving services under the MIECHV program.[256] *(Output)* | FY 2021: 941,003[257] Target: 1,033,000 (Target Not Met) | 945,000[258] | 1,132,000 | +191,000 |

[255] In 2021, the COVID-19 pandemic continued to negatively impact new enrollment of families throughout the year.
[256] A home visit is the service provided by qualified professionals, delivered over time within the home to build relationships with the enrolled caregiver and the index child to achieve improved child and family outcomes. The number of "home visits" demonstrates the level of effort and service utilization for all enrollees and index children participating in the MIECHV Program.
[257] The data source for this measure is the Home Visiting Information System (HVIS). Results reflect the most recent data available, which include FY 2020 data for state, jurisdictional, and Tribal grants.
[258] FY2022 Target reflects FY2020 results impacted by sequestration, COVID-19, and a reporting error in one state.

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3110.02**:** Number and percent of grantees that meet benchmark area data requirements for demonstrating improvement. *(Outcome)* | State/Jurisdiction FY 2020: 56 (100%)[259]<br>Target: 55 (98%)<br>(Target Exceeded)<br><br>Tribal FY 2020: 14 (74%)[260]<br>Target: 20 (80%)<br>(Target Not Met) | State/Jurisdiction: 47 (84%), Tribal 22 (88%) | State/Jurisdiction: 53 (95%), Tribal 22 (88%) | State/Jurisdiction +6 percentage points (+11 percentage points), Tribal (maintain) |
| 3110.03**:** Number of participants served by the MIECHV Program *(Outcome)* | FY 2021: 144,182[261]<br>Target: 160,000<br>(Target Not Met) | 144,000[262] | 163,000 | +19,000 |
| 3110.04**:** Percentage of children enrolled in MIECHV who received daily early language and literacy support from a family member *(Outcome and Developmental)* | FY 2021: 79.5%[263]<br>Target: 65.4%[264]<br>(Target Exceeded) | 65.4% | 71.5% | +6.1 percentage points |

[259] Results reflect the most recent data available.
[260] Results reflect the most recent data available.
[261] Ibid. Results reflect the most recent data available, which includes FY 2021 data for state, jurisdictional, and Tribal grants.
[262] FY2022 Target reflects FY2020 results impacted by sequestration, COVID-19, and a reporting error in one state.
[263] Ibid. Results reflect state and jurisdictional grants only and reflect a two-year average from FY 2020 and FY 2021.
[264] Ibid. Results reflect state and jurisdictional grants only and reflect a two-year average from FY 2017 and FY 2018.

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 3110.05**:** Percentage of parents enrolled in MIECHV who were screened for depression after enrollment or after giving birth *(Outcome and Developmental)* | FY 2021: 80.9%[265] Target: 76.5%[266] (Target Exceeded) | 76.5% | 78.7% | +2.2 percentage points |

[265] Ibid. Results reflect state and jurisdictional grants only and reflect a two-year average from FY 2020 and FY 2021.
[266] Ibid. Results reflect state and jurisdictional grants only and reflect a two-year average from FY 2017 and FY 2018.

**Grant Awards Tables**[267]

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 79 | 85 | 83 |
| **Average Award** | $4,813,618[268] | $5,157,477[269] | $5,096,5064 |
| **Range of Awards** | $392,400-$22,016,376 | $500,000-$24,657,403 | $300,000-$20,831,185 |

[267] The table does not include carryover funding. FY 2021, and FY 2022 reflect post-sequestration funding. No sequestration in FY 2023
[268] Includes ARPA awards in FY 21
[269] Includes ARPA planned awards in FY 22

# RYAN WHITE HIV/AIDS TAB

# RYAN WHITE HIV/AIDS

## Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP) funds and coordinates with cities, states, and local clinics/community-based organizations to deliver efficient and effective HIV care, treatment, and support to low-income people with HIV. Nearly sixty one percent of clients (patients) live at or below 100 percent of the federal poverty level and nearly three-quarters of RWHAP clients are from racial and ethnic minority populations.[270] 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[271] or state programs, or private insurance. Since 1990, RWHAP has developed a comprehensive system of safety net providers who deliver high quality direct health care and support services to over half a million people with HIV – more than half of all people with diagnosed HIV in the United States.[272] 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. For example, according to the most recent Centers for Disease Control and Prevention (CDC) data, 71 percent of people with diagnosed HIV in the United States are racial and ethnic minorities, while 73 percent of RWHAP clients are racial and ethnic minorities, meeting the target of not being lower than 3 percentage points of the national HIV prevalence data as reported by CDC.[273] Similarly, 23 percent of people with diagnosed HIV in the United States are women, while nearly 26 percent of RWHAP clients are women, meeting the target of not being lower than 3 percentage points of the national HIV prevalence data as reported by CDC.

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

[270] Published December 2021.Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2020. http://hab.hrsa.gov/data/data-reports. Published December 2021. Accessed January 2022.
[271] The Indian Health Service is statutorily exempted from the payor of last resort provision.
[272] 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 2022.
[273] 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 7, 2022.

further transmission of the virus,[274] which furthers the public health goal of ending the HIV epidemic in the United States.[275] Research studies demonstrate that people with HIV who take HIV medications daily as prescribed, and achieve and then maintain an undetectable viral load, have effectively no risk of sexually transmitting the virus to a partner.[276,277] In the RWHAP, 89.4 percent of patients receiving RWHAP medical care are virally suppressed[278] compared to the general population of people with diagnosed HIV, who have a viral suppression of 66.5 percent[279] - an outcome measure that demonstrates the success of the program and results in major public health benefits.

According to a study published in *Clinical Infectious Diseases*, 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.[280] Furthermore, RWHAP patients are more likely to reach viral suppression regardless of other health care coverage (e.g., uninsured, Medicaid, Medicare, or private insurance). Not only do improved viral suppression rates reduce the transmission of HIV, they also result in significant cost-savings to the health care system.[281]

The RWHAP has made tremendous progress toward ending the HIV epidemic in the United States: from 2010 to 2020, HIV viral suppression among RWHAP patients has increased from 69.5 percent to 89.4 percent, and racial and ethnic, age-based, and regional disparities have decreased.[282] 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

[274] 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.
[275] 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.
[276] 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.
[277] 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.
[278] 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.
[279] Centers for Disease Control and Prevention. Social determinants of health among adults with diagnosed HIV infection, 2018. HIV Surveillance Supplemental Report 2020;25(No. 3). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published November 2020. Accessed January 2022.
[280] 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.
[281]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.
[282] 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.

United States have HIV, and 1 in 8 are unaware of their HIV.[283] In addition, over 36,000 HIV diagnoses occur every year.[284]

***Coronavirus Pandemic***

On April 15, 2020, the Department of Health and Human Services (HHS), through HRSA, awarded $90 million for RWHAP recipients across the country to prevent, prepare for, and respond to coronavirus disease 2019 (COVID-19).

CARES Act funding supports RWHAP Parts A-D and Part F AIDS Education and Training Center (AETC) Program recipients to prepare for, prevent, and respond to the COVID-19 pandemic. HRSA continues to closely monitor the impact of COVID-19 on the RWHAP.

Using FY 2020 CARES Act funds, providers tested 87,000 RWHAP-eligible clients and immediate household members for COVID-19, and provided services to over 18,000 people. RWHAP providers quickly pivoted to find ways to safely serve people with HIV, such as extending prescription refills from 30 days to 90 days and creating accessible telehealth services for medical care, mental health and substance use disorder services. Early data show that telehealth capacity grew due to FY 2020 CARES Act funding, with the number of RWHAP sites providing telehealth services doubling in 2020 to over 70 percent.[285]

The Consolidated Appropriations Act, 2021, Pub. L. 116-260, Division M, § 307 included language which allowed flexibilities related to penalties and administrative requirements that the Secretary could exercise to provide relief to RWHAP recipients. HRSA responded by providing opportunities to reduce or delay requirements without compromising the integrity, scope, and implementation of the RWHAP. Given the on-going nature of the pandemic, the Budget proposes to extend this language in FY 2023 to allow continued flexibilities.

***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., San Juan (PR), 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.

In spite of EHE funding beginning at the height of the COVID-19 pandemic, HRSA EHE-funded service providers served nearly 19,500 clients (8% higher than the FY 2020 goal) who were new or re-engaged in HIV care and treatment during March 2020 through December 2020.

In FY 2021, HRSA awarded EHE funds to the 39 RWHAP Part A recipients and 8 Part B recipients that encompass the 48 counties, Washington, D.C., San Juan (PR), as well as 7 states that have a substantial rural HIV burden. Jurisdictions will utilize their existing RWHAP

[283] 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.
[284] 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 August 2021.
[285] Health Resources and Services Administration. Ryan White HIV/AIDS Program COVID-19 Data Report January 20, 2020 through December 31, 2020. http://hab.hrsa.gov/data/data-reports. Published June 2021. Accessed January 2022.

infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. Key strategies include:

- Implementing evidence-informed and emerging strategies shown to increase linkage, engagement, and retention in care targeted to those not yet diagnosed, those diagnosed but not in HIV care, and those who are in HIV care but not yet virally suppressed;
- Developing new partnerships and models of care to reach those people with HIV;
- Providing technical assistance and systems coordination to support effective strategic plans and activities to successfully implement the new initiative; and
- Expanding workforce capacity through the efforts of the Part F AIDS Education and Training Center (AETC) Program.

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

***Additional Priorities and Collaborative Efforts***

In FY 2023, the RWHAP will continue to ensure effective use of resources and a coordinated and focused public health response to HIV. RWHAP will also continue to coordinate and collaborate with other federal, state, and local entities as well as national HIV organizations to further leverage and promote efforts to address the unmet care and treatment needs of people with HIV who are uninsured and underserved. These efforts help to align priorities, policies, and activities in sustaining a multi-faceted and comprehensive federal response to the HIV epidemic. Federal partners include the Office of the Assistant Secretary for Health (OASH), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), the Indian Health Service (IHS), the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), the Department of Housing and Urban Development (HUD), the Department of Veterans Affairs (VA), and the Department of Justice (DOJ), as well as other HRSA-funded programs, such as the Health Center Program. With many clients in common, RWHAP will also coordinate with the Administration for Community Living (ACL) to leverage existing resources in both programs to advance the health outcomes of older adults living with HIV.

*National HIV/AIDS Strategy (NHAS) (2022-2025)*[286]*:* Released on December 1, 2021, this plan builds on the targets for the Ending the HIV Epidemic in the United States initiative by 2030. The new strategy focuses on engagement from stakeholders across the Federal government 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. For stakeholders across the nation, NHAS articulates goals, objectives, and strategies to prevent new infections, improve HIV-related health outcomes for people with HIV, reduce HIV-related disparities and health inequities, and achieve integrated and coordinated efforts that address the HIV epidemic among all partners and stakeholders to achieve the bold targets for ending the HIV epidemic in the United States. The RWHAP will continue to coordinate with other federal partners, grant recipients, and other partners to work towards

[286] The White House. 2021. National HIV/AIDS Strategy for the United States 2022-2025. Washington, DC.

achieving these four goals. The RWHAP is developing a coordinated response to produce an implementation response that outlines the specific actions that the agency will take to achieve the goals and objectives that are outlined in NHAS and accelerate our efforts toward ending the HIV epidemic.

The RWHAP will also coordinate with federal partners, grant recipients, and other partners to address the syndemics of HIV, viral hepatitis, STIs, and substance use disorders through the following HHS efforts:

- *Sexually Transmitted Infections (STI) National Strategic Plan for the United States: A Roadmap to Elimination 2021-2025:* The STI plan will develop, enhance and expand STI prevention and care programs over the next five years. The aim is to reverse the recent dramatic rise in STIs in the United States. The STI Plan includes a set of goals, objectives, and strategies to respond to this STI epidemic and includes indicators with measurable targets to track progress.

- *Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination 2021-2025:* The Viral Hepatitis Plan is intended to serve as a comprehensive, data-driven roadmap for federal and other stakeholders to reverse the rates of viral hepatitis, prevent new infections, improve care and treatment and ultimately eliminate viral hepatitis as a public health threat in the United States.

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

***Reauthorization***

The Administration looks forward to working with Congress, along with a broad public engagement process, to reauthorize the RWHAP to ensure that the allocation of federal funds address the changing landscape of HIV across the United States. The FY 2023 Budget Request notes the following proposed statutory change which should be included in any RWHAP authorization, which will also help support the Ending the HIV Epidemic initiative:

- *Zip Code Information:* The proposed changes would modify the restriction on submission or collection of individually identifiable health information to allow the collection and submission of ZIP codes for RWHAP patient residential addresses. It would also update terminology to ensure consistency with HIPAA. This change would continue to protect patient privacy. The restriction on collection of residential ZIP codes from RWHAP program participants limits the ability to understand geographic distribution of patient demographics as well as outcomes and service utilization. It also limits the ability to track and describe patient engagement in the program over time (years), understand the impact of the RWHAP by geographic location, including urban and rural differences, and display RWHAP patient data in alignment with CDC HIV surveillance data to determine shifts and trends.

This change will also allow for a more refined approach to addressing HIV health disparities to improve HIV health outcomes. There will be no increased data collection burden, but there will be slight changes to data submission files, which must be maintained in accordance with applicable privacy protections.

**Measuring Future Performance**

Together, in FY 2023 RWHAP Parts A-D programs are anticipated to achieve the following performance goals:

- In FY 2023, the RWHAP will serve racial and ethnic minorities at a proportion not lower than three percentage points of national HIV prevalence data as reported by CDC.
- In FY 2023, the RWHAP will serve women at a proportion that is not lower than three percentage points of national HIV prevalence data as reported by CDC.
- In FY 2023, at least 84 percent of all patients receiving HIV medical care and at least one viral load test will be virally suppressed.

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

**Outcomes and Outputs Table for Over-Arching Performance Measures**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 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) | 2020: 73.4% Target: Not lower than 3 percentage points of CDC data (Target Met) | Not lower than 3 percentage points of CDC data | Not lower than 3 percentage points of CDC data | Maintain |
| 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) | 2020: 25.8% Target: Not lower than 3 percentage points of CDC data (Target Met) | Not lower than 3 percentage points of CDC data | Not lower than 3 percentage points of CDC data | Maintain |
| 4000.03: Percentage of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test who are virally suppressed. (Outcome) | 2020: 89.4% Target: 83% (Target Exceeded) | 83% | 84% | +1 percentage point |

## RWHAP Part A - Emergency Relief Grants

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $655,706,000 | $655,876,000 | $665,876,000 | +$10,000,000 |
| **FTE** | 44 | 44 | 48 | +4 |

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Public Law 116-136

FY 2023 Authorization……..……..…….Expired

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

**Program Description and Accomplishments**

Ryan White HIV/AIDS Program (RWHAP) Part A provides grants to cities with a population of at least 50,000, which are areas severely affected by the HIV epidemic. These jurisdictions are funded as either an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA), depending on the severity of the epidemic in their jurisdiction. Over 71 percent of all people with diagnosed HIV reside in a RWHAP Part A EMA or TGA.[287,288]

Formula and supplemental grants directly support the HHS goals to protect and strength equitable access to high quality and affordable healthcare. 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. The RWHAP requires EMAs and TGAs to utilize local needs assessments and planning processes to develop coordinated systems of HIV care in order to improve health outcomes for low-income people with HIV, thereby reducing transmission of HIV.

RWHAP Part A prioritizes primary medical care, access to antiretroviral treatment, and other core medical and supportive services in order to engage and retain people with HIV in care. These grants fund systems of care to provide services for people with HIV in 24 EMAs and 28 TGAs. EMAs are jurisdictions with 2,000 or more AIDS cases over the last five years, whereas TGAs are jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases over the last five years as reported to the Centers for Disease Control and Prevention. Two-thirds of the funds

[287] Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Updated); vol. 32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed January 2022.
[288] Centers for Disease Control and Prevention. HIV/AIDS data through December 2019 provided for the Ryan White HIV/AIDS Program, for fiscal year 2021.

available for EMAs and TGAs are awarded according to a formula, based on the number of people with diagnosed HIV in the EMAs and TGAs.

The remaining funds are awarded as discretionary supplemental grants based on the demonstration of additional need by the eligible EMAs and TGAs, and as Minority AIDS Initiative (MAI) grants. The MAI funds are a statutory set-aside funding component for RWHAP Parts A – D, and Part F AIDS Education and Training Center Program to evaluate and address the disproportionate impact of HIV on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. MAI funds are also awarded based on a formula utilizing the number of minorities with diagnosed HIV and AIDS in a jurisdiction and support HIV care, treatment, and support services to racial and ethnic minorities.

The RWHAP Part A funds are awarded to the Chief Elected Official who is required to establish a local Planning Council/Body that determines the allocation of RWHAP resources based on local needs assessments. Seventy-five percent of RWHAP Part A service funds must be used to support core medical services. Eligible sub-recipients are community health centers, health departments, ambulatory care facilities, and other non-profit organizations providing services for people with HIV.

In 2020, nearly 78 percent of RWHAP Part A clients were racial and ethnic minorities and 25 percent were women. In 2020, RWHAP Part A funded sites provided nearly 3.3 million core medical service visits for health-related care utilizing a combination of RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of increasing the availability and accessibility of care.

***Ending the HIV Epidemic in the U.S. - RWHAP Part A Jurisdictions***

Thirty-nine of the RWHAP Part A jurisdictions received a cooperative agreement to implement Ending the HIV Epidemic (EHE) initiative activities related to Pillar Two (Treat) and Pillar Four (Respond) in FY 2021. This initiative is now in its third year and jurisdictions will utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. See the EHE initiative for more information.

**RWHAP Part A Funding History[289]**

| FY | Amount |
|---|---|
| FY 2012 | $666,071,000 |
| FY 2013 | $624,262,000 |
| FY 2014 | $649,373,000 |
| FY 2015 | $655,220,000 |
| FY 2016 | $655,876,000 |
| FY 2017 | $654,296,000 |
| FY 2018 | $655,876,000 |
| FY 2019 | $655,876,000 |
| FY 2020 | $655,876,000 |
| FY 2021 Final | $655,706,000 |
| FY 2022 CR | $655,876,000 |
| FY 2023 President's Budget | $665,876,000 |

**Budget Request**

The FY 2023 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part A of $665.9 million is $10.0 million above the FY 2022 Continuing Resolution level. The FY 2023 President's Budget request will support the provision of core medical and support services for people with HIV in the 24 EMAs and 28 TGAs.

The RWHAP has seen a significant increase in utilization during the COVID-19 pandemic due to people with HIV losing other sources of health coverage (such as employer insurance), and state governments' revenue dropping, resulting in state funding cuts. Due to this, the Budget includes $10.0 million for the RWHAP Part A to expand services for significantly impacted populations, particularly racial and ethnic minorities. RWHAP Part A jurisdictions encompass over 70 percent of all HIV cases in the US, therefore this increase in funding will help meet this need driven by the pandemic.

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. In 2020, 66 percent of all RWHAP clients were served by one of the 52 metropolitan areas funded under the RWHAP Part A, an increase of nearly one percent from the previous year. Over 70 percent of all people with diagnosed HIV reside within these metropolitan areas. The RWHAP serves populations that are diverse with multiple structural barriers to care (e.g., people with HIV at or below 100 percent of the federal poverty level and/or those who are homeless).

The FY 2023 funding request will support the RWHAP Part A in achieving its target of providing 3.3 million core medical service visits for health-related care. RWHAP Part A funding will also contribute to achieving the FY 2023 targets for performance goals that relate to cross-cutting activities, such as the percentage of racial and ethnic minorities and women served,

[289] EHE funding is not included in this table.

percentage of clients who achieved viral suppression, and percentage of HIV-positive pregnant women served by RWHAP who receive antiretroviral medications.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 17.I.A.2: Number of RWHAP Part A visits for health-related care. *(Output)* | 2020: 3.28M<br>Target: 3.6M<br>(Target Not Met) | 3.3M | 3.3M | Maintain |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 52 | 52 | 52 |
| **Average Award** | $11,950,579 | $11,950,579 | $11,950,579 |
| **Range of Awards** | $2,774,766 - $90,652,054 | $2,774,766 - $90,652,054 | $2,774,766 - $90,652,054 |

**RWHAP Part A – FY 2021 Formula, Supplemental & MAI Grants**[290]

**Table 1. Eligible Metropolitan Areas**

| EMAs | Formula | Supplemental | MAI | Total |
|---|---|---|---|---|
| Atlanta, GA | $17,447,791 | $8,105,718 | $2,636,137 | $28,189,646 |
| Baltimore, MD | $9,274,492 | $4,841,989 | $1,483,028 | $15,599,509 |
| Boston, MA | $9,396,337 | $4,534,077 | $1,023,734 | $14,954,148 |
| Chicago, IL | $16,615,268 | $8,552,630 | $2,339,248 | $27,507,146 |
| Dallas, TX | $11,672,645 | $5,270,655 | $1,513,597 | $18,456,897 |
| Detroit, MI | $5,855,186 | $2,914,225 | $818,647 | $9,588,058 |
| Ft. Lauderdale, FL | $9,561,516 | $4,913,216 | $1,250,116 | $15,724,848 |
| Houston, TX | $15,101,128 | $7,070,688 | $2,270,349 | $24,442,165 |
| Los Angeles, CA | $27,172,446 | $13,172,056 | $3,632,709 | $43,977,211 |
| Miami, FL | $15,689,960 | $8,139,449 | $2,603,486 | $26,432,895 |
| Nassau-Suffolk, NY | $3,213,852 | $1,787,332 | $427,684 | $5,428,868 |
| New Haven, CT | $3,144,008 | $1,705,038 | $427,116 | $5,276,162 |
| New Orleans, LA | $4,607,167 | $2,515,356 | $625,768 | $7,748,291 |
| New York, NY | $52,930,673 | $29,486,176 | $8,235,205 | $90,652,054 |
| Newark, NJ | $7,083,322 | $3,895,571 | $1,177,621 | $12,156,514 |
| Orlando, FL | $6,502,137 | $3,107,672 | $835,398 | $10,445,207 |
| Philadelphia, PA | $13,165,374 | $7,536,805 | $1,911,469 | $22,613,648 |
| Phoenix, AZ | $6,198,799 | $2,937,909 | $615,168 | $9,751,876 |
| San Diego, CA | $7,124,107 | $3,469,994 | $742,177 | $11,336,278 |
| San Francisco, CA | $9,040,998 | $5,055,673 | $751,641 | $14,848,312 |
| San Juan, PR | $6,039,228 | $3,341,329 | $1,119,701 | $10,500,258 |
| Tampa-St. Petersburg, FL | $6,343,585 | $3,327,442 | $681,228 | $10,352,255 |
| Washington, DC-MD-VA- | $18,589,259 | $10,053,491 | $2,836,777 | $31,479,527 |
| West Palm Beach, FL | $4,295,162 | $2,385,506 | $623,970 | $7,304,638 |
| **Subtotal EMAs** | **$286,064,440** | **$148,119,997** | **$40,581,974** | **$474,766,411** |

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

**Table 2. Transitional Grant Areas**

| TGAs | Formula | Supplemental | MAI | Total |
|---|---|---|---|---|
| Austin, TX | $3,199,689 | $1,583,529 | $366,262 | $5,149,480 |
| Baton Rouge, LA | $2,703,633 | $1,332,299 | $438,094 | $4,474,026 |
| Bergen-Passaic, NJ | $2,300,805 | $1,201,602 | $333,232 | $3,835,639 |
| Charlotte-Gastonia, NC-SC | $3,870,736 | $1,839,631 | $578,353 | $6,288,720 |
| Cleveland, OH | $2,848,212 | $1,405,845 | $370,899 | $4,624,956 |
| Columbus, OH | $2,906,044 | $1,372,784 | $287,993 | $4,566,821 |
| Denver, CO | $4,745,690 | $2,341,940 | $385,001 | $7,472,631 |
| Fort Worth, TX | $2,995,782 | $1,453,735 | $390,490 | $4,840,007 |
| Hartford, CT | $1,783,311 | $993,627 | $243,323 | $3,020,261 |
| Indianapolis, IN | $2,807,331 | $1,396,861 | $310,423 | $4,514,615 |
| Jacksonville, FL | $3,609,497 | $1,776,141 | $501,031 | $5,886,669 |
| Jersey City, NJ | $2,802,345 | $1,537,933 | $439,798 | $4,780,076 |
| Kansas City, MO | $2,671,227 | $1,301,229 | $273,702 | $4,246,158 |
| Las Vegas, NV | $4,115,524 | $2,025,144 | $474,342 | $6,615,010 |
| Memphis, TN | $4,083,118 | $2,007,756 | $681,796 | $6,772,670 |
| Middlesex-Somerset-Hunterdon, NJ | $1,630,256 | $912,544 | $231,966 | $2,774,766 |
| Minneapolis-St. Paul, MN | $3,683,282 | $1,785,678 | $375,820 | $5,844,780 |
| Nashville, TN | $2,777,418 | $1,333,051 | $304,745 | $4,415,214 |
| Norfolk, VA | $3,530,227 | $1,703,457 | $522,230 | $5,755,914 |
| Oakland, CA | $4,341,367 | $2,091,355 | $567,753 | $7,000,475 |
| Orange County, CA | $3,929,565 | $1,909,044 | $453,426 | $6,292,035 |
| Portland, OR | $2,574,010 | $1,232,435 | $145,653 | $3,952,098 |
| Riverside-San Bernardino, CA | $5,094,674 | $2,464,015 | $573,242 | $8,131,931 |
| Sacramento, CA | $2,137,779 | $1,036,408 | $205,655 | $3,379,842 |
| Saint Louis, MO | $3,851,293 | $1,891,624 | $469,988 | $6,212,905 |
| San Antonio, TX | $3,509,787 | $1,674,462 | $540,496 | $5,724,745 |
| San Jose, CA | $1,979,241 | $980,827 | $247,771 | $3,207,839 |
| Seattle, WA | $4,449,552 | $2,065,987 | $367,871 | $6,883,410 |
| **Subtotal TGAs** | **$90,931,395** | **$44,650,943** | **$11,081,355** | **$146,663,693** |
| **TOTAL EMAs/TGAs** | **$376,995,835** | **$192,770,940** | **$51,663,329** | **$621,430,104** |

## RWHAP Part B - HIV Care Grants to States

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $1,314,622,000 | $1,315,005,000 | $ 1,345,005,000 | +$30,000,000 |
| **FTE** | 52 | 52 | 66 | +14 |

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Public Law 116-136

FY 2023 Authorization……Expired

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

**Program Description and Accomplishments**

The Ryan White HIV/AIDS Program (RWHAP) Part B is the largest RWHAP Part and provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and five Associated Pacific Jurisdictions to provide services for people with HIV. RWHAP Part B grants 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 ADAP, which supports the provision of HIV medications and related services, including health insurance premium and cost-sharing assistance. These funds are distributed by a formula based on prevalent HIV cases. In addition, ADAP supplemental funds are a five percent set aside for states with severe need. ADAP provides FDA-approved prescription medications for people with HIV who cannot afford HIV

medications. ADAP is instrumental in efforts to end the HIV epidemic across the nation. ADAP provides the access to medications and insurance necessary for people with HIV to achieve optimal health outcomes and viral suppression. Individual ADAPs operate in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands.

The MAI funds are a statutory set-aside funding component for RWHAP Parts A – D and Part F AIDS Education and Training Center Program to evaluate and address the disproportionate impact of HIV on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. The RWHAP Part B MAI funding is statutorily required to specifically support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to the RWHAP ADAP.

Of all the clients served by the RWHAP Part B program in 2020, nearly 70 percent were racial and/ethnic minorities, and 25 percent were women. Per statute, 75 percent of RWHAP Part B service funds must be used to support core medical services and in 2020, RWHAP Part B funded sites provided 2.2 million core medical service visits for health-related care utilizing RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of RWHAP Part B in delivering primary care and related services for people with HIV by increasing the availability and accessibility of care.

***Ending the HIV Epidemic 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 2021. This initiative is now in its third year and jurisdictions will continue to utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. See the EHE initiative section for more information.

***AIDS Drug Assistance Program***

The RWHAP Part B has been successful in helping to ensure that people with HIV have access to the care and treatment services they need to live longer, healthier lives. According to the RWHAP ADAP Report, ADAPs, which are run by states and territories, continue to provide robust formularies of antiretroviral medications to treat HIV infection, prevent and treat opportunistic infections, manage side effects, and treat co-morbidities. Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral suppression are not at risk to transmit HIV to others. The RWHAP provides the care and treatment services that support the achievement of viral suppression and therefore, has a significant public health impact on HIV incidence as well. These efforts demonstrate the central role of the RWHAP in ending the HIV epidemic by ensuring that people with HIV have access to regular care, are started on, and adhere to, their antiretroviral medications.

According to the RWHAP ADAP data, the number of people with HIV receiving ADAP services has grown 44 percent over the last ten years from 208,809 clients in 2010, to 300,785 clients in

2020, exceeding the FY 2020 target by 34,785. 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 and 70 percent of all clients served by ADAPs were racial and ethnic minorities. Of all the ADAP clients served nationwide, 72 percent had incomes at or below 200 percent of the federal poverty level.

*ADAP Cost Containment:* Increased demand for RWHAP ADAP services has led States to implement cost-containment strategies for their ADAPs. Cost-containment measures include using drug-purchasing strategies such as cost recovery through drug rebates and third party billing and directly negotiating pharmaceutical pricing. In addition, states have implemented cost-savings strategies such as recovering costs when another payor was primary, coordinating benefits with Medicare Part D, and improving drug-purchasing models. ADAPs have reported significant savings by participating in the 340B program, manufacturer rebate programs and recovering costs through insurance reimbursement.

Across the RWHAP, grant recipients are encouraged to maximize resources and leverage efficiencies. One example of this is within RWHAP Part B, where ADAPs use a variety of the above-mentioned strategies to maximize resources, which result in effective funds management, enabling ADAPs to serve more people. In 2020, ADAPs participating in cost-savings strategies on medications saved $2.5 billion, falling slightly under the FY 2020 performance target of $2.6 billion. Over the last 5 years, ADAPs participating in medication cost-savings strategies saved $9.4 billion.

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

In FY 2023, HRSA will continue the use of RWHAP ADAP Emergency Relief Funds (ERF) through “311 authority” in order to maintain infrastructure in the states and territories that had previously imposed waiting lists and to mitigate the risk of the establishment new wait lists. This is particularly important as public health efforts diagnose more people with HIV and engage people who are out of HIV care and treatment, increasing the number of patients in care. This funding also addresses the gaps in access created by ongoing cost-containment measures in many ADAPs such as HIV medication formulary reductions, lower client financial eligibility levels, and capped enrollment. However, with no individuals on the ADAP waiting lists, states requested and HRSA distributed $75 million in ERF funding in FY 2021. These funds are required to be used for ADAP services, including the purchase of medications, insurance premium assistance, and medication copay assistance. States that developed need through unforeseen events also have the ability to request RWHAP Part B supplemental funds to assist in meeting shortfalls. HRSA continues to closely monitor the impact of COVID-19 on the ADAPs as they anecdotally report an increase in client applications due to the loss of employment and/or health care coverage.

The RWHAP ADAP plays a crucial role that ensures access to HIV medications for pregnant women. Due to availability of effective HIV medications, mother-to-child transmission in the United States has decreased dramatically since its peak in 1992 due to 1) an increased focus on HIV testing for all pregnant women; and 2) the use of antiretroviral therapy, which significantly reduces the risk of HIV transmission from the mother to her baby. In 2020, 99 percent of HIV-positive pregnant women served by the RWHAP were prescribed antiretroviral therapy to prevent maternal-to-child transmission of HIV, exceeding the FY 2020 performance target by 3 percentage points.

**Funding History**[291]

| FY | Amount | ADAP (Non-Add) |
|---|---|---|
| FY 2012 | $1,360,827,000 | ($933,299,000) |
| FY 2013 | $1,287,535,000 | ($886,313,000) |
| FY 2014 | $1,314,446,000 | ($900,313,000) |
| FY 2015 | $1,315,005,000 | ($900,313,000) |
| FY 2016 | $1,315,005,000 | ($900,313,000) |
| FY 2017 | $1,311,837,000 | ($900,313,000) |
| FY 2018 | $1,309,251,000 | ($894,559,000) |
| FY 2019 | $1,315,005,000 | ($900,313,000) |
| FY 2020 | $1,315,005,000 | ($900,313,000) |
| FY 2021Final | $1,314,622,000 | ($900,313,000) |
| FY 2022 CR | $1,315,005,000 | ($900,313,000) |
| FY 2023 President's Budget | $1,345,005,000 | ($900,313,000) |

**Budget Request**

The FY 2023 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part B of $1.3 billion is $30.0 million above FY 2022 Continuing Resolution level. The FY 2023 President's Budget request will support the provision of core medical and support services for people with HIV in the 24 EMAs and 28 TGAs. These levels include $900.3 million for RWHAP ADAPs to provide access to life saving HIV related medications and direct health care services to people with HIV in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and five Associated Pacific Jurisdictions. HRSA will continue to utilize the 311 authority to implement the Emergency Relief Fund to prevent, reduce, or eliminate ADAP waiting lists through cost containment and/or cost savings measures.

The RWHAP Part B ADAP program has seen a significant increase in utilization during the COVID-19 pandemic, due to people with HIV losing other sources of health coverage (such as employer insurance) and state government revenue dropping, resulting in state funding cuts. Due to this, the Budget includes $30.0 million for the RWHAP Part B program base to meet this greater need. By increasing the RWHAP Part B program base, states will have the greatest flexibility in utilizing the funds, whether for ADAP or for other critical services. Additionally, a portion of the additional funding will be directed by statute to the RWHAP Part B supplemental, which will be available to states with the highest unmet needs.

[291] EHE funding is not included in this table.

As part of the program's efforts to continue to provide access to life-saving medications and related services for low-income people with HIV, the RWHAP has established a target for FY 2023 of serving at least 285,000 RWHAP ADAP clients. This target is based on anticipated steady funding, not on demand. While the number of ADAP clients is projected to remain constant in future years with anticipated steady funding, health care coverage and costs related to co-pays, co-insurance, premiums, etc., are difficult to anticipate. The increased demand for ADAP services in recent years has required many states to recover costs when possible by coordinating benefits with Medicare Part D or exhausting all coverage options, participating in rebate programs, and improving drug-purchasing models.

An important contributing factor to the demand for services for RWHAP ADAP continues to be access to HIV medications and high cost-sharing requirements for these medications for patients with many types of health coverage plans. In order to meet this demand, the number of ADAPs participating in cost-savings strategies on medications will need to remain steady (the FY 2023 target is to maintain the previous year's output measure).

RWHAP Part B grant recipients will continue to work directly with uninsured people with HIV to ensure access to health care coverage and will continue to support HIV medications not on health plan formularies and the cost sharing required by health coverage plans. ADAP resources will also support the continued:

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

HRSA and the CDC continue to collaborate to accelerate the elimination of perinatal HIV transmission in the United States. The FY 2023 funding request will support RWHAP ADAP to ensure that at least 97% of HIV-positive pregnant women served by the RWHAP will receive antiretroviral medications. RWHAP Part B funding will also contribute to achieving the FY 2023 targets for performance goals that related to cross-cutting activities, such as the percentage of racial and ethnic minorities and women served, and percentage of clients who achieved viral suppression.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 18.I.A.2: Number of RWHAP Part B visits for health-related care. *(Output)* | 2020: 2.2M Target: 3.4M (Target Not Met) | Proposed for retirement | Proposed for retirement | N/A |
| 4020.01: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. (Output) | 2020: 300,785 Target: 285,000 (Target Exceeded) | 280,000 | 285,000 | +5,000 |
| 4020.02: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. (Efficiency) | 2020: $2.5B Target: Sustain Prior Year Results (Target Not Met) | Sustain Prior Year Results | Sustain Prior Year Results | Maintain |
| 4020.03: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive antiretroviral medications.[292] *(Output)* | 2020: 99% Target: 96% (Target Exceeded) | 96% | 97% | +1 percentage point |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 59 | 59 | 59 |
| **Average Award** | $21,532,782 | $22,288,220 | $22,288,220 |
| **Range of Awards** | $50,000 - $142,918,132 | $50,000 - $143,743,510 | $50,000 - $143,743,510 |

[292] This RWHAP overarching performance measure applies to RWHAP Parts A, B, C, and D and is not Part B specific.

**RWHAP Part B – FY 2021 State Table[293]**

| State / Territory | Base | Supplemental | ADAP Total | Emerging Communities | MAI | Total |
|---|---|---|---|---|---|---|
| Alabama | $8,199,973 | $0 | $10,398,912 | $325,239 | $153,407 | $19,077,531 |
| Alaska | $500,000 | $110,390 | $553,315 | $0 | $0 | $1,163,705 |
| Arizona | $4,228,135 | $7,467,314 | $11,805,532 | $0 | $0 | $23,500,981 |
| Arkansas | $3,381,841 | $0 | $4,399,853 | $0 | $51,066 | $7,832,760 |
| California | $33,261,340 | $7,248,688 | $100,955,147 | $176,050 | $1,276,907 | $142,918,132 |
| Colorado | $3,358,147 | $3,676,971 | $9,280,431 | $0 | $78,637 | $16,394,186 |
| Connecticut | $2,549,277 | $5,391,112 | $7,927,143 | $0 | $0 | $15,867,532 |
| Delaware | $1,914,632 | $562,913 | $2,428,067 | $183,682 | $35,839 | $5,125,133 |
| District of Columbia | $3,354,361 | $0 | $11,268,513 | $0 | $190,747 | $14,813,621 |
| Florida | $30,031,995 | $8,100,675 | $84,839,389 | $468,324 | $1,253,307 | $124,693,690 |
| Georgia | $14,781,330 | $7,631,954 | $47,995,391 | $181,621 | $622,698 | $71,212,994 |
| Hawaii | $1,502,267 | $294,483 | $1,905,122 | $0 | $0 | $3,701,872 |
| Idaho | $565,979 | $1,508,589 | $717,754 | $0 | $0 | $2,792,322 |
| Illinois | $9,320,495 | $6,156,954 | $35,633,676 | $0 | $415,935 | $51,527,060 |
| Indiana | $3,688,604 | $7,229,249 | $10,695,041 | $0 | $0 | $21,612,894 |
| Iowa | $1,473,063 | $5,347,350 | $1,868,086 | $0 | $0 | $8,688,499 |
| Kansas | $1,119,077 | $1,382,537 | $2,491,769 | $0 | $0 | $4,993,383 |
| Kentucky | $4,254,477 | $0 | $5,395,375 | $286,320 | $47,140 | $9,983,312 |
| Louisiana | $6,523,941 | $0 | $16,616,482 | $0 | $254,453 | $23,394,876 |
| Maine | $765,736 | $42,064 | $971,079 | $0 | $0 | $1,778,879 |
| Maryland | $7,572,923 | $2,404,310 | $24,289,559 | $0 | $422,999 | $34,689,791 |
| Massachusetts | $5,143,378 | $843,968 | $15,261,713 | $0 | $183,446 | $21,432,505 |
| Michigan | $5,049,655 | $692,229 | $12,964,011 | $0 | $176,456 | $18,882,351 |
| Minnesota | $2,088,637 | $0 | $6,268,680 | $0 | $66,680 | $8,423,997 |
| Mississippi | $5,756,920 | $0 | $7,540,489 | $272,737 | $124,037 | $13,694,183 |
| Missouri | $3,493,560 | $0 | $9,846,338 | $0 | $0 | $13,339,898 |
| Montana | $500,000 | $0 | $364,432 | $0 | $0 | $864,432 |
| Nebraska | $1,254,615 | $1,219,032 | $1,591,058 | $0 | $0 | $4,064,705 |
| Nevada | $2,276,972 | $1,256,227 | $6,863,474 | $0 | $0 | $10,396,673 |
| New Hampshire | $500,000 | $0 | $911,081 | $0 | $0 | $1,411,081 |
| New Jersey | $9,606,744 | $1,430,717 | $27,791,664 | $0 | $452,205 | $39,281,330 |
| New Mexico | $1,900,029 | $0 | $2,409,549 | $0 | $0 | $4,309,578 |
| New York | $31,323,099 | $5,609,788 | $94,039,080 | $558,524 | $1,532,697 | $133,063,188 |
| North Carolina | $11,467,918 | $7,737,029 | $22,842,200 | $303,719 | $350,727 | $42,701,593 |
| North Dakota | $500,000 | $0 | $299,249 | $0 | $0 | $799,249 |
| Ohio | $7,182,488 | $0 | $16,760,181 | $350,498 | $0 | $24,293,167 |
| Oklahoma | $3,714,198 | $0 | $4,710,213 | $240,457 | $0 | $8,664,868 |
| Oregon | $1,754,794 | $0 | $4,719,102 | $0 | $0 | $6,473,896 |

[293] Awards include prior year unobligated balances.

| State/Territory | Base | Supplemental | ADAP Total | Emerging Communities | MAI | Total |
|---|---|---|---|---|---|---|
| Pennsylvania | $10,454,210 | $0 | $26,372,453 | $274,797 | $373,063 | $37,474,523 |
| Puerto Rico | $5,360,190 | $5,496,370 | $17,155,851 | $0 | $273,488 | $28,285,899 |
| Rhode Island | $1,471,311 | $1,828,752 | $1,865,864 | $187,039 | $20,849 | $5,373,815 |
| South Carolina | $10,176,496 | $7,546,108 | $13,152,153 | $562,416 | $203,997 | $31,641,170 |
| South Dakota | $500,000 | $646,853 | $448,133 | $0 | $0 | $1,594,986 |
| Tennessee | $5,168,245 | $7,216,417 | $13,704,727 | $0 | $181,379 | $26,270,768 |
| Texas | $24,784,368 | $7,503,431 | $86,908,382 | $0 | $1,042,142 | $120,238,323 |
| Utah | $1,796,062 | $1,765,348 | $2,864,743 | $0 | $0 | $6,426,153 |
| Vermont | $500,000 | $280,366 | $374,062 | $0 | $0 | $1,154,428 |
| Virginia | $7,075,070 | $0 | $17,862,366 | $368,584 | $257,428 | $25,563,448 |
| Washington | $3,641,633 | $0 | $9,770,785 | $0 | $84,035 | $13,496,453 |
| West Virginia | $1,013,483 | $1,235,743 | $1,384,398 | $0 | $0 | $3,633,624 |
| Wisconsin | $3,555,838 | $739,686 | $4,532,441 | $259,993 | $53,044 | $9,141,002 |
| Wyoming | $500,000 | $0 | $242,214 | $0 | $0 | $742,214 |
| Guam | $200,000 | $0 | $83,701 | $0 | $0 | $283,701 |
| Virgin Islands | $500,000 | $0 | $453,318 | $0 | $8,372 | $961,690 |
| American Samoa | $50,000 | $0 | $741 | $0 | $15 | $50,756 |
| Marshall Islands | $50,000 | $22,844 | $741 | $0 | $0 | $73,585 |
| Mariana Island | $50,000 | $0 | $11,111 | $0 | $0 | $61,111 |
| Republic of Palau | $50,000 | $0 | $6,666 | $0 | $0 | $56,666 |
| F. States Micronesia | $50,000 | $0 | $0 | $0 | $0 | $50,000 |
| **TOTALS** | $312,807,506 | $117,626,461 | $824,813,000 | $5,000,000 | $10,187,195 | $1,270,434,162 |

## RWHAP Part C - Early Intervention Services

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $201,079,000 | $ 201,079,000 | $207,079,000 | +$6,000,000 |
| **FTE** | 46 | 46 | 63 | +17 |

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Public Law 116-136

FY 2023 Authorization……..……..……..…...Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

**Program Description and Accomplishments**

HRSA's Ryan White HIV/AIDS Program (RWHAP) Part C provides grants directly to community and faith-based organizations, health centers, health departments, and university or hospital-based clinics in 49 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. RWHAP Part C supports comprehensive primary health care and support services in an outpatient setting for low-income, uninsured, and underserved people with HIV.

Minority AIDS Initiative (MAI) funds are a statutory set-aside funding component for RWHAP Parts A – D, and Part F AIDS Education and Training Center Program to evaluate and address the disproportionate impact of HIV on, racial and ethnic minorities. RWHAP Part C MAI funding supports HIV care, treatment, and support services to racial and ethnic minorities. RWHAP Part C is also authorized to fund capacity development grants that strengthen organizational development and infrastructure, resulting in a more effective delivery of HIV care and services.

The RWHAP Part C provides services for people with HIV disproportionately affected by the HIV epidemic and who have poor health outcomes, including ethnic and minority populations and youth. In 2020, RWHAP Part C funded sites served over 330,000 clients utilizing a combination of RWHAP Parts A, B, C, and D funding. Of the total clients served, 73 percent were racial and ethnic minorities and 25 percent were female.

The RWHAP has a history of creating effective patient-centered services that support strong provider and patient relationships. Providers funded through RWHAP Part C have the clinical expertise and cultural competency to provide quality care and treatment to low-income, diverse people with HIV. In 2020, RWHAP Part C funded sites provided nearly 2.3 million medical service visits for health-related care utilizing a combination of RWHAP Parts A, B, C, and D funding. The number of visits for health-related services demonstrates the scope of RWHAP Part

C in delivering primary care and related services for people with HIV by increasing the availability and accessibility of care.

**Funding History**

| FY | Amount |
|---|---|
| FY 2012[294] | $215,086,000 |
| FY 2013 | $194,444,000 |
| FY 2014 | $205,544,000 |
| FY 2015 | $204,179,000 |
| FY 2016 | $205,079,000 |
| FY 2017 | $200,585,000 |
| FY 2018 | $201,079,000 |
| FY 2019 | $201,079,000 |
| FY 2020 | $201,079,000 |
| FY 2021 Final | $201,079,000 |
| FY 2022 CR | $201,079,000 |
| FY 2023 President's Budget | $207,079,000 |

**Budget Request**

The FY 2023 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part C of $207.1 million is $6.0 million above the FY 2022 Continuing Resolution level. This funding will support comprehensive medical, treatment and support services necessary to achieve improved health outcomes, such as improved viral suppression rates, essential to ending the HIV epidemic.

The RWHAP has seen a significant increase in utilization during the COVID-19 pandemic as people with HIV have lost other sources of health coverage (such as employer insurance) and state governments' revenue has dropped, resulting in state funding cuts. Due to this, the Budget includes $6.0 million for new RWHAP Part C community based clinics in areas of the country with the greatest need.

RWHAP Part C supports direct health care services for low-income people with HIV who are uninsured or underserved. These services are considered essential to improving health outcomes and are a crucial part of the care network that links and retains people with HIV into health care. Such critical health care services include intensive case management and care coordination services, linking and retaining people with HIV into care, and getting them on antiretroviral medications as early as possible.

The funding request will support the RWHAP Part C in achieving its target of providing 2.2 million visits for health-related care in FY 2023. RWHAP Part C funding will also contribute to achieving the FY 2023 targets for performance goals that relate to cross-cutting activities, such as percentage of racial and ethnic minorities and women served, percentage of clients who

[294] Reflects Ryan White Budget Authority only (does not include $5.089 million in Health Center Program Budget Authority for RWHAP Part C grant recipients in FY 2012).

achieved viral suppression, and percentage of HIV-positive pregnant women served by the RWHAP who receive antiretroviral medications.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 19.II.A.3: Number of RWHAP Part C visits for health-related care. *(Output)* | 2020: 2.2M<br>Target: 2.3M<br>(Target Not Met) | 2.2M | 2.2M | Maintain |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 CR | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 347 | 345 | 355 |
| **Average Award** | $518,183 | $520,000 | $520,000 |
| **Range of Awards** | $92,999-$1,507,775 | $94,486-$1,086,342 | $94,486-$1,086,342 |

## RWHAP Part D - Women, Infants, Children and Youth

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $72,888,000 | $75,088,000 | $75,088,000 | ---- |
| **FTE** | 10 | 10 | 12 | +2 |

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Public Law 116-136

FY 2023 Authorization……Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

**Program Description and Accomplishments**

The Ryan White HIV/AIDS Program (RWHAP) Part D provides grants directly to public or private community-based organizations, hospitals, and State and local governments. Currently, there are 114 RWHAP Part D grant recipients located in 39 states, the District of Columbia and Puerto Rico. The RWHAP Part D focuses on providing access to coordinated, comprehensive, culturally and linguistically competent, family-centered HIV primary medical care and support services. RWHAP services focus on low-income, uninsured, and underserved women, infants, children, and youth with HIV and their affected[295] family members. RWHAP Part D also funds essential support services, such as case management and transportation that help clients' access medical care and stay in care.

Minority AIDS Initiative Funds (MAI) funds are a statutory set-aside funding component for RWHAP Parts A – D, and Part F AIDS Education and Training Center Program to evaluate and address the disproportionate impact of HIV on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. RWHAP Part D MAI funding supports HIV care, treatment, and support services to racial and ethnic minorities. In 2020, RWHAP Part D funded sites provided nearly 1.6 million visits for health-related care and support services utilizing a combination of RWHAP Parts A, B, C, and D funding.

The RWHAP Part D serves women, infant, children, and youth – populations disproportionately affected by HIV epidemic that have poor health outcomes. In 2020, RWHAP Part D funded sites

[295] 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.

served 213,152 clients utilizing a combination of RWHAP Parts A, B, C, and D funding. Of the total clients served, 75 percent were racial and ethnic minorities and 28 percent were female.

RWHAP Part D providers have the clinical expertise and cultural competency to provide quality care and treatment to low-income, diverse women, infant, children, and youth with HIV.

**Funding History**

| FY | Amount |
|---|---|
| FY 2012 | $77,167,000 |
| FY 2013 | $72,361,000 |
| FY 2014 | $72,395,000 |
| FY 2015 | $73,008,000 |
| FY 2016 | $75,088,000 |
| FY 2017 | $74,907,000 |
| FY 2018 | $75,088,000 |
| FY 2019 | $75,088,000 |
| FY 2020 | $75,088,000 |
| FY 2021 Final | $72,888,000 |
| FY 2022 CR | $75,088,000 |
| FY 2023 President's Budget | $75,088,000 |

**Budget Request**

The FY 2023 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part D of $75.1 million is equal to the FY 2022 Continuing Resolution level. These funding levels will support comprehensive the comprehensive array of medical and supports services necessary to achieve improved health outcomes, such as improved viral suppression rates, essential to ending the HIV epidemic.

RWHAP Part D supports health care services for low-income people with HIV who are uninsured or underserved. These services are considered essential to improving health outcomes and are a crucial part of the care network that links and retains people with HIV into health care, especially for women, infants and children and youth. Such critical health care services include intensive case management and care coordination services, linking and retaining people with HIV into care, and getting them on antiretroviral medications as early as possible.

The funding request will support the RWHAP Part D in achieving its target of providing 1.6 million visits for health-related care in FY 2023. RWHAP Part D funding will contribute to achieving the FY 2023 targets for performance goals that relate to cross-cutting activities, such as the percentage of racial and ethnic minorities and women served, percentage of clients who achieved viral suppression, and percentage of pregnant women with HIV served by the RWHAP who receive antiretroviral medications.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 20.II.A.2 Number of RWHAP Part D visits for health-related care and support services.*(Output)* | 2020: 1.6M Target: 1.7M (Target Not Met) | 1.5M | 1.6M | +100,000 |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 115 | 115 | 115 |
| **Average Award** | $583,894 | $583,894 | $583,894 |
| **Range of Awards** | $113,823 - $2,185,691 | $113,823 - $2,185,691 | $113,823 - $2,185,691 |

## RWHAP Part F - AIDS Education and Training Center Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $33,510,000 | $33,611,000 | $33,611,000 | --- |
| **FTE** | 6 | 6 | 6 | --- |

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Public Law 116-136

FY 2023 Authorization……...….Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

**Program Description and Accomplishments**

The Ryan White HIV/AIDS Program (RWHAP) Part F AIDS Education and Training Center (AETC) Program supports a network of eight regional centers and two national centers that conduct targeted, multidisciplinary education and training programs for health care providers serving people with HIV in all states, DC, Puerto Rico, the U.S. Virgin Islands, and the Associated Jurisdictions. The RWHAP AETC improves the quality of life of people with or at-risk of HIV through the provision of specialized professional education and training. The program uses a strategy of implementation of multidisciplinary education and training programs for health care providers in the prevention and treatment of HIV, bolstering the health workforce to ensure delivery of quality services and care for underserved populations.

The RWHAP AETC Program targets training to health care providers who serve minority populations, the homeless, rural communities, incarcerated persons, federally qualified community and migrant health centers, and RWHAP sites. In addition, over half the providers themselves are racial and ethnic minorities, exceeding the target by six percent. AETC-trained health care providers are trained to offer innovative and culturally- and linguistically-appropriate healthcare services and empowers underserved populations with choices. 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.

***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 2021. This initiative is now in its third year and jurisdictions will utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. See the EHE initiative section for more information.

**Funding History[296]**

| FY | Amount |
|---|---|
| FY 2012 | $34,542,000 |
| FY 2013 | $32,390,000 |
| FY 2014 | $33,275,000 |
| FY 2015 | $33,349,000 |
| FY 2016 | $33,611,000 |
| FY 2017 | $33,530,000 |
| FY 2018 | $33,611,000 |
| FY 2019 | $33,611,000 |
| FY 2020 | $33,611,000 |
| FY 2021 Final | $33,510,000 |
| FY 2022 CR | $33,611,000 |
| FY 2023 President's Budget | $33,611,000 |

**Budget Request**

The FY 2023 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F-AETC of $33.6 million is equal to the FY 2022 Continuing Resolution level. These funding levels will support targeted, multidisciplinary education and training programs for novice and experienced health care providers treating people with HIV in order to assure access to high quality HIV care delivered by competent providers. The RWHAP AETC program also provides expert advice to providers across the country on HIV treatment, pre-exposure prophylaxis to reduce HIV transmission, substance use disorders, viral hepatitis co-infection, post-exposure prophylaxis, and the treatment of pregnant women with HIV and their newborns to prevent mother-to-child transmission.

The RWHAP AETC program funds a National 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 good patient outcomes through HIV care and treatment that is consistent with established treatment guidelines and reflects current research. This is increasingly important as people with HIV are living longer. In addition, the number of experienced HIV care

[296] EHE funding is not included in this table.

professionals is projected to decrease as many of those who have worked in the epidemic since its inception reach retirement age. Training an expanded cadre of culturally competent, high quality providers is vital to increasing access to quality HIV care and treatment and improving health outcomes for people with HIV.

HRSA will continue to prioritize interactive training and technical assistance that result in health system strengthening and transformation. Focus will be on training health care providers, particularly racial and ethnic minority providers, to deliver high quality HIV care and treatment services in primary care settings – settings that have typically not provided services to people with HIV.

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

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 4051.01 Proportion of RWHAP AETC training intervention participants that are racial and ethnic minorities. (Output) | FY 2020: 52%<br><br>Target: 46%<br><br>(Target Exceeded) | 46% | 46% | Maintain |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 14 | 13 | 13 |
| **Average Award** | $2,187,500 | $2,304,078 | $2,304,078 |
| **Range of Awards** | $300,000 - $4,169,550 | $600,000 - $4,205,789 | $600,000 - $4,205,789 |

## RWHAP Part F - Dental Programs

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $13,083,000 | $13,122,000 | $13,122,000 | --- |
| **FTE** | --- | --- | --- | --- |

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Public Law 116-136

FY 2023 Authorization……..……..Expired

Allocation Method:

- Competitive Grants
- Formula Grants
- Contracts

**Program Description and Accomplishments**

The Ryan White HIV/AIDS Program (RWHAP) Part F funding supports two dental programs: 1) HIV/AIDS Dental Reimbursement Program (DRP); and 2) Community-Based Dental Partnership Program (CBDPP).

The RWHAP DRP ensures access to oral health care for low-income people with HIV by reimbursing dental education programs for the non-reimbursed costs they incur providing such care. By offsetting the costs of non-reimbursed HIV care in accredited dental education institutions, the RWHAP DRP improves access to oral health care for low-income, people with HIV and ensures quality services by dental students, dental hygiene students, and dental residents for providing oral health care services to people with HIV. The care provided through the program includes a full range of diagnostic, preventive, and treatment services, including oral surgery, as well as oral health education and health promotion. Dental schools, post-doctoral dental education programs, and dental hygiene education programs accredited by the Commission on Dental Accreditation that have documented non-reimbursed costs for providing oral health care to people with HIV are eligible to apply for reimbursement. Funds are then distributed to eligible organizations taking into account the number of people served and the cost of providing care.

In FY 2020, the RWHAP DRP awards were able to provide over 36 percent of the total non-reimbursed costs requested by 49 participating institutions in support of oral health care. These institutions reported providing care to 17,933 people with HIV (7,036 for whom no other funded source was available), a 33 percent drop from 2019. In 2020, COVID-19 disrupted the delivery of oral health care nationwide – not just within the RWHAP – with nearly half of U.S. adults

reported delaying dental care due to the COVID-19 pandemic.[297] FY 2020, the demographic characteristics of patients who were cared for by institutions participating in the RWHAP DRP were 64 percent minority and 28 percent women.

The RWHAP CBDPP supports collaborations between dental education programs and community-based partners to deliver oral health services in community settings while supporting students and residents enrolled in accredited dental educations programs. In FY 2020, RWHAP CBDPP funded 12 partnership grants to support collaboration and coordination between the dental education programs and the community-based partners in the delivery of oral health services.

| Part F-Dental Subprograms | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| RWHAP Dental Reimbursement Program | $9,133,546 | $9,133,546 | $9,133,546 |
| RWHAP Community-Based Dental Partnership Program | $3,475,672 | $3,475,672 | $3,475,672 |

**Funding History**

| FY | Amount |
|---|---|
| FY 2012 | $13,485,000 |
| FY 2013 | $12,646,000 |
| FY 2014 | $12,991,000 |
| FY 2015 | $13,020,000 |
| FY 2016 | $13,122,000 |
| FY 2017 | $13,090,000 |
| FY 2018 | $13,122,000 |
| FY 2019 | $13,122,000 |
| FY 2020 | $13,122,000 |
| FY 2021 Final | $13,083,000 |
| FY 2022 CR | $13,122,000 |
| FY 2023 President's Budget | $13,122,000 |

[297] Kranz AM, Gahlon G, Dick AW, Stein BD. Characteristics of US adults delaying dental care due to the COVID-19 pandemic. JDR Clin Transl Res. 2021;6(1):8-14.

**Budget Request**

The FY 2023 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F-Dental of $13.2 million is equal to the FY 2022 Continuing Resolution level. These funding 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 2023 funding request will support RWHAP target for reimbursing at least 26,000 people with HIV for a portion of their unreimbursed oral health costs through the RWHAP Dental Reimbursement Program.

The FY 2023 funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology, and other program support costs.

**Outcomes and Outputs Table**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 4052.01: Number of persons for whom a portion/percentage of their unreimbursed oral health costs were reimbursed. *(Output)* | 2020: 17,933 Target: 26,000 (Target Not Met)[298] | 26,000 | 26,000 | Maintain |

[298] . In 2020, COVID-19 disrupted the delivery of oral health care nationwide - not just within the RWHAP - with nearly half of US adults reported delaying dental care due to the COVID-19 pandemic. Kranz AM, Gahlon G, Dick AW, Stein BD. Characteristics of US adults delaying dental care due to the COVID-19 pandemic. JDR Clin Transl Res. 2021;6(1):8-14.

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 56 | 56 | 56 |
| **Average Award** | $220,926 | $220,926 | $220,926 |
| **Range of Awards** | $2,483 - $1,259,850 | $2,483 - $1,259,850 | $2,483 - $1,259,850 |

## RWHAP Part F - Special Projects of National Significance

| | FY 2021 Final | FY 2022 CR | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $25,000,000 | $25,000,000 | $25,000,000 | --- |
| **FTE** | 1 | 1 | 2 | +1 |

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Public Law 116-136

FY 2023 Authorization……..…….…..Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

**Program Description and Accomplishments**

The Ryan White HIV/AIDS Program (RWHAP) Part F Special Projects of National Significance (SPNS) supports the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of RWHAP clients. Through its demonstration and implementation projects SPNS evaluates the design, utilization, cost, and health-related outcomes of treatment strategies while promoting the dissemination and replication of successful interventions. This unique program advances knowledge and skills in the delivery of health care and support services to underserved populations.

As healthcare systems work under increasingly dynamic conditions, evidence-based, evidence-informed, and emerging strategies are essential in order to ensure that research investments maximize healthcare value and improve public health. Implementation science plays a critical role in supporting these efforts. RWHAP SPNS-funded projects use implementation science - the scientific study of methods to promote the systematic uptake of research findings into routine practice - to document and capture how well interventions and strategies improve the quality and effectiveness of health services, maximize resources, and improve health outcomes for people with HIV.

The RWHAP SPNS evaluates the effectiveness of various models, interventions, strategies, implementation, utilization, cost, and health-related outcomes. Systematic strategies are used to identify emerging strategies among RWHAP recipients and to coordinate, develop tools kits and other modalities that allow for rapid dissemination and uptake. Through these special projects, RWHAP SPNS grant recipients implement a variety of interventions, which contribute to the advancement of public health knowledge and the ultimate goal of ending the HIV epidemic in the United States.

Of the 39 FY 2021 RWHAP SPNS grant recipients currently funded, 26 percent are community-based/AIDS services organizations; 8 percent are state/county/local departments of health; 26 percent are community health centers; 15 percent are academic-based clinics; 8 percent are public health research/training institute; and 17 percent are universities/evaluation and technical assistance providers.

Current SPNS initiatives include: Improving collecting and reporting viral suppression data to the Medicaid adult core set; using innovative intervention strategies to improve health outcomes among people with HIV; leverage a data to care approach to cure hepatitis C within RWHAP; building capacity to implement rapid art start for improved care engagement in RWHAP; developing a compendium of promising rapid antiretroviral therapy start in RWHAP – dissemination assistance provider; improving care and treatment coordination focusing on black women with HIV; building capacity to support innovative program model replication among RWHAP jurisdictions; enhancing linkages of sexually transmitted infections (STI) and HIV surveillance data in the RWHAP; strengthening systems of care for people with HIV and opioid use disorder; and implementation of evidence-informed behavioral health models to improve HIV health outcomes for Black Men Who Have Sex With Men.

**Funding History**

| FY | Amount |
|---|---|
| FY 2012 | $25,000,000 |
| FY 2013 | $25,000,000 |
| FY 2014 | $25,000,000 |
| FY 2015 | $25,000,000 |
| FY 2016 | $25,000,000 |
| FY 2017 | $24,940,000 |
| FY 2018 | $25,000,000 |
| FY 2019 | $25,000,000 |
| FY 2020 | $25,000,000 |
| FY 2021 Final | $25,000,000 |
| FY 2022 CR | $25,000,000 |
| FY 2023 President's Budget | $25,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F-SPNS of $25 million is equal to the FY 2022 Continuing Resolution level. These funding levels will support the continued development of innovative models of HIV care and treatment for populations that are significantly difficult to engage in continuous care and achieve viral suppression.

Through its funded demonstration projects, RWHAP SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models, interventions, and strategies, while promoting the dissemination and replication of successful ones. RWHAP SPNS funding also supports projects to build capacity in the health information technology

(HIT) systems of RWHAP grant recipients and provider organizations to report client-level data and to improve health outcomes.

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

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 39 | 48 | 19 |
| **Average Award** | $506,304 | $450,415 | $959,137 |
| **Range of Awards** | $205,000 - $4,825,000 | $205,000 - $4,825,000 | $300,000 - $4,825,000 |

## RWHAP – Ending the HIV Epidemic Initiative (EHE)

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $105,000,000 | $105,000,000 | $290,000,000 | +$185,000,000 |
| **FTE** | 25 | 25 | 29 | +4 |

Authorizing Legislation: Public Health Service Act, Section 2601, as amended by Public Law 116-136

FY 2023 Authorization…….……..Not Specified

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

**Program Description and Accomplishments**

The Ending the HIV Epidemic in the U.S. (EHE) initiative is an HHS-wide effort to reduce new 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 PrEP services uptake) on priority communities, and costs related to provision of these services. To reach the goals of EHE, HRSA needs to enroll and provide HIV services to183,000 people with HIV by year five. At current funding levels, this will require a focus on building capacity to quickly expand in years four and five

Despite the FY 2020 funding reaching grantees in March 2020, at the beginning of the COVID epidemic nationally, HRSA exceeded the FY 2020 goal of serving 18,000 people. EHE jurisdictions funded by HRSA served nearly 19,500 clients (8% more than the FY 2020 goal) who were new or re-engaged in HIV care and treatment during March 2020 through December 2020. Of the new clients receiving EHE initiative services during 2020, 59% received antiretroviral therapy (ART).

In 2021, HRSA expects to serve 27,000 people with HIV through the EHE initiative (includes continued care for 18,000 people from year 1 and 9,000 new and re-engaged people in year 2). In 2022 HRSA expects to continue to serve 27,000 EHE clients.

The EHE-funded technical assistance (TA) and systems coordination cooperative agreements will continue to support strategies such as data to care efforts; using acuity tools to identify and provide care for the most challenging patients; developing models such as low-barrier clinics to meet patients where they are; rapid engagement and medication initiation protocols; and others that have been successful in the field. As lessons are learned from the second year, HRSA and the TA entity will work to utilize and disseminate those lessons nationally.

The EHE jurisdictions funded by HRSA HAB will continue to work with their respective AIDS Drug Assistance Programs (ADAPs) to ensure necessary resources are available to provide assistance for medications and health care coverage premiums and cost sharing for people newly diagnosed with HIV or re-engaged in care through the EHE initiative.

As part of the EHE initiative, the RWHAP 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 work plans in spite of the COVID-19 pandemic. This progress included developing administrative infrastructure and service delivery infrastructure, engaging with community members and new partners, and delivering services to clients. HRSA continues to monitor the impact of COVID-19 on the RWHAP and is working to more fully understand the impact the pandemic is having on the EHE initiative.

**Funding History**

| FY | Amount |
|---|---|
| FY 2013 | --- |
| FY 2014 | --- |
| FY 2015 | --- |
| FY 2016 | --- |
| FY 2017 | --- |
| FY 2018 | --- |
| FY 2019 | --- |
| FY 2020 | $70,000,000 |
| FY 2021 Final | $105,000,000 |
| FY 2022 CR | $105,000,000 |
| FY 2023 President’s Budget | $290,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Ending the HIV Epidemic in the U.S. (EHE) initiative is $290.0 million. This request 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. HRSA estimates

that 76,000 clients will be served by EHE recipients through FY 2023, an increase of 49,000 clients from the FY 2022 estimates. The increase from FY 2022 to FY 2023 will represent a significant expansion in the EHE initiative.[299]

In FY 2023, 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 requires coordination with the respective AIDS Drug Assistance Program (ADAPs) to ensure necessary resources are available to provide assistance for medications and health care coverage premiums and cost sharing for people newly diagnosed with HIV or re-engaged in care through the initiative. The RWHAP's comprehensive system of HIV care and support services and effective system for medication delivery creates a very efficient and effective service delivery mechanism for this initiative.

The FY 2023 request of $290.0 million will support HIV care and treatment needs for an estimated 76,000 – this includes 27,000 people from year 3 and 49,000 newly identified and re-engaged people in year 4, who prior to the start of the initiative were not in care. This 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 the first three years of the initiative. As more people with HIV receive HIV care and treatment, the initiative funding will be critical for keeping an increasing number of patients on medications to prevent HIV transmissions and improve HIV health outcomes.

HRSA will fund the 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.

[299] Details on the PrEP Delivery Program to End the HIV Epidemic are included in Mandatory Proposals section of the Departmental Management Congressional Justification.

## Outcomes and Outputs Table

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 4060.01 Number of new clients served through the EHE initiative *(Output)*[300] | FY 2021: Results expected April 30, 2022 | 50,000 | 76,000 | + 26,000 |
| 4060.02 Viral suppression among new clients served by the EHE initiative *( Outcome)*[1] | FY 2021: Results expected April 30, 2022 | Not Defined | Not Defined | Not Defined |

## Grants Awards Table

The table below includes the awards to jurisdictions only (47 total):

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Jurisdiction Awards** | 47 | 47 | 47 |
| **Average Award** | $1,861,166 | Unavailable | Unavailable |
| **Range of Awards** | $1,000,000 – $10,900,000 | Unavailable | Unavailable |

[300] The first target is 18,200 new clients in FY 2020, for FY 2021, the estimated number of clients served is now 27,000 people with HIV, based on amount of funds appropriated.
[1] This is a long-term measure without annual targets. The first target will be set for FY 2024 to align with the first 5-year phase of the initiative.

The table below includes the awards to jurisdictions (47), AIDS Education and Training Centers (12), and Technical Assistance and Coordination Providers (2):

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Jurisdiction, AETC, and Technical Assistance Awards** | 61 | 61 | 61 |
| **Average Award** | $1,625,570 | Unavailable | Unavailable |
| **Range of Awards** | $86,000 – $10,900,000 | Unavailable | Unavailable |

# Health Systems
# TAB

# HEALTHCARE SYSTEMS

## Organ Transplantation

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $29,549,000 | $29,049,000 | $29,049,000 | --- |
| **FTE** | 2 | 2 | 9 | +7 |

Authorizing Legislation: Public Health Service Act, Sections 371-378, as amended by Public law 108-216, Public Law 109-129, Public Law 110-144, Public Law 110-413, and Public Law 113-51

FY 2023 Authorization……..……..……..……...……..……..…..... Expired

Allocation Method:
- Contracts
- Competitive Grants/Co-operative Agreements
- Other (Interagency Support)

**Program Description**

The Organ Transplantation Program extends and enhances the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment. HRSA oversees a national system, the Organ Procurement and Transplantation Network (OPTN), to allocate and distribute donor organs to individuals waiting for transplants. Organ allocation is guided by OPTN policies informed by analytical support from the Scientific Registry of Transplant Recipients (SRTR). 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 paid by transplant centers for each transplant candidate placed on the waiting list. The OPTN collects fees under the authority of 42 CFR §121.5(c).

The OPTN final rule (42 CFR §121.12) established the Advisory Committee on Organ Transplantation (ACOT), which is composed of experts in organ transplantation, to provide recommendations to the Secretary on issues related to organ donation and transplantation. HRSA provides logistics and analytical support for periodic ACOT meetings. HRSA also engages in interagency activities that support organ donation and transplantation.

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, download, and social media
- Radio Ad Spotlights during high traffic drive-time hours in designated markets with the highest numbers of African Americans, Asians, Hispanics or Latinos, and people 50 years and older. Data reveals gaps between the numbers of patients waiting for an organ and the number of donors from these groups
- Organ donation and transplantation related articles for newspapers and journals
- 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.

**Program Accomplishments**

Deceased organ donation and transplantation reached annual record numbers in 2020 and 2021. Living organ donation declined from March to May 2020, as living organ donation was deferred temporarily to avoid exposing potential living organ donors and recipients to COVID-19. Beginning in June 2020, living donation and transplantation returned to rates more similar to those seen pre-pandemic, but the overall number of living donors and transplants performed from living donor organs in 2020 (5,726) and 2021 (6,541) was less than in 2019 (7,397). The Living Organ Donation Reimbursement Program exceeded its monthly goals throughout 2021, processing more than 1,552 applications in 2021 compared to 852 in 2020.

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 increased annual numbers of deceased donor organs procured, and organ transplants performed year after year since 2015. The number of deceased donor organs transplanted in CY 2021 was 38,098, a 4.25 percent increase over the CY 2020 total of 36,544.

Another important program goal is to increase the deceased organ donor conversion rate, which is the rate potential organ donors become actual organ donors after death. The conversion rate has been a key performance metric and a priority for the Organ Transplantation Program since 2003. The conversion rate has averaged at approximately 71 percent for the last five years, as shown in Table 1. HRSA will continue to monitor conversion rates and determine potential next steps.

The organ donor conversion rate is based on "eligible deaths," including potential donors aged 75 or below who are legally declared dead by neurologic criteria (brain death) and not excluded for other defined reasons related to certain risk factors. The number of "eligible deaths" does not include: 1) donors declared dead by circulatory determination of death (cardiac death) rather than neurologic criteria; and, 2) donors whose organs were transplanted despite donor age or other risk factors that may have excluded them from being counted as "eligible deaths."

**Table 1. Conversion Rates and Eligible Deaths 2017-2021**

| Year | Number of Donors | Number of Eligible Deaths | Conversion Rate (%) | Change in Eligible Deaths (%) |
|---|---|---|---|---|
| **2017** | 8,104 | 11,653 | 69.5 | 8.8 |
| **2018** | 8,272 | 11,661 | 70.9 | 0.1 |
| **2019** | 8,703 | 12,116 | 71.8 | 3.9 |
| **2020** | 8,973 | 12,653 | 70.9 | 4.4 |
| **2021*** | 9,187 | 13,068 | 70.3 | 3.3 |

*Figures are based on CY2021 data through October 2021.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $25,437,000 |
| FY 2020 | $27,549,000 |
| FY 2021 Final | $29,549,000 |
| FY 2022 CR | $29,049,000 |
| FY 2023 President's Budget | $29,049,000 |

**Budget Request**

The FY 2023 Budget Request for the Organ Transplantation program of $29.0 million is equal to the FY 2022 Continuing Resolution level. HRSA is committed to strengthening the Organ Transplantation Program. HRSA will be re-competing the OPTN contract in FY 2023. HHS - will continue efforts to enhance oversight and accountability with respect to this critical function. The FY 2023 Request also provides resources to continue to support policies and initiatives designed to remove financial barriers to living organ donation.

This request also includes funding for the OPTN, SRTR, and public and professional education to increase public awareness about organ donation. Additionally, this request supports activities related to the Advisory Committee, interagency agreements, and other internal support and Program-related activities.

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

**Outputs and Outcomes Tables**

| Measure | Year and Most Recent Result/ Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 5010.01: Annual number of deceased donor organs transplanted[301] | FY 2021: 38,098 Target: 32,652 (Target Exceeded) | 32,652 | 33,311 | +659 |
| 5010.02: Annual conversion rate of eligible donors. (Efficiency) | FY 2021: 71% Target: 74% (Target Not Met) | 74% | 74% | Maintain |

[1] Performance Measure 5010.01 using OPTN data as of January 13, 2021 (Outcome).

**Grants Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 1 | 1 | 1 |
| **Average Award** | $9,700,000 | $8,290,523 | $8,290,523 |
| **Range of Awards** | $9,700,000-$9,700,000 | $8,290,523 - $8,290,523 | $8,290,523 - $8,290,523 |

## The Blood Stem Cell Transplantation Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $48,063,000 | $49,275,000 | $49,275,000 | --- |
| **FTE** | 9 | 9 | 11 | +2 |

Authorizing Legislation: Public Health Service Act, Section 379-379B, as amended by Public Law 117-15

FY 2023 Authorization…….....$54,009,000

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[302] 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), were combined in FY 2022.

Blood stem cell transplantation, which includes bone marrow and cord blood, is a potentially curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year, nearly 18,000 people in the U.S. are diagnosed with life-threatening illnesses where blood stem cell transplantation from matched donors is the best treatment option. Often, the ideal donor is a suitably matched family member, but only 30 percent of people have a fully matched relative. The other 70 percent, or approximately 12,600 people, often search for a matched unrelated adult donor or umbilical cord blood unit.
The BSCTP operates through four major contractual functions that require close coordination and oversight and supports an Advisory Council that provides recommendations to the HHS Secretary and HRSA on activities related to the BSCTP. The major functions of the BSCTP are:

[302] 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 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 related donor transplant pairs from adult and pediatric participating centers in the C. W. Bill Young Cell Transplantation Program (CWBYCTP) that provides a representative sample of U.S. related transplant activity.

- 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.

**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 2021, more than 23 million potential adult volunteer donors and 116,930 HRSA-funded CBU (see Table 1) were listed on the C.W. Bill Young Cell Transplantation Program's registry.

**Table 1. Cord Blood Collections**

| Fiscal Year | Number of Units Contracted | Cord Blood Units Collected and Made Available[303] for Patient Searches | Cumulative Units Made Available |
|---|---|---|---|
| **2016** | 5,840 | 6,660 | 90,261 |
| **2017** | 6,369 | 7,719 | 97,980 |
| **2018** | 7,785 | 4,889 | 102,869 |
| **2019** | 4,585 | 4,594 | 107,463 |
| **2020** | 4,567 | 4,049 | 111,512 |
| **2021** | 4,117 | 5,418 | 116,930 |

The FY 2021 goal of 4.08 million adult donors who self-identify as belonging to an underrepresented racial or ethnic population was not met. One of the primary reasons for the unmet goal was the limited in-person recruitment activity during the COVID-19 pandemic. Due to the anticipated ongoing impact of COVID-19, HRSA expects the registry will add 4.02 million adult donors who self-identify as belonging to an underrepresented racial or ethnic population and 2,000 cord blood units in FY 2023. 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.

As shown in Table 2, the number of cord blood units released for transplants decreased in FY 2021 from FY 2020, at 313 and 344 cord blood units, respectively. The total number of cord blood units released for transplantation has been decreasing since FY 2016 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 | Units Released for Transplantation | Total Cord Blood Units (HRSA-funded and Non- HRSA funded) released for Transplantation through the BSCTP |
|---|---|---|
| **2016** | 529 | 1,154 |
| **2017** | 494 | 1,050 |
| **2018** | 493 | 949 |
| **2019** | 459 | 848 |
| **2020** | 344 | 702 |
| **2021** | 313 | 589 |

[303] Due to the lag between when cord blood units are collected and when they have been fully tested and qualified for listing on the public registry, not all of the units collected with funds from a given fiscal year will be available on the registry during that same fiscal year.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $40,696,000 |
| FY 2020 | $47,275,000 |
| FY 2021 Final | $48,063,000 |
| FY 2022 CR | $49,275,000 |
| FY 2023 President's Budget | $49,275,000 |

**Budget Request**

The FY 2023 Budget Request for the Blood Stem Cell Transplantation Program of $49.3 million is equal to the FY 2022 Continuing Resolution level. The FY 2023 Request supports continued progress toward the statutory goal of building a genetically and ethnically diverse inventory of at least 150,000 new units of high-quality cord blood for transplantation. HRSA estimates that approximately 2,000 additional cord blood units and 4 million adult volunteer donors from underrepresented racial and ethnic populations will be added and made available for patient searches in FY 2023. 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 international transplant centers to obtain data on U.S. stem cell products provided by U.S. products for international transplants; 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 grant review and award process, follow-up performance reviews, and information technology and other program support costs.

**Outputs and Outcomes Tables**

| Measure | Year and Most Recent Result/ Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 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[304] (Outcome) | FY 2021: 154,333 Target: 145,721 (Target Exceeded) | 148,721 | 149,721 | +1,000 |
| 5020.02: The number of HRSA-funded cord blood units banked and available through the C.W. Bill Young Cell Transplantation Program (Outcome) | FY 2021: 116,930 Target: 99,000 (Target Exceeded) | 113,000 | 117,000 | +4,000 |
| 5020.03: The annual number of cord blood units released for transplant.[305] (Outcome) | FY 2021: 313 Target: 500 (Target Not Met) | 350 | 350 | Maintain |
| 5020.04: The number of blood stem cell transplants facilitated by the Program. This is a long-term measure. The next target will be set for FY 2025. (Outcome) | FY 2021: 5,949 Target: Not Defined (Historical Actual) | Not Defined | Not Defined | Not Defined |
| 5020.05: The number of blood stem cell transplants facilitated for minority patients by the Program.[306] (Outcome) | FY 2021: 576 Target: Not Defined (Historical Actual) | Not Defined | Not Defined | Not Defined |

[304]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.
[305]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.
[306]This is a long-term measure. The next target will be set for FY 2025.

| Measure | Year and Most Recent Result/ Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 5020.06: The rate of patient survival at one year, post-transplant.[307] (Outcome) | FY 2021: 71% Target: Not Defined (Historical Actual) | Not Defined | Not Defined | Not Defined |
| 5020.07: The number of blood stem cell transplants facilitated for domestic patients by the Program.[308] (Outcome) | FY 2021: 5,129 Target: Not Defined (Historical Actual) | Not Defined | Not Defined | Not Defined |
| 5020.08: The unit cost of human leukocyte antigen (HLA) typing of potential donors. (Efficiency) | FY 2021: $58.00 Target: $58.00 (Target Met) | $58.00 | $62.00 | +$4.00 |
| 5020.09: The number of adult volunteer potential donors of blood stem cells from under-represented racial and ethnic populations. (Outcome) | FY 2021: 3.9 million Target: 4.08 million (Target Not Met) | 4 million | 4.02 million | +0.02 million |

**Contracts Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 9 | 9 | 9 |
| **Average Award** | $5,475,000 | $5,475,000 | $5,475,000 |
| **Range of Awards** | $60,000-$21,600,000 | $60,000-$21,600,000 | $60,000 - $21,600,000 |

[307]This is a long-term measure. The next target will be set for FY 2025.
[308]This is a long-term measure. The next target will be set for FY 2025.

## National Hansen's Disease Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $13,165,000 | $13,706,000 | $13,706,000 | --- |
| **FTE** | 38 | 38 | 44 | +6 |

Authorizing Legislation: Public Health Service Act, Section 320, as amended by Public Law 105-78, Section 211

FY 2023 Authorization ..... Not Specified

Allocation Methods:
- Direct Federal/Intramural
- Contract

**Program Description and Accomplishments**

The National Hansen's Disease Program (NHDP) provides medical care, education, and research for Hansen's disease (HD, leprosy) and related conditions as authorized since 1917. Medical care includes providing direct patient care (diagnosis, treatment, and rehabilitation), HD drug regimens at no cost to patients, consultations, laboratory services, and outpatient referral services to any patient 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 indigent 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.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $13,646,000 |
| FY 2020 | $13,706,000 |
| FY 2021 Final | $13,165,000 |
| FY 2022 CR | $13,706,000 |
| FY 2023 President's Budget | $13,706,000 |

**Budget Request**

The FY 2023 Budget Request for the National Hansen's Disease Program of $13.7 million is equal to the FY 2022 Continuing Resolution 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 fund eleven 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 FY 2023 request will allow the NHDP to expand and enhance outreach and training activities to providers to improve early diagnosis and treatment to reduce permanent disability in patients.

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

**Outputs and Outcomes Table**

| Measure | Year and Most Recent Result/ Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 5050.01 Number of health care providers who have received training from NHDP (Output) | FY 2021: 1037<br>Target: 350<br>(Target Met) | 500 | 600 | +100 |
| 5050.02 Number of human tissue samples on which clinically diagnostic Polymerase Chain Reactions were performed (Output) | FY 2021: 235<br>Target: Not Defined<br>(Historical Actual) | 200 | 200 | Maintain |
| 3.II.B.1 Number of reagent-grade leprosy bacilli packages provided to research scientists outside of NHDP (Output) | FY 2021: 32<br>Target: Not Defined<br>(Historical Actual) | 12 | 12 | Maintain |

In FY 2021, NHDP filled the new role of Outreach and Education Coordinator. This role will increase HD outreach and education efforts to both the medical provider community and the general public through the use of increased virtual training, and an enhanced learning management system. Due to COVID-19 and the imposed travel restrictions, NHDP's traditional forms of outreach and education were less effective, and therefore target numbers were not met for FY 2020 and FY 2021.

Beginning in 2017, NHDP started conducting 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.

The request will allow NHDP to continue support 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.

## National Hansen's Disease Program – Buildings and Facilities

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $122,000 | $122,000 | $122,000 | --- |
| **FTE** | --- | --- | --- | --- |

Authorizing Legislation: Public Health Service Act, Sections 320 and 321(a)

FY 2023 Authorization ..... Not Specified

Allocation Method ..... Direct Federal

**Program Description and Accomplishments**

This activity provides for facility related expenses for the buildings of the Gillis W. Long Hansen's Disease Center in the vicinity of Baton Rouge, Louisiana, to eliminate deficiencies according to applicable laws, and in keeping with accepted standards of safety, comfort, human dignity, efficiency, and effectiveness.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $122,000 |
| FY 2020 | $122,000 |
| FY 2021 Final | $122,000 |
| FY 2022 CR | $122,000 |
| FY 2023 President's Budget | $122,000 |

**Budget Request**

The FY 2023 Budget Request for the National Hansen's Disease Program - Buildings and Facilities of $122,000 is equal to the FY 2022 Continuing Resolution level. The request will facilitate the upgrade to NHDP's Laboratory Research Branch (LRB) facilities. The Program is currently working with GSA to procure a complete program of requirements necessary to relocate its LRB off the campus of the Louisiana State University where it has resided since 1992. In FY 2023, HRSA operations that remain at Carville are solely for the Museum.

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.

## Payment to Hawaii

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $1,851,000 | $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 2023 Authorization ..... Not Specified

Allocation Method ..... Direct Federal

**Program Description and Accomplishments**

Payments are made to the State of Hawaii for the medical care and treatment of persons with Hansen's disease in its hospital and clinic facilities at Kalaupapa, Molokai, and Honolulu. Expenses above the level of the Federal funds appropriated for the support of medical care are borne by the State of Hawaii.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $1,849,000 |
| FY 2020 | $1,857,000 |
| FY 2021 Final | $1,851,000 |
| FY 2022 CR | $1,857,000 |
| FY 2023 President's Budget | $1,857,000 |

**Budget Request**

The FY 2023 Budget Request for the National Hansen's Disease Program – Payment to Hawaii of $1.9 million is equal to the FY 2022 Continuing Resolution level. This request supports the payment made to the State of Hawaii for the medical care and treatment of persons with Hansen's disease.

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.

# Rural Health Policy

# TAB

# FEDERAL OFFICE OF RURAL HEALTH POLICY

## Rural Health Policy Development

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $11,043,000 | $11,076,000 | $11,076,000 | --- |
| **FTE** | 3 | 3 | 3 | --- |

Authorizing Legislation: Social Security Act, Section 711

FY 2023 Authorization ..... Not Specified

Allocation Method .....Competitive Cooperative Agreements

**Program Description and Accomplishments**

The Federal Office of Rural Health Policy (FORHP) is charged with advising the HHS Secretary on how rural health care is affected by current policies as well as proposed statutory, regulatory, administrative, and budgetary changes in the Medicare, Medicaid and other key HHS programs. The authorizing legislation requires FORHP to advise on: (1) the financial viability of small rural hospitals; (2) the ability of rural areas (particularly rural hospitals) to attract and retain physicians and other health professionals; and (3) access to and quality of health care in rural areas. FORHP is also charged with overseeing compliance, per the requirements of section 1102(b) of the Social Security Act, related to assessing the impact of key regulations affecting a substantial number of small rural hospitals. Rural Health Policy Development funds a number of programs to carry out these advisory and compliance roles, including supporting clearinghouses for collecting and disseminating information on rural health care issues, promising approaches to improving and enhancing health care delivery in rural communities, and policy-relevant research findings addressing rural health care delivery.

FORHP provides funding for the only Federal research programs specifically designed to provide publically available, policy relevant studies on rural health issues: The Rural Health Research Center Program, the Rapid Response Rural Data Analysis and Issue Specific Research Studies Program, and the Rural Health Research Dissemination Program.

The Rural Health Research Center (RHRC) Program funds eight core research centers to conduct policy-oriented health services research. The RHRCs produce policy briefs and peer-reviewed journal manuscripts and make their publications available to policy makers and other rural stakeholders at 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 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 substance use, access to care and health equity.

In FY 2021, these Federally-funded research programs conducted and disseminated 77 research reports, including policy briefs posted on the Rural Health Research Gateway website and manuscripts published in peer-reviewed journals.

The National Rural Health Information Clearinghouse Program, currently awarded to the Rural Health Information Hub, serves as a clearinghouse for information on rural health, including HRSA's rural health programs, for residents of rural areas in the United States and other rural health stakeholders.

Rural Health Policy Development also supports the staffing for the National Advisory Committee on Rural Health and Human Services (NACRHHS), which advises the HHS Secretary on rural health and human service programs and policies, produces policy briefs, and makes recommendations on emerging rural policy issues.

In addition, FORHP continues to monitor and track the number of rural hospitals 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 December 31, 2021, 137 rural hospitals have closed. FORHP has funded a number of grants that focus on addressing hospital closures, particularly mitigating the loss of services due to hospitals closing or facing financial distress.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $9,284,000 |
| FY 2020 | $10,351,000 |
| FY 2021 Final | $11,043,000 |
| FY 2022 CR | $11,076,000 |
| FY 2023 President's Budget | $11,076,000 |

**Budget Request**

The FY 2023 Budget Request for Rural Health Policy Development of $11.1 million is equal to the FY 2022 Continuing Resolution level.

This request would allow HRSA to continue funding the following: Rural Health Research Center Program; Rapid Response Rural Data Analysis and Issue Specific Rural Research Studies Program; Rural Health Research Dissemination Program; National Rural Health Information Clearinghouse Program; National Rural Health Policy, Community, and Collaboration 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.

**Outputs and Outcomes Tables**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 6010.01 Conduct and disseminate policy relevant research reports on rural health issues. (Output) | FY 2021: 77<br>Target:43<br>(Target Exceeded) | 47 | 47 | Maintain |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 16 | 16 | 16 |
| **Average Award** | $874,287 | $874,287 | $874,287 |
| **Range of Awards** | $100,000 - 2,960,221 | $100,000 - 2,960,221 | $100,000 - $2,960,221 |

## Rural Health Care Services Outreach, Network and Quality Improvement Grants

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $82,153,000 | $82,500,000 | $90,000,000 | +$7,500,000 |
| **FTE** | 10 | 10 | 10 | --- |

Authorizing Legislation: Public Health Service Act, Section 330A, as amended by Public Law 110-355, Section 4 and Social Security Act, Section 711

FY 2023 Authorization .....$79,500,000

Allocation Method .....Competitive Grants and Cooperative Agreement

**Program Description and Accomplishments**

The Rural Health Care Services Outreach, Network and Quality Improvement Grants (Outreach programs) improve rural community health by focusing on quality improvement, increasing health care access, coordination of care, and integration of services.

Outreach grant programs support collaborative models to deliver basic health care services to rural areas and are uniquely designed to meet rural needs. The grants allow rural communities to compete for funding against other rural communities, rather than competing against larger metropolitan communities with greater resources. The Outreach programs are among the only non-categorical grants within HHS, allowing grantees to determine the best ways to meet local needs. This flexibility responds to the unique health care challenges in rural communities and enables communities to determine the best approaches for addressing needs.

- Outreach Service Grants focus on improving access to health care in rural communities through community coalitions and evidence based and promising practice models. These grants focus on disease prevention, health promotion, and can support the expansion of services around primary care, opioid use disorder treatment and prevention, behavioral health, and oral health care. HRSA will support 61 continuing awards in FY 2023.

- Rural Network Development Grants support formalized partnerships among health care providers and social and community service organizations collaborating to improve access and enhance the quality of healthcare in rural areas. The program focuses on demonstrating improved health outcomes resulting from network collaboration, as well as positioning healthcare networks and their products and services to be sustainable as the health care landscape continues to evolve. Grantees under this program are likely to focus on improving health outcomes, enhancing health care quality, and increasing services provided by the network. HRSA will make 44 new awards in FY 2023.

- Network Planning Grants assist in the development of integrated healthcare networks to address local health care challenges. The Network Planning program provides an opportunity for grantees to work on priority and emerging local public health issues, such as care coordination, patient engagement, rural hospital closure/conversion, telehealth, mental health, and substance use (particularly opioid use disorder). HRSA will make 20 new awards in FY 2023.

- 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 40 continuing awards in FY 2023.

- 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 new awards in FY 2023.

- Delta Region Community Health Systems Development Program helps rural communities address their health care needs in a targeted manner and assists small rural hospitals and clinics improve their financial and operational performance. The program also provides resources to help rural communities develop partnerships and jointly address health problems that affect the Delta region. HRSA will support 20 continuing communities and 10 new communities in FY 2023 under one grantee. HRSA runs this program in coordination with the Delta Regional Authority and will continue to support the Delta Region Community Health Systems Development award in FY 2023.

- 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. The goals of the program is to 1) enhance integrated systems to collaborate and share data among member organizations; 2) develop effective care coordination workforce to meet needs within the rural communities; 3) improve access, delivery, and quality of services and overall patients' health outcomes; and 4) increase program financial sustainability. HRSA will make 10 new awards in FY 2023.

- Rural Maternity and Obstetrics Management Strategies (RMOMS) grants improve access and continuity of maternal and obstetrics care in rural communities. In FY 2019, HRSA

created RMOMS in response to research by the University of Minnesota that revealed a decreasing availability of obstetric units in rural areas.[309] RMOMS goals include:

(1) improve maternal and neonatal outcomes within a rural region;
(2) develop a sustainable network approach to increase the delivery and access of preconception, pregnancy, labor and delivery, and postpartum services;
(3) develop a safe delivery environment with the support and access to specialty care for perinatal women and infants; and
(4) develop sustainable financing models for the provision of maternal and obstetrics care in rural hospitals and communities.

As part of an HHS-wide initiative to improve maternal health, HRSA will support 3 continuing awards and make additional 7 new awards in FY 2023.

The Outreach programs continue to conduct program evaluations and build evidence-based models for new ways to improve health care in rural communities. Evaluations focus on measuring program impact on the health status of rural residents with chronic conditions and economic impact of the Federal investment in rural communities. Grantees use the Rural Health Information (RHI) Hub's Economic Impact Analysis[310] tool to assess the economic impact of Federal investments. The tool translates project impacts into community-wide benefits, such as number of jobs created, new spending, and impacts of new and expanded services.

Grantees are also required to demonstrate program impact through outcome-focused measures. Grantees track and submit to HRSA baseline data throughout their project periods and implement programs that are adapted from promising practices or evidence-based models. The programs support innovative models that offer rural communities the tools and resources to enhance health care services and ease the transition to health care models focusing on improved quality and value.

While making the initial Federal investment in a rural area, each of the grant programs expects the communities to continue providing the services at the conclusion of the grant funding. As each project periods end, the Outreach programs continually assess program sustainability. While sustainability rates may vary across grantee cohorts, HRSA expects the majority of projects to continue after Federal funding. Across the investments made in the Outreach programs, findings and key lessons learned from evaluations and case studies are gathered and made available on the RHI Hub's Community Health Gateway[311] so that rural communities from across the country can benefit from Outreach program investments and results. Grant funds are also used to support the technical assistance for grantees to ensure successful implementation of their programs and evaluation to demonstrate outcomes of the program.

[309] 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
[310] https://www.ruralhealthinfo.org/econtool
[311] https://www.ruralhealthinfo.org/community-health

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $77,500,000 |
| FY 2020 | $79,500,000 |
| FY 2021 Final | $82,153,000 |
| FY 2022 CR | $82,500,000 |
| FY 2023 President's Budget | $90,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Rural Health Care Services Outreach, Network and Quality Improvement Grants programs of $90.0 million is $7.5 million above the FY 2022 Continuing Resolution level. This request will support the continuation of 104 existing grantees, and 94 new competitive grants that will positively affect health care service delivery for over 516,000 people. As part of an HHS-wide initiative to improve maternal health, the Budget includes an additional $5.0 million to support a cohort of 7 new grants for the RMOMS program. This investment will help address unmet needs for rural mothers, 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.

**Outputs and Outcomes Table**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 6020.01 Track number of unique individuals who received direct services through FORHP Outreach grants, subject to availability of resources. (Output) | FY 2020: 474,863 Target: 200,000 (Target Exceeded) | 430,000 | 516,000 | +86,000 |

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 6020.02 Percent of Outreach Authority grantees that will continue to offer services after the Federal grant funding ends. (Output) | FY 2020: 100%[312] Target:75% (Target Exceeded) | 75% | 80% | +5 percentage points |
| 6020.03 Percentage of grantees that showed improvement in one or more clinical quality measure (Outcome) | FY 2020: Results Expected July 31, 2022 | Not Defined | Not Defined | Not Defined |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 188 | 194 | 198 |
| **Average Award[313]** | $290,820 | $346,307 | $364,818 |
| **Range of Awards** | $100,000 - $10,000,000[314] | $100,000 - $12,000,000[315] | $100,000 - $12,000,000[316] |

312Outreach programs have varying three-year project periods. When sustainability data is captured at the end of a program project period, sustainability rates may vary based on the nature of the program ending.

[313]Average award amount does not include the Delta Region Community Health Systems Development Cooperative Agreement, which is $10.0 million in and FY 2021 and $12.0 million in FY2022 and FY 2023

[314] This represents one cooperative agreement worth up to $10.0 million for the Delta Region Community Health Systems Development Cooperative Agreement.

[315] This represents one cooperative agreement worth up to $12.0 million for the Delta Region Community Health Systems Development Cooperative Agreement.

[316] This represents one cooperative agreement worth up to $12.0 million for the Delta Region Community Health Systems Development Cooperative Agreement.

## Rural Hospital Flexibility Grants

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $55,442,000 | $55,609,000 | $57,509,000 | +$1,900,000 |
| **FTE** | 1 | 1 | 3 | +2 |

Authorizing Legislation: Social Security Act, Section 1820(j), as amended by Public Law 105-33, Section 4201(a), and Public Law 108-173, Section 405 (f), as amended by Section 121, Public Law 110-275; Social Security Act, Section 711

FY 2023 Authorization .....Expired

Allocation Method ..... Competitive Grants and Cooperative Agreements

**Program Description and Accomplishments**

The Rural Hospital Flexibility Grants are offered through three grant programs:

- Medicare Rural Hospital Flexibility Grant (Flex) Program supports a partnership between 45 states and more than 1,300 Critical Access Hospitals (CAHs) to work on quality and performance improvement activities, as well as help eligible rural hospitals convert to CAH status and enhance CAH-related emergency medical services. The Flex Program's goal is to help CAHs maintain high quality and economically viable facilities to ensure that rural community residents, particularly Medicare beneficiaries, have access to high-quality health care services. States use Flex resources to address identified CAH needs and to achieve improved and measurable outcomes in each selected program area. With FY 2023 funds, HRSA will continue to support a second year of a two-year initiative supporting emergency medical services (EMS) across six states and focusing on quality and operational improvement initiatives. Funding supports technical assistance and data analysis activities to build the capacity of states and hospitals to carryout quality and performance improvement areas of need in meeting the goals of this program.

  The Flex Program plays a key role in ensuring that CAHs are aligned with certain Medicare Program quality initiatives. All prospective payment system hospitals (PPS) are required to submit quality data to the Centers for Medicare & Medicaid Services (CMS) to receive a full Medicare payment update. While not subject to this CMS requirement, CAHs, through this program, can elect to submit quality data to CMS to demonstrate areas of high quality while also identifying areas for improvement. This provides an avenue for ensuring that CAH quality efforts are aligned with broader Medicare quality initiatives. HRSA continues strategic planning efforts for the future direction of the Medicare Beneficiary Quality Improvement Project to ensure it aligns with hospital priorities in providing high quality care, and in FY 2022, is running a quality improvement initiative encourage peer learning on quality priorities.

State Flex grantees adjusted their activities, moved trainings online, and adjusted topics based on the emerging needs of hospitals given the impacts on the pandemic. Given the focus of hospitals during the pandemic, the results below show a decrease in the percent of hospitals showing improvement as hospitals focused on pandemic related care and not on planned grant improvement initiatives. The participation in CAHs in the Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) patient experience remained high in spite of the pandemic. Given the focus of hospitals on continued pandemic response, the target for FY 2023 has been adjusted to reflect this change.

- Small Rural Hospital Improvement Program (SHIP) provides support to rural hospitals with fewer than 50 beds to enhance their administrative capabilities in meeting information technology and reporting requirements under value-based care through awards to 46 states with eligible hospitals. SHIP provides funding for equipment and training to upgrade billing requirements, such as incorporating new ICD-10 standards, and for software, that captures patient satisfaction data.

- 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 best serving veterans. HRSA collaborates with the Veteran's Health Administration (VHA) Office of Rural Health to connect the state level grantees with VHA knowledge and expertise.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $53,223,000 |
| FY 2020 | $53,609,000 |
| FY 2021 Final | $55,442,000 |
| FY 2022 CR | $55,609,000 |
| FY 2023 President's Budget | $57,509,000 |

**Budget Request**

The FY 2023 Budget Request for the Rural Hospital Flexibility grant program of $57.5 million is $1.9 million above the FY 2022 Continuing Resolution level. This request will increase support to states for the Medicare Rural Hospital Flexibility Grant and support the continued efforts for the Small Rural Hospital Improvement Grant and the Rural Veterans Health Access Program.

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

**Outputs and Outcomes Table**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/-FY 2022 |
|---|---|---|---|---|
| 30.V.B.6 Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (Output) | FY 2020: 89.8%<br>Target: 70%<br>(Target Exceeded) | 70% | 71% | +1 percentage point |
| 6030.01 Percentage of CAHs participating in one or more Flex-funded required quality improvement initiatives that showed improvement in one or more specified quality domains. (Outcome and Developmental) | FY 2020: 61.1%<br>Target: 70%<br>(Target Not Met) | 70% | 75%[317] | +5 percentage points |
| 6030.02 Percentage of CAHs participating in one or more Flex-funded optional quality improvement initiatives that showed improvement in one or more specified quality domains. (Outcome and Developmental) | FY 2020: 35.2%<br>Target: 40%<br>(Target Not Met) | 50% | 55%[318] | +5 percentage points |

[317] The rural hospitals supported through this grant are targeted through state grant funding for quality improvement initiatives, and recent program trends indicate results lower than the target, given the factors within the hospital that impact their participation in quality improvement initiatives.

[318] The rural hospitals supported through this grant are targeted through state grant funding for quality improvement initiatives, and recent program trends indicate results lower than the target, given the factors within the hospital that impact their participation in quality improvement initiatives.

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 99 | 99 | 99 |
| **Average Award** | $565,000 | $565,000 | $585,000 |
| **Range of Awards** | $23,732-$945,000 | $23,732 - $945,000 | $38,508 - $1,565,992 |

## State Offices of Rural Health

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $12,462,000 | $12,500,000 | $12,5000,000 | --- |
| **FTE** | --- | --- | --- | --- |

Authorizing Legislation: State Offices of Rural Health Reauthorization Act of 2018, Section 338J of the Public Health Service Act (42 U.S.C. 254r)

FY 2023 Authorization ..... Expired

Allocation Method ..... Competitive Grants

**Program Description and Accomplishments**

This grant program provides funding to establish and maintain a State Office of Rural Health (SORH) within states to strengthen rural health care delivery systems. Every dollar of Federal support is matched by three state dollars. SORHs serve as focal points and clearinghouses for the collection and dissemination of information on rural health issues, research findings, innovative approaches, and best practices pertaining to the delivery of health care in rural areas.

As the state's rural institutional framework, SORHs help link rural communities with state and Federal resources to develop long-term solutions to rural health problems. SORHs form collaborative partnerships to better coordinate rural health activities, maximize limited resources, and avoid duplication of effort and activities. SORHs facilitate clinical placements through recruitment initiatives and help rural constituents meet recruitment challenges by sharing information. SORHs identify Federal, state, and nongovernmental programs and funding opportunities and provide technical assistance to public and nonprofit private entities regarding participation in rural health programs.

All SORHs played a role in supporting COVID-19 information sharing on public health information during the pandemic, and many SORHs were actively involved in state response efforts. The number of TA encounters and clients increased for the second year of the pandemic year as SORH continued to play a key role in sharing information and resources with rural communities during the pandemic.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $9,928,000 |
| FY 2020 | $12,500,000 |
| FY 2021 Final | $12,462,000 |
| FY 2022 CR | $12,500,000 |
| FY 2023 President's Budget | $12,500,000 |

**Budget Request**

The FY 2023 Budget Request for the State Offices of Rural Health program of $12.5 million is equal to the FY 2022 Continuing Resolution level. This request will continue to invest in the State Offices of Rural Health. With this level of funding, states will continue to support rural communities by connecting them with resources about funding opportunities, information on health care policy changes. 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.

**Outputs and Outcomes Tables**

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 31.V.B.5 Number of clinician placements facilitated by the SORHs through their recruitment initiatives (Output) | FY 2020: 1,952 Target:1,260 (Target Exceeded) | 1,300 | 1,350 | +50 |
| 6040.01 Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Output) | FY 2020: 93,118 Target:67,000 (Target Exceeded) | 68,371 | 69,054 | +683 |
| 6040.02 Number of clients (unduplicated) that received technical assistance directly from SORHs. (Output) | FY 2020: 26,712 Target:23,484 (Target Exceeded) | 23,611 | 23,729 | +118 |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 50 | 50 | 50 |
| **Average Award** | $229,270 | $229,270 | $229,270 |
| **Range of Awards** | $229,270 – $229,270 | $229,270 – $229,270 | $229,270 – $229,270 |

## Radiation Exposure Screening and Education Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $1,828,000 | $1,834,000 | $2,734,000 | +$900,000 |
| **FTE** | 1 | 1 | 1 | --- |

Authorizing Legislation: Public Health Service Act, Section 417C, as amended by Public Law 109-482, Sections 103 and 104

FY 2023 Authorization ..... Not Specified

Allocation Method ..... Competitive Grants

**Program Description and Accomplishments**

The Radiation Exposure Screening and Education Program (RESEP) provides grants to states, local governments, and appropriate health care organizations to support programs for cancer screening for individuals adversely affected by the mining, transport and processing of uranium and the testing of nuclear weapons for the Nation's weapons arsenal. The RESEP grantees also help clients with appropriate medical referrals, engage in public information development and dissemination, and facilitate claims documentation to aid individuals who may wish to apply for support under the Radiation Exposure Compensation Act. In FY 2020, the number of individuals screened at RESEP was 738.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $1,821,000 |
| FY 2020 | $1,834,000 |
| FY 2021 Final | $1,828,000 |
| FY 2022 CR | $1,834,000 |
| FY 2023 President's Budget | $2,734,000 |

**Budget Request**

The FY 2023 Budget Request for the Radiation Exposure and Screening Education program of $2.7 million is $0.9 million above the FY 2022 Continuing Resolution level. This request will expand current support activities such as: implementing cancer screening programs; developing education programs; disseminating information on radiogenic diseases and the importance of early detection; screening eligible individuals for cancer and other radiogenic diseases; providing appropriate referrals for medical treatment; and facilitating documentation of Radiation Exposure Compensation Act (RECA) claims.

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

**Outputs and Outcomes Tables**

RESEP is authorized under the Radiation Exposure Compensation Act (RECA), which is under the purview of the Department of Justice (DOJ). Per the Act, compensation claims processed by DOJ cannot be processed after July 11, 2022. Thus, HRSA has updated its performance measure targets in alignment with the statute.

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 32.1 Percent of RECA successful claimants screened at RESEP centers. (Outcome) | FY 2019: 21%<br>Target: 13%<br>(Target Exceeded) | Discontinued | Discontinued | N/A |
| 32.2 Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits. (Outcome) | FY 2019: 92%<br>Target: 77%<br>(Target Exceeded) | Discontinued | Discontinued | N/A |
| 6050.01 Total number of individuals screened per year. (Output) | FY 2020: 738<br>Target: 1,300<br>(Target Not Met) | 300 | 300 | Maintain |
| 6050.02 Percentage of successful RECA claims filed by RESEP clinics. (Outcome) | FY 2020: 76%<br>Target: Not Defined<br>(Historical Actual) | Not Defined | Not Defined | Not Defined |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 8 | 8 | 8 |
| **Average Award** | $205,913 | $205,913 | $312,594 |
| **Range of Awards** | $107,016 – 223,956 | $107,016 – 223,956 | $162,500 – 340,000 |

## Black Lung

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $11,565,000 | $11,500,000 | $12,190,000 | +$690,000 |
| **FTE** | --- | --- | --- | --- |

Authorizing Legislation: Federal Mine, Health, and Safety Act of 1977, Public Law 91-173, Section 427(a), as amended by Public Law 95-239, Section 9

FY 2023 Authorization .....$10,000,000

Allocation Method .....Competitive Grants and Cooperative Agreement

**Program Description and Accomplishments**

The Black Lung Clinics Program (BLCP) funds eligible public, private, and state entities that provide medical, outreach, educational, and benefits counseling services to active, inactive, retired, and disabled coal miners throughout the United States with the goal of reducing the morbidity and mortality associated with occupationally related coal-mine dust lung disease. To support the longer-term need faced by miners with severe disability due to black lung disease, grantees may also assist coal miners and their families in preparing the detailed application for Federal Black Lung benefits from the Department of Labor (DOL). In the recent years, most grantees have been able to use funds to upgrade equipment, enhance their workforce capacity and increase behavioral health screenings and care integration.

HRSA also funds the Black Lung Data and Resource Center (BLDRC), formerly known as Black Lung Centers for Excellence (BLCE), in supporting and strengthening the operations of BLCP awardees and their ability to examine and treat respiratory and pulmonary impairments in active and inactive coal miners. BLDRC supports BLCP awardees through improved data collection, analysis and expanding the body of knowledge of the health status and needs of coal miners nationally.

HRSA uses a patient-level data reporting system to better capture the number of coal miners served, and the number and types of medical and benefits counseling services received. HRSA can track a unique coal miner patient's disease and case progression to better assess the quality and breadth of services provided. The data collected also better aligns with other publically available data such as the National Institute for Occupational Safety and Health's (NIOSH) Coal Workers' Health Surveillance Program and Department of Labor's (DOL) Division of Coal Mine Workers' Compensation program.

HRSA continues to monitor black lung disease across its grantees and in coordination with NIOSH. This includes focusing on previously identified clusters of progressive massive fibrosis (PMF), which affects miners at a younger age and with greater clinical severity.

The impact of COVID-19 was felt within the Black Lung Clinic Program. The screening process that Black Lung Clinic grantees work through with their patients include aerosol generating activities, such as the pulmonary function test (PFT), that must be performed in person. The population served by these grantees, former and current black lung miners suffering from respiratory diseases, are also at very high risk for death or severe illness if exposed to COVID-19. All grantees made the necessary adjustments to adhere to recommended COVID-19 precautions, and several have taken the steps to install negative pressure rooms in their clinics. However, the steps necessary to minimize risk to patients and staff, decreased the number of patients that can be screened and treated. Consequently, grantees have seen lowered patient numbers at clinics and attendance at outreach events in the last year.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $10,921,000 |
| FY 2020 | $11,500,000 |
| FY 2021 Final | $11,565,000 |
| FY 2022 CR | $11,500,000 |
| FY 2023 President's Budget | $12,190,000 |

**Budget Request**

The FY 2023 Budget Request for the Black Lung program of $12.2 million is $0.7 million above the FY 2022 Continuing Resolution level. HRSA will continue to fund 15 Black Lung Clinic Program awards that provide primary care and other services to coal miners and a cooperative agreement with the Black Lung Data and Resource Center to enhance the quality of services provided by BLCP grantees. Increased funding will allow Black Lung Clinics to expand precautionary measures and screening activities given the unique health concerns of the population served by Black Lung Clinics and the effects of long COVID on patients with respiratory and pulmonary impairments. The Black Lung Data and Resource Center will work closely with HRSA to strengthen the quality of data collection and analysis.

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

**Outputs and Outcomes Tables**

HRSA has lowered the Program's FY 2023 performance measure targets in anticipation of the long-term impact of the coronavirus pandemic on Black Lung Clinics.

| Measure | Year and Most Recent Result /Target for Recent Result<br><br>(Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 33.I.A.2 Number of medical encounters from Black Lung each year. (Output) | FY 2020: 7,399<br>Target: 19,000<br>(Target Not Met) | 19,000 | 19,100 | +100 |
| 6060.01 Number of miners served each year. (Output) | FY 2020: 5,321<br>Target:13,800<br>(Target Not Met) | 12,000 | 12,100 | +100 |
| 6060.02 Number of miners screened each year. (Output) | FY 2020: 3,206<br>Target: Not Defined<br>(Historical Actual) | Not Defined | Not Defined | Not Defined |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 16 | 16 | 16 |
| **Average Award** | $711,168 | $711,168 | $754,293 |
| **Range of Awards** | $125,000 - $2,064,465 | $125,000 - $2,064,465 | $125,000 - $2,168,815 |

## Rural Residency Planning and Development

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $10,468,000 | $10,500,000 | $12,700,000 | +$2,200,000 |
| **FTE** | 2 | 2 | 2 | --- |

Authorizing Legislation: Social Security Act, Section 711

FY 2023 Authorization ..... Not Specified

Allocation Method .....Competitive Grants/Cooperative Agreement

**Program Description and Accomplishments**

The purpose of the Rural Residency Planning and Development Program is to expand the number of rural residency training programs and subsequently increase the number of physicians choosing to practice in rural areas. For the purpose of this program, rural residencies are allopathic and osteopathic physician residency training programs that primarily train in rural communities. This includes Rural Track Programs (RTPs), a specific model of rural residency training in which residents receive more than 50 percent of their training in a rural location after spending their initial year in a larger, often urban, residency setting. Research has shown that residents often practice near where they complete their residency training. RTP graduates are twice as likely to practice family medicine in a rural setting as compared to family medicine residents trained in an urban program. The Federal Office of Rural Health Policy collaborates with HRSA's Bureau of Health Workforce (BHW) to fund two programs:

- 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 performance period through public (i.e., Medicare or Medicaid), other state, or private funding. Recipients may use funds to cover planning and development costs incurred while achieving program accreditation through the Accreditation Council for Graduate Medical Education (ACGME).

- Rural Residency Planning and Development Technical Assistance (RRPD-TA) Program funds a cooperative agreement that serves as a technical assistance center to support RRPD recipients.

Since program inception in FY 2018, the RRPD Program has issued 46 awards across three cohorts of grantees as well as continuous funding for technical assistance under the RRPD-TA Program. As of February 2022, 25 RRPD recipients have received ACGME accreditation ahead of schedule.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $9,956,000 |
| FY 2020 | $10,000,000 |
| FY 2021 Final | $10,468,000 |
| FY 2022 CR | $10,500,000 |
| FY 2023 President's Budget | $12,700,000 |

**Budget Request**

The FY 2023 Budget Request for the Rural Residency Planning and Development program of $12.7 million is $2.2 million above the FY 2022 Continuing Resolution level. With increased funding in FY 2023, HRSA anticipates making 16 new awards under the RRPD Program and providing additional support for technical assistance under the RRPD-TA Program. 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 2023 competition. In December 2021, the Centers for Medicare & Medicaid Services (CMS) finalized regulations implementing policies based on legislative changes relative to Medicare graduate medical education (GME) for teaching hospitals provided by sections 126, 127, and 131 of the Consolidated Appropriations Act (CAA), 2021 (86 FR 73416). These policy changes may increase interest among rural hospitals in developing medical residency programs and increase the demand for RRPD grant awards.

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

**Outputs and Outcomes Table**

| Measure | Year and Most Recent Result/ Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 6080.01 Percentage of RRPD grantees who achieve ACGME accreditation by the end of the period of performance (Outcome) | FY 2022: Result Expected Dec 31, 2022 Target: Not Defined (Historical Actual) | Not Defined | Not Defined | Not Defined |

**Grant Awards Table**

| | FY 2021 Final[319] | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 11 | 14 | 16 |
| **Average Award** | $1,071,944 | $750,000 | $750,000 |
| **Range of Awards** | $741,760 - $4,300,000 | $750,000 - $750,000 | $750,000 - $750,000 |

[319] Data represents 10 RRPD awards and one RRPD-TA ($4,300,000) award that were fully funded at the beginning of the project period using FY 2021 multi-year funds.

## Rural Communities Opioid Response

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $109,670,000 | $110,000,000 | $165,000,000 | +$55,000,000 |
| **FTE** | 18 | 18 | 21 | +3 |

Authorizing Legislation: Social Security Act, Section 711

FY 2023 Authorization ..... Not Specified

Allocation Method .....Competitive Grants/Cooperative Agreement

**Program Description and Accomplishments**

The Rural Communities Opioid Response Program (RCORP) initiative aims to reduce the morbidity and mortality associated with substance use disorder (SUD), including opioid use disorder (OUD), in high 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 $404 million in grants and technical assistance to rural communities serving more than 1,500 counties across 47 states and two territories. The most recent performance measurement data reports shows that RCORP grantees active in FY 2020 provided direct SUD/OUD prevention, treatment, and recovery services to 2,079,373 rural residents, and ensured that 70,869 rural residents received medication assisted treatment (MAT) services. The RCORP initiative aligns with, and is a part of, the Department of Health and Human Services' (HHS) Overdose Prevention Strategy released in October 2021.

HRSA supports the following grant and cooperative agreement programs through RCORP:

- RCORP-Implementation provides multi-year support to rural communities to reduce the morbidity and mortality associated with SUD/OUD by establishing and/or expanding SUD/OUD services. The core/required activities of this program include, but are not limited to, naloxone training, distribution, and administration; identifying and screening at risk individuals for SUD/OUD and referring them to harm reduction services, treatment, and other support services; building the workforce and infrastructure to support evidence-based Medication-Assisted Treatment (MAT) provision; and expanding the peer recovery workforce and recovery support services. HRSA awarded 78 Implementation awards in FY 2021 and approximately 50 awards in FY 2022. HRSA anticipates recompeting RCORP-Implementation in FY 2025, when the FY 2022 cohort's period of performance has ended. HRSA does not anticipate recompeting this program in FY 2023.

- 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. HRSA will support the continuation of approximately 26 awards in FY 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. HRSA will recompete these cooperative agreements in FY 2023.

- RCORP-Behavioral Health Care Technical Assistance and RCORP-Evaluation provide technical assistance and evaluation support encompassing the entire RCORP initiative. HRSA will support the continuation of funding for one RCORP-initiative wide technical assistance HRSA will also recompete the RCORP initiative-wide evaluation cooperative agreement in FY 2023.

- 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 2023.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $120,000,000 |
| FY 2020 | $110,000,000 |
| FY 2021 Final | $109,670,000 |
| FY 2022 CR | $110,000,000 |
| FY 2023 President's Budget | $165,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Rural Community Opioid Response program of $165.0 million is $55.0 million above the FY 2022 Continuing Resolution level. This request will support the development and continuation of grant programs that provide needed behavioral health, including SUD/OUD, services to rural residents.

With the increased resources, HRSA will fund new awards allowing rural communities to respond to new and ongoing behavioral health needs of rural residents impacted by SUD/OUD. Programs will include support for approximately 30 rural communities to increase access to

medication-assisted treatment services and training for providers. HRSA will also address health equity through the RCORP initiative by funding approximately 20 awards through a tribal-focused behavioral health support program. HRSA will continue engaging with rural stakeholders and Federal partners to identify new and emerging areas to combatting this devastating epidemic and identifying additional priority areas.

This request will also enable HRSA to continue expanding RCORP's focus to include other, emergent behavioral health needs in rural communities. In FY 2022, HRSA piloted a new program targeting rural individuals with SUD/OUD and/or co-occurring disorders, in recognition of the fact that about half of those who experience an SUD during their lifetime will also experience a mental illness, and vice versa.[320]

In FY 2023, HRSA plans to continue funding the FY 2022 behavioral health pilot program, existing cooperative agreements that provide needed technical assistance, evaluation, and workforce development support, and the new medication-assisted treatment and tribal-focused grant programs.

Finally, this request will enable HRSA to strengthen RCORP's commitment to reducing disparities in health outcomes and access among vulnerable populations. 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 live in underserved communities that have been denied such treatment.

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

**Outputs and Outcomes Table**

| Measure | Year and Most Recent Result /Target for Recent Result | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 6090.01 Number of individuals screened for Substance Use Disorder (Output and Developmental) | FY 2020: 1,327,656 Target: Not Defined (Historical Actual) | Not Defined | Not Defined | Not Defined |
| 6090.02 Percentage of Rural Communities Opioid Response Program (RCORP) grantees with other sources of funding for sustainability (aside from RCORP grant) (Output and Developmental) | FY 2020: 97% Target: Not Defined (Historical Actual) | Not Defined | Not Defined | Not Defined |

[320] https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness

| Measure | Year and Most Recent Result /Target for Recent Result | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 6090.03 Number of providers who have provided Medication-Assisted Treatment (Output and Developmental) | FY 2020: 2,676 Target: Not Defined (Historical Actual) | 2,000 | 2,100 | +100 |

**Grant Awards Table**

| | FY 2021 Final [321] | FY 2022 Continuing Resolution[322] | FY 2023 President's Budget[323] |
|---|---|---|---|
| **Number of Awards** | 100 | 110 | 185 |
| **Average Award** | $1,048,650 | $916,818 | $812,162 |
| **Range of Awards** | $455,000 - $6,000,000 | $455,000 - $10,000,000 | $455,000 - $10,000,000 |

[321] Data represents awards funded using one-year funds appropriated in FY 2021. Awards made during the FY 2021 project period using multi-year funds are not included.
[322] Data represents awards funded using one-year funds appropriated in FY 2022. Awards made during the FY 2022 project period using multi-year funds are not included.
[323] Data represents awards funded using one-year funds appropriated in FY 2023. Awards made during the FY 2023 project period using multi-year funds are not included.

## Rural Health Clinic Initiative

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | --- | --- | $10,000,000 | +$10,000,000 |
| **FTE** | --- | --- | 1 | +1 |

Authorizing Legislation: Social Security Act, Section 711

FY 2023 Authorization ……Not Specified

Allocation Method .....Grants

**Program Description and Accomplishments**

The FY 2023 Rural Health Clinic Initiative will fund rural health clinics to provide behavioral health services, which are often different to access in rural areas. Funding will focus on rural communities that are not already served by Federally Qualified Health Centers (FQHC) providing behavioral and mental health services. RHCs are key safety net providers for rural residents and serve as a vital link to primary and ambulatory care services in the 712 counties where there is no FQHC.[324] This initiative will target areas where there are no other 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 mental and 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.[325] Over 13 percent of rural counties have no behavioral health care providers at all.[326] Rural suicide rates outpace urban suicide rates, and this difference has continued to widen over time.[327] 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.[1,328] More specifically:

- 406 RHCs are located within and serve 127 of the 192 majority-minority counties[329]:
    - 115 RHCs serve 45 of the 66 counties with populations that are majority Black
    - 272 RHCs serve 71 of the 99 counties with populations that are majority Hispanic

[324] HRSA analysis of 2021 CMS Provider of Services data
[325] Designated HPSA Quarterly Summary, 2020
[326] WWAMI, 2019
[327] https://www.cdc.gov/nchs/products/databriefs/db373.htm
[328] National Association of Rural Health Clinics
[329] HRSA Rural Health Clinic data

- 19 RHCs serve 11 of the 27 counties with populations that are majority Indigenous people

This Initiative will focus on the rural areas where there is the greatest need for essential services. RHCs are an underutilized critical health care resource for rural communities and have the capacity to fulfill a need if given targeted financial resources and technical assistance. This was recently demonstrated when HRSA made 791 COVID-19 capacity grants to RHCs to increase vaccine confidence in rural communities.

Less than 10 percent of RHCs employ either a social worker and/or psychologist. To address this inequity, RHCs funded through this program will be able to use 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 screenings, counseling, and therapy. This is of particular importance as the nation looks to rebound from the impacts of the COVID-19 pandemic. This program will afford RHCs the time build their mental and behavioral health practice and develop sustainable billing capacity to allow these activities to sustain beyond the three year grant program. This short-term investment will provide long-term impact, with sustainability a key tenet of this program.

**Funding Request**

| FY | Amount |
|---|---|
| FY 2019 | --- |
| FY 2020 | --- |
| FY 2021 Final | --- |
| FY 2022 CR | --- |
| FY 2023 President's Budget | $10,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Rural Health Clinic Initiative of $10.0 million is a new initiative and not included in the FY 2022 CR level. The request will fund approximately 18 RHCs at $500,000 per clinic and includes the cost of technical assistance, program evaluation, and other administrative costs. This funding will bring critical health care services to rural communities through RHCs, such as behavioral health services, where those services do not exist. This pilot initiative will result in an increase in the number of rural residents who receive behavioral and mental health services, the number of behavioral and mental health professionals in rural communities, and the number of RHCs that are able to bill for behavioral and mental health services.

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

**Outputs and Outcomes Tables**

The intended outcome of the Rural Health Clinic Initiative as a whole 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.

| Measure | Year and Most Recent Result /Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 6100.01 Number of individuals receiving mental health services (Developmental) | FY 2022: Result Expected Nov 30, 2023 Target: Not Defined (Pending) | Not Defined | Not Defined | Not Defined |
| 6100.02 Number of RHCs that offer new and/or expanded behavioral health services as a result of the program (Developmental) | FY 2022: Result Expected Nov 30, 2023 Target: Not Defined (Pending) | Not Defined | Not Defined | Not Defined |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | --- | --- | 18 |
| **Average Award** | --- | --- | $500,000 |
| **Range of Awards** | --- | --- | $500,000 - $500,000 |

# OTHER PROGRAMS TAB

# Program Management

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2022 President's Budget | FY 2022 +/- FY 2021 |
|---|---|---|---|---|
| **BA** | $154,834,000 | $155,300,000 | $168,971,000 | +$13,671,000 |
| **FTE** | 770 | 770 | 886 | +116 |

Authorizing Legislation: Public Health Service Act, Section 301

FY 2023 Authorization……...……Indefinite

Allocation Method……....Other

To achieve its mission, HRSA requires qualified staff to operate at maximum efficiency. One of HRSA's goals is to strengthen program management and operations by improving program customer satisfaction, increasing employee engagement, and implementing organizational improvements and innovative projects. Program Management is the primary means of support for staff, business operations and processes, information technology and overhead expenses such as rent, utilities, and miscellaneous charges for HRSA.

**Improving Processes and Business Operations**

HRSA continues to improve operational planning processes to foster cross-agency collaboration. HRSA has automated its contracting process to operate in a totally paperless environment, including the receipt of committed funds, the obligation of funds, and the generation and storage of contract documents. In FY 2021, HRSA enhanced IT end-user support by transitioning to Zoom for government, implementing Microsoft Teams, and completing a HRSA-wide desktop upgrade.

**Developing a 21st Century Workforce**

Numerous efforts are underway to enhance efficiency and effectiveness of the agency and to ensure the workforce is positioned to succeed in the 21st century. The hiring process has been streamlined, reducing the time it takes to complete the hiring cycle from recruitment to onboarding. HRSA streamlined several hiring processes, which significantly contributed to a 39% increase in new hires for 2021, outpacing separations by almost 3-to-1.

HRSA is focused on intense employee engagement improvement efforts. In 2021, HRSA led HHS in the Federal Employee Viewpoint Survey (EVS) employee engagement (83%) and satisfaction (82%) scores. 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. An agency-wide training on "Burnout and Stress Management" also helped equip supervisors with tools needed to support

their employees during the unprecedented COVID-19 crisis and associated stressors, including significantly increased workloads and the rapid shift to maximum telework.

**Sharing Quality Services**

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.

**Creating a Culture of Program Integrity**

Program Management also supports Enterprise Risk Management (ERM) activities that align with core principles and performance and strategic planning activities to reduce programmatic risk and improve performance. HRSA has established a HRSA-wide governance structure for enterprise-wide business operations and risk management activities to ensure a proactive and customer-focused suite of business operation services and risk management functions.

HRSA is currently engaged in ERM implementation strategies aligned with the revised OMB Circular A-123. Recent revisions to the circular's Appendices A and C, respectively, include prioritizing risk-based assessments and a focus on fraud identification and prevention activities. HRSA's ERM efforts include Governance and Process support for the promotion of a risk-aware organizational culture, the creation of a comprehensive view of risks to drive strategic decision making and the establishment and communication of risk appetite.

**Operations during the COVID-19 Pandemic**

During the COVID-19 pandemic, HRSA used its secure and mobile infrastructure to immediately transition to 100 percent telework for all staff. HRSA averages approximately 3,000 Virtual Private Network sessions per day. HRSA also implemented new technologies to quickly disperse Provider Relief funds to hospitals and healthcare providers on the front lines of the coronavirus response. Using enhanced technologies HRSA was able to reduce its grant award cycle from 90-120 days to 12-18 days for COVID-19 grants. In addition, HRSA enhanced its data warehouse functionality to highlight pandemic response and added testing data to help the public find Health Center COVID-19 testing sites.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $154,568,000 |
| FY 2020 | $155,300,000 |
| FY 2021 Final | $155,300,000 |
| FY 2022 CR | $155,300,000 |
| FY 2023 President's Budget | $168,971,000 |

**Budget Request**

The FY 2023 Budget Request of $168.9 million is $13.7 million above the FY 2022 Continuing Resolution level. This funding level supports program management activities to effectively and efficiently support HRSA's operations. An additional $13.7 million is requested to further support HRSA operations at an overall increased funding level of $1.3 billion over FY 2022 Continuing Resolution.

HRSA is committed to improving quality at a lower cost and improving the effectiveness and efficiency of government operations. HRSA supports telework by increasing the agency-wide utilization of web collaboration tools, which have led to greater business productivity.

HRSA also continues to enhance its program integrity activities by supporting analytical tools using HRSA's electronic grants system, program data, Office of Federal Assistance Management data sources, HHS sources, and government-wide sources. The goal is for HRSA to identify potential issues in the pre- and post-award processes and to address issues before they become audit findings. HRSA plans to focus on a risk-based approach to grantee monitoring using the information and corresponding analysis to help staff spend their time on grantees at risk of noncompliance. HRSA will also continue to provide training for grants management and program staff to support the alignment of program integrity initiatives with planning and performance activities. These efforts will enhance HRSA grantees awareness and ability to avoid potential financial integrity issues.

**IT Investments**
Significant progress has been made in a range of program management activities. Some highlights include:

- Improved HRSA IT security incident prevention, detection and response capabilities by expanding tools into our Sterling colocation center, continuing to enhance network traffic protections via the Palo Alto firewalls, including preventing SSNs from being sent in unencrypted email within the network and preventing it from leaving the HRSA network in clear text, establishing a test environment and playbooks for a new security orchestration tool, Phantom, which automates manual repeatable tasks for incident response staff, enabling them to focus on the more obscure anomalies and threat prevention, and deploying a robust code and open source scanning suite of tools to fill several gaps in vulnerability detection in the HRSA environment.

- Continue implementation of the Enterprise Architecture, Capital Planning and Investment Control (CPIC) and Enterprise Performance Life Cycle (EPLC) processes. Successfully transitioned the CPIC reporting from PROSIGHT to the FOLIO tool for all IT investments.

- Enhanced Electronic Handbooks (EHBs) to support rapid-release timelines for the COVID-19 supplemental funding awards to HRSA grantees by identifying areas for automation to expedite award processing. Improved EHB user's experience by implementing automated Chatbot User Interface to permit self-service by users. Since

implementation, over 2,000 account management requests have been handled via Chatbot.

- Continue modernizing the Data Warehouse by adding COVID-19 dashboards and other resources to highlight HRSA's pandemic response and COVID-19 testing data to find a Health Center to help the public find COVID-19 testing sites.

- Enhanced IT end-user support by transitioning our primary Virtual Meeting platform from Adobe Connect to Zoom for Government. This has provided a more up-to-date platform with additional features as well as a 5 year savings of over $6 million. Additionally implemented 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. MS Teams has become the primary collaboration platform at HRSA.

**Outcomes and Outputs Tables**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 35.VII.B.1. Ensure Critical Infrastructure Protection: Security Awareness Training (Output) | FY 2018: Full participation in Security and Privacy Awareness training by 100% of HRSA staff. specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff<br>(Target Met)<br>Target: Full participation in Security and Privacy Awareness training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff.<br>(Target Met) | 100% | 100% | 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 2018: 100%<br>Target: 100%<br>(Target Met) | 100% | 100% | N/A |

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 35.VII.B.2b Ensure Critical Infrastructure Protection: Security Cyber Sprint (Output) | FY 2018: Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 days<br>(Target Met)<br>Target: Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 days<br>(Target Met) | 30 days | 30 days | N/A |
| 35.VII.B.2c Ensure Critical Infrastructure Protection: Security Privacy Impact Assessment (PIA) or Privacy Threshold Assessment (PTA) (Output) | FY 2018: 90% of systems that required a PIA or a Privacy Threshold Assessment (PTA) were identified<br>(Target Met)<br>Target: Identify 90% of systems that require a PIA or a Privacy Threshold Assessment (PTA)<br>(Target Met) | 90% | 90% | N/A |
| 7010.02 Ensure Critical Infrastructure Protection: Security Phishing: Number of phishing campaigns completed (Output) | FY 2018: 17<br>Target: 6<br>(Target Exceeded) | 24 | 24 | --- |
| 7010.03 Enterprise Architecture: Percentage of IT systems reported to OMB with mapping to at least one HHS segment and domain (Output) | FY 2018: 90%<br>Target: 90%<br>(Target Met) | 90% | 90% | --- |

# Title X Family Planning Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $285,619,000 | $286,479,000 | $400,000,000 | +$113,521,000 |
| **FTE*** | 22 | 22 | 44 | +22 |

**Due to coding error, FTE is reporting lower than actual 38 FTE.*

Authorizing Legislation - Title X of the Public Health Service Act

FY 2023 Authorization…….…....Expired

Allocation Method:

- Direct Federal
- Contract
- Competitive Grant

**Program Description and Accomplishments**

The Title X Family Planning Program is the only federal grant program dedicated to providing individuals with comprehensive family planning and related health services. Enacted in 1970 as part of the Public Health Service Act, the mission of the Title X Program is to assist individuals and families in determining the number and spacing of children and to provide access to voluntary family planning methods, services, and information to all who want and need them. Title X authorizing legislation requires that projects provide a broad range of effective and acceptable family planning methods and services, including fertility awareness-based methods, infertility services and services for adolescents. By law, priority is given to persons from low-income families. The Title X Program is administered by the Office of Population Affairs (OPA) in the Office of the Assistant Secretary for Health (OASH).

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 services 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 services that are client-centered.

The Title X Program fulfills its mission through awarding competitive grants to public and private nonprofit organizations. According to the 2020 Family Planning Annual Report (FPAR) data (the most recent data available), in 2020 Title X services were provided through a nationwide network of 3,031 community-based sites that provided clinical and educational services to 1,536,743 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 331,749 unintended pregnancies. Title X also plays an essential role in helping to prevent and treat sexually transmitted diseases (STDs). In 2020, Title X service sites tested 679,023 female and male clients for chlamydia; 772,620 tests for gonorrhea; 325,813 tests for syphilis; and conducted 429,545 confidential tests for HIV. Of the confidential HIV tests performed, 1,359 were positive for HIV.

As of August 2020, there was at least one Title X services grantee in 44 of the 50 states, the District of Columbia, and in each of the U.S. territories, including the six Pacific jurisdictions. The current Title X grantees are in their third and final year of funding in FY 2021. In October 2021, OPA issued a funding opportunity announcement for a national competition to provide Title X services funding for up to five years. OPA also funded a new cohort of Title X grantees serving in areas with dire need for Title X services In FY 2022, OPA also made available COVID ARP funding to support one-time telehealth enhancement and expansion grants for Title X entities.

In FY 2022, the Title X program also launched FPAR 2.0 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.

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.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $286,479,000 |
| FY 2020 | $286,479,000 |
| FY 2021 Final | $285,619,000 |
| FY 2022 CR | $286,479,000 |
| FY 2023 President’s Budget | $400,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Title X Family Planning Program of $400.0 million is $113.52 million above the FY 2022 CR level. This request will fund family planning services for approximately four million individuals, with 90 percent having family incomes at or below 250

percent of the federal poverty level. Funds will also support demonstration grants to test innovative approaches to family planning service delivery that build on national efforts to achieve health equity and improve health outcomes for medically underserved populations. The FY 2023 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 2023, 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 health services.

**Outputs and Outcomes Tables**

**Long Term Objective:** Increase awareness of voluntary family planning resources and methods by providing Title X family planning services, education and research, with priority for services to low-income individuals.

*The targets for FY 2023 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.*

| Measure | Year and Most Recent Result /Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 Target +/- FY 2022 Target |
|---|---|---|---|---|
| 8000.01: Total number of unduplicated clients served in Title X service sites. *(Outcome)* | FY 2020: 1,536,743 Target: 4,018,000 (Target Not Met) | 3,500,000 | 4,250,000 | +750,000 |
| 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. *(Outcome)* | FY 2020: 87% Target: 90% (Target Not Met) | 90% | 90% | Maintain |

| Measure | Year and Most Recent Result /Target for Recent Result / (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 Target +/- FY 2022 Target |
|---|---|---|---|---|
| 8000.03: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals. *(Outcome)* | FY 2020: 331,749 Target: 905,000 (Target Not Met) | 830,000 | 870,000 | +40,000 |
| 8000.04: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24. *(Outcome)* | FY 2020: 264,100 Target: 1,195,000 (Target Not Met) | 900,000 | 920,000 | +20,000 |
| 8000.05: Increase the proportion of females' ages 15 – 24 attending Title X family planning clinics screened for Chlamydia infection. *(Outcome)* | FY 2020: 52% Target: 64.4% (Target Not Met) | 64.4% | 85% | +20.6 percentage points |

**Efficiency Measure**

| Measure | Year and Most Recent Result /Target for Recent Result / (Summary of Result) | FY 2022 Target | FY2023 Target | FY 2023 Target +/- FY 2022 Target |
|---|---|---|---|---|
| 8000.06: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)* | FY 2020: $394.00 Target: $336.69 (Target Not Met) | $371.00 | $371.00 | Maintain |

**Note:** 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. This resulted in Title X serving fewer clients and therefore not meeting the performance targets for 2019. OPA funded an additional 5 Title X grantees in FY 2020. In FY

2022, OPA will compete all Title X service delivery funds and anticipates increasing the total number of clients served.

**Grant Awards Tables**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 75 | 90 | 90 |
| **Average Award** | $2,650,150 | $2,650,150 | $3,000,000 |
| **Range of Awards** | $150,000 - $21,000,000 | $150,000 - $21,000,000 | $150,000 - $21,000,000 |

**Note:** OPA funded 90 Title X service grantees at the beginning of FY 2019. After implementation of the final rule in FY 2019, 19 grantees discontinued participating in the Title X Program, resulting in 71 Title X service grantees. OPA funded an additional 5 Title X grantees in FY 2020. In FY 2022, OPA will compete all Title X service delivery funds and anticipates funding additional grantees.

# Office of Pharmacy Affairs/340B Drug Pricing Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $10,207,000 | $10,238,000 | $17,238,000 | +$7,000,000 |
| **FTE** | 19 | 19 | 25 | +6 |

Authorizing Legislation: Public Health Service Act, Section 340B, as amended by Public Law 111-309, Section 204

FY 2023 Authorization…….…….…….…….....SSAN

Allocation Method……...…….……..….Contract

**Program Description and Accomplishments**

The Office of Pharmacy Affairs/340B Drug Pricing Program requires drug manufacturers to provide discounts on outpatient prescription drugs to certain safety net health care providers specified in statute, known as covered entities. These include Federally Qualified Health Centers, AIDS Drug Assistance Programs, children's hospitals, and eligible rural and disproportionate share hospitals. The 340B Program helps these safety net health care providers sustain and expand care for their patients.

The 340B ceiling price – the maximum amount a drug manufacturer can charge a covered entity for a given drug – is equal to the Average Manufacturer Price (AMP) minus the Unit Rebate Amount, both set by the Centers for Medicare & Medicaid Services (CMS). In 2020, total sales in the 340B Program were approximately $38 billion. Covered entities saved between 25 to 50 percent on what they would have otherwise paid for covered outpatient drugs. HRSA estimates 340B sales are approximately 7.2 percent of the total U.S. drug market.

HRSA prioritizes the integrity of the 340B Program and continually works to improve Program oversight. Examples of HRSA compliance activities include:

- Audits of covered entities to assure compliance within the Program: Since FY 2012, HRSA completed 1,720 covered entity audits, which included review of 23,278 offsite outpatient facilities and 40,811 contract pharmacies. Final audit results, including statuses of corrective actions, are available on HRSA's website;
- Review of every non-compliance allegation, including, if necessary, through on-site audits;
- Audits of manufacturers: Since FY 2015, HRSA finalized 31 audits of manufacturers which represents 4% of all participating manufacturer to ensure compliance with the one statutory obligation of manufacturers to sell at or below the 340B ceiling price;

- Assistance to covered entities that self-disclose compliance issues, including developing corrective action plans and working with affected manufacturers;
- Implementation of an Administrative Dispute Resolution process to address disputes between covered entities and manufacturers.
- Publication of verified ceiling prices of covered outpatient drugs available for purchase under the 340B Program on a quarterly basis in the 340B Office of Pharmacy Affairs Information System (OPAIS), Pricing Component.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $10,193,000 |
| FY 2020 | $10,238,000 |
| FY 2021 Final | $10,207,000 |
| FY 2022 CR | $10,238,000 |
| FY 2023 President's Budget | $17,238,000 |

**Budget Request**

The FY 2023 Budget Request for the Office of Pharmacy Affairs/340B Drug Pricing Program of $17.2 million is $7.0 million above the FY 2022 Continuing Resolution level. The requested amount will support implementation of 340B Program statutory obligations, oversight of participating manufacturers and covered entities, operational improvements, and increased efficiencies using information technology.

The $7 million increase will allow the 340B Program to continue to build on its program integrity efforts. These additional resources will support the implementation of an Administrative Dispute Resolution process to resolve (1) claims by covered entities of being overcharged for covered outpatient drugs by manufacturers and (2) claims by manufacturers, after the manufacturer has conducted an audit of a covered entity, of violation of the prohibition on diversion or duplicate discounts. This includes establishing an intake system and security controls for protecting proprietary information. Further, this additional funding will increase the audit and oversight functions of the program, including up to 30 additional audits.

HRSA is also proposing general rulemaking authority to strengthen the 340B Program. HRSA has exercised the limited regulatory authority that exists in the 340B statute (regarding ceiling price calculation, civil monetary penalties for manufacturers, and establishing an alternative dispute resolution process), but continues to confront significant operational challenges caused by the lack of broader authority for overseeing the program. General rulemaking authority for the 340B Program through a statutory amendment would allow HHS to set clear, enforceable standards for participation in all aspects of the 340B Program and help ensure compliance and transparency with 340B Program requirements.

The FY 2023 Budget Request also provides resources for the 340B Program to educate participating covered entities and prospective sites on compliance with statutory requirements. For participating covered entities, HRSA will continue to expand its oversight activities, producing a sentinel effect of increased compliance, as 340B data shows education based on

oversight measures reduces the risk of future compliance issues. In addition, the request supports facilitation of refunds and credits to entities that are overcharged by participating manufacturers as well as enhancements to the Pricing Component of the 340B OPAIS whereby covered entities access 340B ceiling price information via a secure website to provide transparency of data to authorized users.

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.

**Performance Measures**

HRSA measures 340B Program performance by two key metrics: numbers of covered entities and manufacturers audits. As of January 1, 2022, participation levels included 13,661 covered entities and 39,485 associated sites participating in the 340B Program, for a total of 53,146 registered sites.

**Outputs and Outcomes Tables**

| Measure | Year and Most Recent Result/ Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 5040.01: Covered Entity Audits Conducted (Output) | FY 2021: 200<br>Target: 200<br>(Target Met) | 200 | 225 | +25 |
| 5040.02: Manufacturer Audits Conducted (Output) | FY 2021: 5<br>Target: 5<br>(Target Met) | 5 | 10 | +5 |

**Contracts Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Contracts** | 3 | 3 | 3 |
| **Average Contract** | $3,000,000 | $3,000,000 | $4,800,000 |
| **Range of Contracts** | $1,000,000 - $4,000,000 | $1,000,000 - $4,000,000 | $4,000,000 - $5,000,000 |

# Office for the Advancement of Telehealth

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | $33,898,000 | $34,000,000 | $44,500,000 | +$10,500,000 |
| **FTE** | 8 | 8 | 9 | +1 |

Authorizing Legislation: Public Health Service Act, Section 330I, Section 330L, and 330N, and Social Security Act, Section 711.

FY 2023 Authorization (Section 330I and 330L).....$29,000,000

Allocation Method .....Competitive Grants/Cooperative Agreements/Contracts

**Program Description and Accomplishments**

The Office for the Advancement of Telehealth (OAT) promotes the use of telehealth technologies for health care delivery, education, and health information services. OAT administers the following 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. HRSA will support 30 continuation awards.

- Evidence-Based Direct to Consumer Telehealth Network Program increases access to healthcare services utilizing Direct to Consumer technologies. The EB-TNP for Direct to Consumer care is expected to enhance the existing health care infrastructure and increase 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 emphasis on data collection and research to further the telehealth evidence base separates this program from other Telehealth Network Grants funded by HRSA. HRSA will support 11 continuation awards and 12 new 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. 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. 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 Telehealth Network Grant Program awardees, helping them quantify and analyze their results and preparing summaries and publications of TNGP's clinical impact. The evidence-based telehealth research center 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. 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. HRSA will support 2 continuation 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. HRSA will support 9 continuation awards.

- Telehealth Data Collection Infrastructure will track funding, projects, and data for telehealth services within HRSA. This project will utilize usable data solutions, policies, and procedures to increase quality and standards of telehealth data. HRSA will support 1 contract award.

- Telehealth.HHS.gov Promotional Campaign will allow for continuation of rapid dissemination of critical telehealth resources for patients and providers through the Telehealth.HHS.gov website, which was initially funded through the CARES Act. HRSA continues to provide important up-to-date telehealth resources for the public and

has expanded the site to include a research section that links HHS-supported telehealth research studies that can serve as HHS's telehealth research gateway. The promotional campaign will support the continual utilization of the website as a key telehealth resource during the pandemic and beyond. HRSA will support 1 contract award.

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | $24,324,000 |
| FY 2020 | $29,000,000 |
| FY 2021 Final | $33,898,000 |
| FY 2022 CR | $34,000,000 |
| FY 2023 President's Budget | $44,500,000 |

**Budget Request**

The FY 2023 President's Budget provides $44.5 million for OAT, an increase of $10.5 million above FY 2022 Continuing Resolution. HRSA will continue to utilize telehealth to provide access to healthcare in rural and underserved areas. In FY 2023, HRSA will support the continuation of 70 existing grantees, and 12 new competitive grants to strengthen the networks and the technical assistance providers that support effective implementation of telehealth services. The requested increase funds 12 new competitive awards in the Evidence-Based Direct to Consumer Telehealth Network Program that increases access to healthcare services utilizing Direct to Consumer technologies. During the COVID-19 public health emergency, telehealth has been a reliable resource for providers to reach patients directly in their homes to ensure access to care and continuity of services. Telehealth has also been able to improve access to care for rural and urban underserved areas to help improve health equity. Funding for the Evidence-Based Direct to Consumer Telehealth Network Program focusing on Direct to Consumer telehealth services continues to build the evidence base for telehealth services, which will be used to inform best practices for telehealth use during emergency or non-emergency situations. The requested increase will also fund the continuation of the promotional contract for the Telehealth.hhs.gov website, which allow for the rapid dissemination of critical telehealth resources for patients, providers, researcher and stakeholders through the Telehealth.HHS.gov website. In addition, the request 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.

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

**Outputs and Outcomes Tables**

| Measure | Year and Most Recent Result/ Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 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 the TNGP grant (Outcome and Developmental) | FY 2020: 74[330] Target: Not Defined (Historical Actual) | Not Defined | TBD | TBD |
| 6070.02: Increase the number of telehealth encounters provided through the TNGP (Output and Developmental) | FY 2020: 31,637[331] Target: Not Defined (Historical Actual) | Not Defined | TBD | TBD |
| 6070.03: Increase the number of unduplicated patients receiving care via telehealth through the TNGP (Output and Developmental) | FY 2020: 5,918[332] Target: Not Defined (Historical Actual) | Not Defined | TBD | TBD |

[330] This data represents FY 20 reporting involving the ED TNGP and EB TNP programs which will be used to identify trending over a three-year period, as the measure is developmental. Once a trend is analyzed, appropriate targets will be identified. It is expected that with turnover in cohorts and focus areas, the target will need to be evaluated on an ongoing basis.
[331] Baseline data is being collected and will be used to identify trending over a three year period as the measure is developmental. Once the trend is analyzed, appropriate targets will be identified.
[332] Baseline data is being collected and will be used to identify trending over a three year period as the measure is developmental. Once the trend is analyzed, appropriate targets will be identified.

| Measure | Year and Most Recent Result/ Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 6070.04: Increase the number of clients receiving technical assistance from the Telehealth Resource Centers program (Output and Developmental) | FY 2020: 9,319[333] Target: Not Defined (Historical Actual) | Not Defined | TBD | TBD |

**Grant Awards Table**

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| **Number of Awards** | 70 | 70 | 82 |
| **Average Award** | $431,919 | $431,919 | $420,126 |
| **Range of Awards** | $162,927 - $3,250,000 | $162,927 - $3,250,000 | $250,000-$3,250,000 |

[333] Data reflects FY 2020 data collection of TA encounters and will be used to identify trending over a three year period as the measure is developmental. Once a trend is analyzed, appropriate targets will be identified.

# Nonrecurring Expenses Fund

Budget Summary

(Dollars in Thousands)

| | FY 2021[2] | FY 2022[3] | FY 2023[4] |
|---|---|---|---|
| **Notification[1]** | $3,700 | $11,790 | $41,940 |

**Authorizing Legislation:**

Authorization…….……Section 223 of Division G of the Consolidated Appropriations Act, 2008

Allocation Method…….……..Direct Federal, Competitive Contract

**Program Description and Accomplishments**

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and subsequent years into the NEF account. Congress authorized use of the funds for capital acquisitions necessary for the operation of the Department, specifically information technology (IT) and facilities infrastructure acquisitions. Since FY 2016, HRSA has requested $144.51 million from the NEF and received $81.90 million.

**Program Description**

In FY 2021 HRSA received $3.7 million in funding for three NEF projects. The first project was for modernizing the HRSA Data Warehouse by reengineering the back-end database architecture to provide a more modern, consolidated and streamlined database design. The second project is enhancing HRSA's Injury Compensation System (ICS) by modernizing its financial management capabilities and improving security, data protection, accuracy, efficiency, and internal controls within program operations. The final project will build enhanced data analytics capabilities that will provide HRSA more robust business intelligence to enhance program decision-making and reporting.

In FY 2022 HRSA received $11.79 million in funding for seven new projects, including the Rural Health Data Solution implementation with a two-phase implementation. Phase one consists of an assessment of the current state of rural health data within the Federal Office of Rural Health Policy (FORHP) and across HHS. Phase two begins in FY 2023 and will expand access to Advanced Data Analytics & Tools and build upon the existing Bureau of Health Workforce (BHW) datasets as well as analysis tools developed as part of the FY 2019 NEF project BHW Data Management Initiative. The other non-OIT specific project is the Budget Planning &

Development System, which will develop an automated platform for HRSA's budget planning and financial management processes and deliverables.

There are four OIT specific projects planned in FY 2022. The first project is the HRSA SharePoint Cloud Migration that will complete the migration of existing on-premise SharePoint platform to a secure and efficient cloud environment. The second project is the Enterprise Site Repositories (ESR) which will modernize and cloud-enable the existing legacy implementation of ESR as well as scale the adoption across multiple HRSA programs. The next project is the HRSA Data Warehouse (HDW) Data Enrichment & Security. With the help of NEF HRSA will further the modernization and enrichment of the HRSA Data Warehouse website with program data, usability improvements, and critical security upgrades. The final OIT specific project is Network Infrastructure Refresh, which will allow HRSA to upgrade its network infrastructure to ensure HRSA staff can securely and reliably connect to network resource, make phone calls, and utilize print services.

**Program Accomplishments**

NEF resources have allowed HRSA to make critical capital investments in information technology that modernize and secure HRSA's systems and improve the effectiveness of agency operations and the utilization of data across HRSA.

The BHW Management Information System Solution (BMISS) Platform Migration to Cloud was awarded in two phases (notification 6) using FY 2019 and FY 2020 NEF funding. The first phase allowed for the design and developed migration plan for the BMISS Platform, addressed how PII would be protected throughout migration, established and configured a Cloud infrastructure for the BMISS Platform that aligned with HRSA OIT provided Microsoft Azure environment, developed a Data Migration Strategy and Data Deployment Strategy, provided the methodology for moving data to the test environments and addressing how production data will be moved, and identified DevSecOps tools and processes to support development in the Cloud environment. Phase two allowed for the purchase of necessary software, virtual machines, Azure agents, and other required items. At the end of the project in January 2021, HRSA successfully migrated the BMISS Platform to the HRSA OIT provided Microsoft Azure environment.

With funds for the HRSA Cybersecurity and Data Warehouse Modernization (notification 5) project, HRSA replaced over 300 static legacy reports with ten interactive dashboards, giving the public easier ways to answer questions about HRSA programs. HRSA placed the dashboards on the new https://data.hrsa.gov website with a streamlined, mobile friendly, intuitive design. HRSA saw a 33% growth in return users after the site went live and a 162% increase in the number of files downloaded. HRSA OIT modernized the agency's outdated Geographic Information Systems (GIS) technology to the latest ESRI platform, re-designed several GIS applications, and added new self-service data analysis and mapping capabilities. The new platform enabled HRSA to rapidly develop new web-based GIS prototypes and applications for both internal and external uses. HRSA also implemented mobile-friendly versions of https://findahealthcenter.hrsa.gov and https://findhivcare.hrsa.gov, used over two million times annually by the public to find nearby health services.

HRSA Security Operations Upgrades (B1) (notification 6) has allowed HRSA to implement a comprehensive Trust but Verify vulnerability scanning and management program that allows all of HRSA's development teams to perform various levels of scanning while they code. This has greatly shortened the release cycle in support of agile development and produced secure code and the number of vulnerabilities discovered just prior to release have dropped significantly. Finally, NEF has allowed HRSA to modernize the Intrusion Detection/Prevention system (IDS/IPS) and the EDR system. The modernization provides for more automation, fewer false positives and a more robust layer of security.

HRSA continues to make critical upgrades to its cybersecurity infrastructure (Notifications #4A, 5, 6 and 7), including implementing new cybersecurity tools and enhanced authentication practices for HRSA systems users. These cybersecurity investments increase the effectiveness of HRSA's technology infrastructure safeguards that protect valuable data and information systems, while supporting standards and requirements set forth by various federal agencies such as the National Institute of Standards and Technology (NIST), Office of Management and Budget (OMB), and Homeland Security.

**Budget Allocation FY 2023**

In FY 2023 HRSA will receive $41.94 million in NEF funding for four projects:

- Tenant Improvement Expense for the National Hansen's Disease Program Lab Research: The lease for the program expires in 2022. In its preliminary work with GSA, NHDP learned that the present location is located within a 100-year flood plain. The funding for this project will help build laboratory and animal housing, cover costs associated with moving and recalibration of the laboratory equipment and movement of the research animals.

- Expanding Access to Advanced Data Analytic Tools: This project will improve HRSA's ability to provide Federal and non-Federal stakeholders improved access to valuable datasets created and managed by the National Center for Health Workforce Analysis.

- Data Solution – Phase Two: This project will implement the identified strategies and solutions from Phase One and will include a soft roll-out to include staff and public training and support for users of the system. The ultimate goal is to ensure that data reporting and sharing is accurate, high-quality, and non-duplicative and to increase ease of use by both public and federal users.

- Data Center and Security Infrastructure: HRSA will be replacing the existing underling physical server hardware that is in use by many applications at HRSA in Rockville, MD and Sterling, VA locations. This modernization will bring the HRSA systems up to the current technology.

**Budget Allocation FY 2022**

In FY 2022 HRSA received a total of $11.79 million for seven projects. These projects include:

- HRSA SharePoint Cloud Migration – Part 2: The existing on-premise SharePoint platform will move to a cloud-based platform consisting of SharePoint Online and Microsoft Teams. SharePoint modernization will enhance usability, collaboration and information exchange across the HRSA community.

- Budget Planning Development System) This project will develop an automated platform to extract financial data from the financial system of record, UFMS, and will provide HRSA with robust data and simplified tools to meet their budget and financial needs.

- Rural Health Data Solution and Implementation – Phase 2 ($2.4 million): This project will build and implement the identified solutions that were identified in Phase One. These solutions will address data presentation that will include both public and government facing dashboard and integrate with Tableau and GIS/geospatial mapping across all levels of rural health data. The project will conclude with a soft roll-out to include staff and public training and support for users of the system. The ultimate goal is to ensure that data reporting and sharing is accurate, high-quality, and non-duplicative and to increase ease of use by both public and federal users.

- Enterprise Site Repository (ESR): This project will modernize and cloud-enable the existing legacy implementation of ESR as well as scale the adoption across multiple HRSA programs.

- Expanding Access to Advanced Data Analytic Tools: This project will allow for more robust business intelligence to enhance program decision-making and reporting in support of the agency mission as well as broader usage of these national resources by external stakeholders.

- Network Infrastructure Refresh: This project will ensure HRSA staff is able securely and reliably connect to network resources, and to HRSA's network infrastructure that supports all HRSA-hosted applications.

- HRSA Data Warehouse: Data Enrichment and Security: This project will modernize and enrich the HRSA Data Warehouse website with additional program data, usability improvements, and important security upgrades. These enhancements will help HRSA tell a more complete story of the agency's impact in states and local communities and strengthen the security of the system.

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 October 22, 2020.

3 Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on June 17, 2021.

4 HHS has not yet notified for FY 2023.

# Supplementary Tables

TAB

# Object Class Tables

## DISCRETIONARY

*(dollars in thousands)*

| OBJECT CLASS | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 178,568 | 179,961 | 225,433 | +45,472 |
| Other than full-time permanent (11.3) | 5,297 | 5,419 | 5,642 | +223 |
| Other personnel compensation (11.5) | 4,950 | 5,622 | 5,849 | +227 |
| Military personnel (11.7) | 19,825 | 19,337 | 20,797 | +1,460 |
| **Special personnel services payments (11.8)** | 74 | 75 | 78 | +3 |
| Subtotal personnel compensation | **208,714** | **210,414** | **257,799** | **+47,385** |
| Civilian benefits (12.1) | 64,805 | 65,361 | 80,364 | +15,003 |
| Military benefits (12.2) | 2,179 | 2,138 | 2,480 | +342 |
| Benefits to former personnel (13.1) | 1,526.00 | 1,560.00 | 1,625 | +65 |
| **Total Pay Costs** | **277,224** | **279,473** | **342,268** | **+62,795** |
| Travel and transportation of persons (21.0) | 86 | 86 | 86 | - |
| Transportation of things (22.0) | 198 | 196 | 196 | - |
| Rental payments to GSA (23.1) | 19,934 | 19,622 | 19,578 | -44 |
| Rental payments to Others (23.2) | 114 | 114 | 114 | - |
| Communication, utilities, and misc. charges (23.3) | 2,843 | 1,860 | 1,860 | - |
| Commercial Reimbursement (23.6) | - | - | - | - |
| Network use data transmission service (23.8) | - | - | - | - |
| Printing and reproduction (24.0) | 170 | 170 | 170 | - |
| **Other Contractual Services: 25.0** | - | - | - | - |
| Advisory and assistance services (25.1) | 24,576 | 13,370 | 13,370 | - |
| Other services (25.2) | 252,292 | 278,777 | 274,795 | -3,982 |
| Purchase of goods/services from government acct (25.3) | 183,438 | 181,662 | 181,511 | -151 |
| Operation and maintenance of facilities (25.4) | 980 | 1,098 | 1,085 | -13 |
| Research and Development Contracts (25.5) | 49 | 49 | 49 | - |
| Medical care (25.6) | 3,431 | 3,431 | 2,388 | -1,043 |
| Operation and maintenance of equipment (25.7) | 3,893 | 3,740 | 3,740 | - |
| Subsistence and support of persons (25.8) | 53 | 53 | 53 | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | 615 | 614 | 614 | - |
| **Subtotal Other Contractual Services** | **469,327** | **482,794** | **477,605** | -5,189 |
| Equipment (31.0) | 9,632 | 9,622 | 9,621 | -1 |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | 6,333,317 | 6,305,367 | 7,525,795 | +1,220,428 |
| Insurance Claims and Indemnities (42.0) | 72,718 | 107,930 | 107,751 | - |
| **Total Non-Pay Costs** | **6,908,339** | **6,927,761** | **8,142,776** | **+1,215,015** |
| **Total Budget Authority by Object Class** | **7,185,563** | **7,207,234** | **8,485,044** | **+1,277,810** |

**PRIMARY HEALTH CARE**

**(***dollars in thousands)*

| Object Class | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 32,974 | 33,724 | 40,628 | +6,904 |
| Other than full-time permanent (11.3) | 643 | 658 | 685 | +27 |
| Other personnel compensation (11.5) | 874 | 895 | 932 | +37 |
| Military personnel (11.7) | 4,395 | 4,527 | 4,699 | +172 |
| Special personnel services payments (11.8) | - | - | - | 0 |
| **Subtotal personnel compensation** | **38,886** | **39,804** | **46,944** | **+7,140** |
| Civilian benefits (12.1) | 11,972 | 12,244 | 14,587 | +2,343 |
| Military benefits (12.2) | 382 | 393 | 409 | +16 |
| Benefits to former personnel (13.1) | - | - | - | 0 |
| **Total Pay Costs** | **51,240** | **52,441** | **61,940** | **+9,499** |
| Travel and transportation of persons (21.0) | 4 | 4 | 4 | - |
| Transportation of things (22.0) | 3 | 3 | 3 | - |
| Rental payments to GSA (23.1) | 2,785 | 2,785 | 2,785 | - |
| Rental payments to Others (23.2) | - | - | | - |
| Communication, utilities, and misc. charges (23.3) | 586 | 586 | 586 | - |
| 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) | 113,432 | 113,412 | 113,318 | -94 |
| Purchase of goods and services from government acct (25.3) | 40,837 | 40,837 | 40,838 | +1 |
| Operation and maintenance of facilities (25.4) | 202 | 202 | 202 | - |
| Research and Development Contracts (25.5) | | | - | - |
| Medical care (25.6) | | - | - | - |
| Operation and maintenance of equipment (25.7) | 737 | 737 | 737 | - |
| Subsistence and support of persons (25.8) | - | - | - | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | 2 | 2 | 2 | - |
| **Subtotal Other Contractual Services** | **155,210** | **155,190** | **155,097** | **-93** |
| Equipment (31.0) | 2,133 | 2,133 | 2,133 | - |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | 1,390,691 | 1,362,886 | 1,508,730 | +145,844 |
| Insurance Claims and Indemnities (42.0) | 72,551 | 107,744 | 107,744 | - |
| **Total Non-Pay Costs** | **1,623,963** | **1,631,331** | **1,777,082** | **+145,751** |
| **Total Budget Authority by Object Class** | **1,675,203** | **1,683,772** | **1,839,022** | **+155,250** |

## HEALTH WORKFORCE

**(***dollars in thousands)*

| Object Class | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 13,549 | 13,858 | 19,520 | +5,662 |
| Other than full-time permanent (11.3) | 477 | 488 | 508 | +20 |
| Other personnel compensation (11.5) | 305 | 911 | 944 | +33 |
| Military personnel (11.7) | 1,534 | 1,580 | 1,556 | -24 |
| Special personnel services payments (11.8) | - | - | - | - |
| **Subtotal personnel compensation** | **15,865** | **16,837** | **22,528** | **+5,691** |
| Civilian benefits (12.1) | 4,957 | 5,069 | 6,931 | +1,862 |
| Military benefits (12.2) | 153 | 158 | 194 | +36 |
| Benefits to former personnel (13.1) | - | - | - | - |
| **Total Pay Costs** | **20,975** | **22,064** | **29,653** | **+7,589** |
| Travel and transportation of persons (21.0) | 2 | 2 | 2 | - |
| Transportation of things (22.0) | | - | - | - |
| Rental payments to GSA (23.1) | 4,351 | 4,351 | 4,307 | -44 |
| Rental payments to Others (23.2) | - | - | - | - |
| Communication, utilities, and misc. charges (23.3) | 602 | 602 | 602 | - |
| Commercial Reimbursement (23.6) | - | - | - | - |
| Network use data transmission service (23.8) | - | - | - | - |
| Printing and reproduction (24.0) | - | - | - | - |
| **Other Contractual Services: 25.0** | - | - | - | - |
| Advisory and assistance services (25.1) | - | - | - | - |
| Other services (25.2) | 25,001 | 25,001 | 24,716 | -285 |
| Purchase of goods and services from government acct (25.3) | 32,749 | 32,749 | 32,597 | -152 |
| Operation and maintenance of facilities (25.4) | - | - | - | - |
| Research and Development Contracts (25.5) | - | - | - | - |
| Medical care (25.6) | - | - | - | - |
| Operation and maintenance of equipment (25.7) | 397 | 397 | 397 | - |
| Subsistence and support of persons (25.8) | - | - | - | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | 4 | 4 | 4 | - |
| **Subtotal Other Contractual Services** | **58,151** | **58,151** | **57,714** | **-437** |
| Equipment (31.0) | 1,030 | 1,030 | 1,030 | - |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | 1,135,220 | 1,137,806 | 1,526,576 | +388,770 |
| Insurance Claims and Indemnities (42.0) | | | - | - |
| **Total Non-Pay Costs** | **1,199,356** | **1,201,942** | **1,590,231** | **+388,289** |
| **Total Budget Authority by Object Class** | **1,220,331** | **1,224,006** | **1,619,884** | **+395,878** |

## MATERNAL AND CHILD HEALTH

**(***dollars in thousands)*

| Object Class | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 11,100 | 11,515 | 16,260 | +4,745 |
| Other than full-time permanent (11.3) | 288 | 296 | 307 | +11 |
| Other personnel compensation (11.5) | 233 | 242 | 252 | +10 |
| Military personnel (11.7) | 572 | 590 | 720 | +130 |
| Special personnel services payments (11.8) | - | - | - | - |
| **Subtotal personnel compensation** | **12,193** | **12,643** | **17,539** | **+4,896** |
| Civilian benefits (12.1) | 4,052 | 4,201 | 5,574 | +1,373 |
| Military benefits (12.2) | 48 | 50 | 89 | +39 |
| Benefits to former personnel (13.1) | - | - | - | - |
| **Total Pay Costs** | **16,293** | **16,894** | **23,202** | **+6,308** |
| Travel and transportation of persons (21.0) | - | - | | - |
| Transportation of things (22.0) | - | - | | - |
| Rental payments to GSA (23.1) | 3,718 | 4,745 | 4,745 | - |
| Rental payments to Others (23.2) | - | - | - | - |
| Communication, utilities, and misc. charges (23.3) | - | 48 | 48 | - |
| Commercial Reimbursement (23.6) | - | - | - | - |
| Network use data transmission service (23.8) | - | - | - | - |
| Printing and reproduction (24.0) | 15 | 15 | 15 | - |
| **Other Contractual Services: 25.0** | - | - | - | - |
| Advisory and assistance services (25.1) | 18,031 | 6,825 | 6,825 | - |
| Other services (25.2) | 8,374 | 9,718 | 9,718 | - |
| Purchase of goods and services from govt. acct (25.3) | 16,270 | 16,935 | 16,935 | - |
| Operation and maintenance of facilities (25.4) | - | - | - | - |
| Research and Development Contracts (25.5) | - | - | - | - |
| Medical care (25.6) | - | - | - | - |
| Operation and maintenance of equipment (25.7) | 557 | 557 | 557 | - |
| Subsistence and support of persons (25.8) | - | - | - | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | 6 | 6 | 6 | - |
| **Subtotal Other Contractual Services** | **43,238** | **34,041** | **34,041** | - |
| Equipment (31.0) | 1,525 | 1,525 | 1,525 | - |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | 932,413 | 942,862 | 1,209,354 | +266,492 |
| Insurance Claims and Indemnities (42.0) | - | - | - | - |
| **Total Non-Pay Costs** | **980,909** | **983,236** | **1,249,728** | **+266,492** |
| **Total Budget Authority by Object Class** | **997,202** | **1,000,130** | **1,272,930** | **+272,800** |

## HIV/AIDS

**(***dollars in thousands)*

| Object Class | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 19,164 | 19,600 | 25,134 | +5,534 |
| Other than full-time permanent (11.3) | 471 | 482 | 502 | +20 |
| Other personnel compensation (11.5) | 416 | 425 | 443 | +18 |
| Military personnel (11.7) | 3,681 | 3,792 | 4,164 | +372 |
| Special personnel services payments (11.8) | - | - | - | - |
| **Subtotal personnel compensation** | **23,732** | **24,299** | **30,243** | **+5,944** |
| Civilian benefits (12.1) | 6,918 | 7,075 | 8,835 | +1,760 |
| Military benefits (12.2) | 424 | 436 | 491 | +55 |
| Benefits to former personnel (13.1) | - | - | - | - |
| **Total Pay Costs** | **31,074** | **31,810** | **39,569** | **+7,759** |
| Travel and transportation of persons (21.0) | 1 | 1 | 1 | - |
| Transportation of things (22.0) | 9 | 9 | 9 | - |
| Rental payments to GSA (23.1) | 2,116 | 2,116 | 2,116 | - |
| Rental payments to Others (23.2) | - | - | - | - |
| Communication, utilities, and misc. charges (23.3) | 983 | - | - | - |
| 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) | 41,095 | 41,095 | 41,095 | - |
| Purchase of goods and services from govt. acct (25.3) | 65,304 | 65,304 | 65,304 | - |
| Operation and maintenance of facilities (25.4) | - | - | - | - |
| Research and Development Contracts (25.5) | - | - | - | - |
| Medical care (25.6) | - | - | - | - |
| Operation and maintenance of equipment (25.7) | 1,120 | 1,120 | 1,120 | - |
| Subsistence and support of persons (25.8) | - | - | - | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | 44 | 44 | 44 | - |
| **Subtotal Other Contractual Services** | **107,563** | **107,563** | **107,563** | **-** |
| Equipment (31.0) | 3,178 | 3,178 | 3,178 | - |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | 2,275,964 | 2,279,104 | 2,502,345 | +223,241 |
| Insurance Claims and Indemnities (42.0) | - | - | - | - |
| **Total Non-Pay Costs** | **2,389,814** | **2,391,971** | **2,615,212** | **+223,241** |
| **Total Budget Authority by Object Class** | **2,420,888** | **2,423,781** | **2,654,781** | **+231,000** |

## HEALTH SYSTEMS

**(***dollars in thousands)*

| Object Class | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 6,734 | 4,854 | 6,629 | +1,775 |
| Other than full-time permanent (11.3) | 139 | 142 | 148 | +6 |
| Other personnel compensation (11.5) | 217 | 189 | 197 | +8 |
| Military personnel (11.7) | 1,970 | 945 | 1,204 | +259 |
| Special personnel services payments (11.8) | - | - | - | - |
| **Subtotal personnel compensation** | **9,060** | **6,130** | **8,178** | **+2,048** |
| Civilian benefits (12.1) | 2,509 | 1,880 | 2,482 | +602 |
| Military benefits (12.2) | 208 | 108 | 187 | +79 |
| Benefits to former personnel (13.1) | | - | - | - |
| **Total Pay Costs** | **11,777** | **8,118** | **10,847** | **+2,729** |
| Travel and transportation of persons (21.0) | 52 | 52 | 52 | - |
| Transportation of things (22.0) | 57 | 55 | 55 | - |
| Rental payments to GSA (23.1) | 2,873 | 1,678 | 1,678 | - |
| Rental payments to Others (23.2) | 114 | 114 | 114 | - |
| Communication, utilities, and misc. charges (23.3) | 302 | 254 | 254 | - |
| 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) | 6 | 6 | 6 | - |
| Other services (25.2) | 34,607 | 63,732 | 63,175 | -557 |
| Purchase of goods and services from government acct (25.3) | 4,526 | 2,961 | 2,961 | - |
| Operation and maintenance of facilities (25.4) | 167 | 285 | 285 | - |
| Research and Development Contracts (25.5) | 49 | 49 | 49 | - |
| Medical care (25.6) | 3,431 | 3,431 | 2,388 | -1,043 |
| Operation and maintenance of equipment (25.7) | 243 | 192 | 192 | - |
| Subsistence and support of persons (25.8) | 53 | 53 | 53 | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | 307 | 306 | 306 | - |
| **Subtotal Other Contractual Services** | **43,389** | **71,015** | **69,415** | **-1,600** |
| Equipment (31.0) | 676 | 666 | 666 | - |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | 33,510 | 12,050 | 10,921 | -1,129 |
| Insurance Claims and Indemnities (42.0) | | 7 | 7 | - |
| **Total Non-Pay Costs** | **80,973** | **85,891** | **83,162** | **-2,729** |
| **Total Budget Authority by Object Class** | **92,750** | **94,009** | **94,009** | **-** |

## RURAL HEALTH

**(***dollars in thousands)*

| Object Class | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 4,315 | 3,615 | 4,438 | +823 |
| Other than full-time permanent (11.3) | 148 | 151 | 158 | +7 |
| Other personnel compensation (11.5) | 104 | 93 | 97 | +4 |
| Military personnel (11.7) | | - | - | - |
| Special personnel services payments (11.8) | - | - | - | - |
| **Subtotal personnel compensation** | **4,567** | **3,859** | **4,693** | +834 |
| Civilian benefits (12.1) | 1,594 | 1,343 | 1,624 | +281 |
| Military benefits (12.2) | | - | - | - |
| Benefits to former personnel (13.1) | - | - | - | - |
| **Total Pay Costs** | **6,161** | **5,202** | **6,317** | +1,115 |
| Travel and transportation of persons (21.0) | | - | - | - |
| Transportation of things (22.0) | | - | - | - |
| Rental payments to GSA (23.1) | 1,020 | 876 | 876 | - |
| 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) | 74 | 74 | 74 | - |
| Other services (25.2) | 11,092 | 9,731 | 9,731 | - |
| Purchase of goods and services from govt. acct (25.3) | 3,763 | 2,887 | 2,887 | - |
| Operation and maintenance of facilities (25.4) | - | - | - | - |
| Research and Development Contracts (25.5) | - | - | - | - |
| Medical care (25.6) | - | - | - | - |
| Operation and maintenance of equipment (25.7) | 538 | 436 | 436 | - |
| Subsistence and support of persons (25.8) | - | - | - | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | - | - | - | - |
| **Subtotal Other Contractual Services** | **15,467** | **13,128** | **13,128** | - |
| Equipment (31.0) | 86 | 86 | 86 | - |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | 271,897 | 276,227 | 353,302 | +77,075 |
| Insurance Claims and Indemnities (42.0) | - | - | - | - |
| **Total Non-Pay Costs** | **288,470** | **290,317** | **367,392** | **+77,075** |
| **Total Budget Authority by Object Class** | **294,631** | **295,519** | **373,709** | **+78,190** |

## PROGRAM MANAGEMENT

**(***dollars in thousands)*

| Object Class | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 84,275 | 86,192 | 102,685 | +16,493 |
| Other than full-time permanent (11.3) | 2,987 | 3,055 | 3,181 | +126 |
| Other personnel compensation (11.5) | 2,625 | 2,685 | 2,796 | +111 |
| Military personnel (11.7) | 6,337 | 6,528 | 6,914 | +386 |
| Special personnel services payments (11.8) | 74 | 75 | 78 | +3 |
| **Subtotal personnel compensation** | **96,298** | **98,535** | **115,654** | **+17,119** |
| Civilian benefits (12.1) | 30,481 | 31,174 | 36,773 | +5,599 |
| Military benefits (12.2) | 842 | 868 | 942 | +74 |
| Benefits to former personnel (13.1) | 1,526 | 1,560 | 1,625 | +65 |
| **Total Pay Costs** | **129,147** | **132,137** | **154,994** | **+22,857** |
| Travel and transportation of persons (21.0) | 11 | 11 | 11 | - |
| Transportation of things (22.0) | 33 | 33 | 33 | - |
| Rental payments to GSA (23.1) | 2,706 | 2,706 | 2,706 | - |
| Rental payments to Others (23.2) | - | - | - | - |
| Communication, utilities, and misc. charges (23.3) | 354 | 354 | 354 | - |
| Commercial Reimbursement (23.6) | - | - | - | - |
| Network use data transmission service (23.8) | - | - | - | - |
| Printing and reproduction (24.0) | 141 | 141 | 141 | - |
| **Other Contractual Services: 25.0** | - | - | - | - |
| Advisory and assistance services (25.1) | - | - | - | - |
| Other services (25.2) | 11,536 | 8,992 | | -8,992 |
| Purchase of goods and services from government acct (25.3) | 9,009 | 9,009 | 9,009 | - |
| Operation and maintenance of facilities (25.4) | 596 | 596 | 582 | -14 |
| Research and Development Contracts (25.5) | - | - | - | - |
| Medical care (25.6) | - | - | - | - |
| Operation and maintenance of equipment (25.7) | 138 | 138 | 138 | - |
| Subsistence and support of persons (25.8) | - | - | - | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | 219 | 219 | 219 | - |
| **Subtotal Other Contractual Services** | **21,498** | **18,954** | **9,948** | **-9,006** |
| Equipment (31.0) | 785 | 785 | 784 | -1 |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | - | - | - | - |
| Insurance Claims and Indemnities (42.0) | 159 | 179 | - | -179 |
| **Total Non-Pay Costs** | **25,687** | **23,163** | **13,977** | **-9,186** |
| **Total Budget Authority by Object Class** | **154,834** | **155,300** | **168,971** | **+13,671** |

## FAMILY PLANNING

**(***dollars in thousands)*

| Object Class | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 3,846 | 3,934 | 6,684 | +2,750 |
| Other than full-time permanent (11.3) | 144 | 147 | 153 | +6 |
| Other personnel compensation (11.5) | 136 | 140 | 145 | +5 |
| Military personnel (11.7) | 284 | 291 | 298 | +7 |
| Special personnel services payments (11.8) | - | - | - | - |
| **Subtotal personnel compensation** | **4,410** | **4,512** | **7,280** | **+2,768** |
| Civilian benefits (12.1) | 1,427 | 1,460 | 2,382 | +922 |
| Military benefits (12.2) | 19 | 19 | 20 | +1 |
| Benefits to former personnel (13.1) | | - | | - |
| **Total Pay Costs** | **5,856** | **5,991** | **9,682** | **+3,691** |
| Travel and transportation of persons (21.0) | 16 | 16 | 16 | - |
| Transportation of things (22.0) | 94 | 94 | 94 | - |
| Rental payments to GSA (23.1) | 53 | 53 | 53 | - |
| Rental payments to Others (23.2) | - | - | - | - |
| Communication, utilities, and misc. charges (23.3) | 16 | 16 | 16 | - |
| Commercial Reimbursement (23.6) | - | - | - | - |
| Network use data transmission service (23.8) | - | - | - | - |
| Printing and reproduction (24.0) | 14 | 14 | 14 | - |
| **Other Contractual Services: 25.0** | - | - | - | - |
| Advisory and assistance services (25.1) | 6,465 | 6,465 | 6,465 | - |
| Other services (25.2) | 345 | 345 | 345 | - |
| Purchase of goods/services from govt. acct (25.3) | 9,205 | 9,205 | 9,205 | - |
| Operation and maintenance of facilities (25.4) | 15 | 15 | 15 | - |
| Research and Development Contracts (25.5) | - | - | - | - |
| Medical care (25.6) | - | | | - |
| Operation and maintenance of equipment (25.7) | 10 | 10 | 10 | - |
| Subsistence and support of persons (25.8) | - | - | - | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | 32 | 32 | 32 | - |
| **Subtotal Other Contractual Services** | **16,072** | **16,072** | **16,072** | - |
| Equipment (31.0) | 209 | 209 | 209 | - |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | 263,281 | 264,014 | 373,844 | +109,830 |
| Insurance Claims and Indemnities (42.0) | 8 | - | | - |
| **Total Non-Pay Costs** | **279,763** | **280,488** | **390,318** | **+109,830** |
| **Total Budget Authority by Object Class** | **285,619** | **286,479** | **400,000** | **+113,521** |

## 340B DRUG PRICING PROGRAM//OFFICE OF PHARMACY AFFAIRS

**(***dollars in thousands)*

| Object Class | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 1,829 | 1,870 | **2,510** | +640 |
| Other than full-time permanent (11.3) | - | - | - | - |
| Other personnel compensation (11.5) | 28 | 29 | 29 | - |
| Military personnel (11.7) | 1,052 | 1,084 | 1,242 | +158 |
| Special personnel services payments (11.8) | - | - | - | - |
| **Subtotal personnel compensation** | **2,909** | **2,983** | **3,781** | **+798** |
| Civilian benefits (12.1) | 615 | 628 | 842 | +214 |
| Military benefits (12.2) | 103 | 106 | 148 | +42 |
| Benefits to former personnel (13.1) | - | - | - | - |
| **Total Pay Costs** | **3,627** | **3,717** | **4,771** | **+1,054** |
| Travel and transportation of persons (21.0) | - | - | - | - |
| Transportation of things (22.0) | 2 | 2 | 2 | - |
| Rental payments to GSA (23.1) | 168 | 168 | 168 | - |
| 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) | 5,449 | 5,390 | 11,335 | +5,945 |
| Purchase of goods and services from government acct (25.3) | 899 | 899 | 900 | +1 |
| Operation and maintenance of facilities (25.4) | - | - | - | - |
| Research and Development Contracts (25.5) | - | - | - | - |
| Medical care (25.6) | - | - | - | - |
| Operation and maintenance of equipment (25.7) | 51 | 51 | 50 | -1 |
| Subsistence and support of persons (25.8) | - | - | - | - |
| Discounts and Interest (25.9) | | - | - | - |
| Supplies and materials (26.0) | 1 | 1 | 1 | - |
| **Subtotal Other Contractual Services** | **6,400** | **6,341** | **12,286** | **+5,945** |
| Equipment (31.0) | 10 | 10 | 11 | +1 |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | - | - | - | - |
| Insurance Claims and Indemnities (42.0) | - | - | - | - |
| **Total Non-Pay Costs** | **6,580** | **6,521** | **12,467** | **+5,946** |
| **Total Budget Authority by Object Class** | **10,207** | **10,238** | **17,238** | **+7,000** |

## TELEHEALTH

**(***dollars in thousands)*

| Object Class | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 782 | 799 | 945 | +146 |
| Other than full-time permanent (11.3) | | - | - | - |
| Other personnel compensation (11.5) | 12 | 13 | 13 | - |
| Military personnel (11.7) | - | - | - | - |
| Special personnel services payments (11.8) | - | - | - | - |
| **Subtotal personnel compensation** | **794** | **812** | **958** | **+146** |
| Civilian benefits (12.1) | 280 | 287 | 336 | +49 |
| Military benefits (12.2) | - | - | - | - |
| Benefits to former personnel (13.1) | - | - | - | - |
| **Total Pay Costs** | **1,074** | **1,099** | **1,294** | **+195** |
| Travel and transportation of persons (21.0) | - | - | - | - |
| Transportation of things (22.0) | - | - | - | - |
| Rental payments to GSA (23.1) | 144 | 144 | 144 | - |
| 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) | 1,361 | 1,361 | 1,361 | - |
| Purchase of goods and services from government acct (25.3) | 876 | 876 | 876 | - |
| Operation and maintenance of facilities (25.4) | - | - | - | - |
| Research and Development Contracts (25.5) | - | - | - | - |
| Medical care (25.6) | - | - | - | - |
| Operation and maintenance of equipment (25.7) | 102 | 102 | 102 | - |
| Subsistence and support of persons (25.8) | - | - | - | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | - | - | - | - |
| **Subtotal Other Contractual Services** | **2,339** | **2,339** | **2,339** | **-** |
| Equipment (31.0) | - | - | - | - |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | 30,341 | 30,418 | 40,723 | +10,305 |
| Insurance Claims and Indemnities (42.0) | - | - | - | - |
| **Total Non-Pay Costs** | **32,824** | **32,901** | **43,206** | **+10,305** |
| **Total Budget Authority by Object Class** | **33,898** | **34,000** | **44,500** | **+10,500** |

## MANDATORY

**(***dollars in thousands)*

| OBJECT CLASS | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | 60,685 | 62,065 | 74,413 | +12,348 |
| Other than full-time permanent (11.3) | 682 | 697 | 726 | +29 |
| Other personnel compensation (11.5) | 1,889 | 1,932 | 2,011 | +79 |
| Military personnel (11.7) | 7,916 | 8,154 | 8,497 | +343 |
| Special personnel services payments (11.8) | - | - | - | - |
| **Subtotal personnel compensation** | **71,172** | **72,848** | **85,647** | **+12,799** |
| Civilian benefits (12.1) | 21,928 | 22,427 | 26,615 | +4,188 |
| Military benefits (12.2) | 817 | 842 | 877 | +35 |
| Benefits to former personnel (13.1) | - | - | - | - |
| **Total Pay Costs** | **93,917** | **96,117** | **113,139** | **+17,022** |
| Travel and transportation of persons (21.0) | - | - | - | - |
| Transportation of things (22.0) | 9 | - | - | - |
| Rental payments to GSA (23.1) | 5,843 | 5,843 | 5,843 | - |
| Rental payments to Others (23.2) | 20 | 20 | 20 | - |
| Communication, utilities, and misc. charges (23.3) | 2,238 | 1,844 | 1,844 | - |
| Commercial Reimbursement (23.6) | - | - | - | - |
| Network use data transmission service (23.8) | - | - | - | - |
| Printing and reproduction (24.0) | 1 | 1 | 1 | - |
| **Other Contractual Services: 25.0** | 5,385 | 5,385 | 5,385 | - |
| Advisory and assistance services (25.1) | 117,519 | 23,958 | 23,958 | - |
| Other services (25.2) | 30,446 | 29,698 | 29,698 | - |
| Purchase of goods and services from government acct (25.3) | 26,481 | 149,738 | 137,984 | -11,754 |
| Operation and maintenance of facilities (25.4) | | | | - |
| Research and Development Contracts (25.5) | 167 | 167 | 167 | - |
| Medical care (25.6) | - | - | - | - |
| Operation and maintenance of equipment (25.7) | 378 | 368 | 368 | - |
| Subsistence and support of persons (25.8) | - | - | - | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | - | - | - | - |
| **Subtotal Other Contractual Services** | **180,377** | **209,314** | **197,560** | **-11,754** |
| Equipment (31.0) | 4,149 | 4,249 | 4,249 | - |
| Investments and Loans (33.0) | - | - | - | - |
| Grants, subsidies, and contributions (41.0) | 4,532,804 | 4,382,438 | 4,466,970 | **+84,532** |
| Insurance Claims and Indemnities (42.0) | - | - | - | - |
| **Total Non-Pay Costs** | **4,725,441** | **4,603,709** | **4,676,487** | **+72,778** |
| **Total Budget Authority by Object Class** | **4,819,358** | **4,699,826** | **4,789,626** | **+89,800** |

# Salaries and Expenses

## DISCRETIONARY

**(***dollars in thousands)*

| OBJECT CLASS | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | $ 178,568 | $ 179,961 | $ 225,433 | +45,472 |
| Other than full-time permanent (11.3) | 5,297 | 5,419 | 5,642 | +223 |
| Other personnel compensation (11.5) | 4,950 | 5,622 | 5,849 | +227 |
| Military personnel (11.7) | 19,825 | 19,337 | 20,797 | +1,460 |
| Special personnel services payments (11.8) | 74.00 | 75.00 | 78.00 | +3 |
| **Subtotal personnel compensation** | **$ 208,714** | **$ 210,414** | **$ 257,799** | **+47,385** |
| Civilian benefits (12.1) | 64,805 | 65,361 | 80,364 | +15,003 |
| Military benefits (12.2) | 2,179 | 2,138 | 2,480 | +342 |
| Benefits to former personnel (13.1) | 1,526.00 | 1,560.00 | 1,625 | +65 |
| **Total Pay Costs** | **$ 277,224** | **$ 279,473** | **$ 342,268** | **+62,795** |
| Travel and transportation of persons (21.0) | 86 | 86 | 86 | - |
| Transportation of things (22.0) | 198 | 196 | 196 | - |
| Rental payments to Others (23.2) | 114 | 114 | 114 | - |
| Communication, utilities, and misc. charges (23.3) | 2,843 | 1,860 | 1,860 | - |
| Commercial Reimbursement (23.6) | - | - | - | - |
| Network use data transmission service (23.8) | - | - | - | - |
| Printing and reproduction (24.0) | 170 | 170 | 170 | - |
| **Other Contractual Services: 25.0** | - | - | - | - |
| Advisory and assistance services (25.1) | 24,576 | 13,370 | 13,370 | - |
| Other services (25.2) | 252,292 | 278,777 | 274,795 | -3,982 |
| Purchase of goods/services from government accounts (25.3) | 183,438 | 181,662 | 181,511 | -151 |
| Operation and maintenance of facilities (25.4) | 980 | 1,098 | 1,085 | -13 |
| Medical care (25.6) | 3,419 | 3,431 | 3,431 | - |
| Operation and maintenance of equipment (25.7) | 3,431 | 3,431 | 2,388 | -1,043 |
| Subsistence and support of persons (25.8) | 3,893 | 3,740 | 3,740 | - |
| Discounts and Interest (25.9) | 53 | 53 | 53 | - |
| Supplies and materials (26.0) | 615 | 614 | 614 | - |
| **Subtotal Other Contractual Services** | **$ 472,867** | **$ 486,346** | **$ 481,157** | **-5,189** |
| **Total Non-Pay Costs** | **$ 476,278** | **$ 488,772** | **$ 483,583** | **-5,189** |
| **Total Budget Authority by Object Class** | **$ 753,502** | **$ 768,245** | **$ 825,851** | **+57,606** |

## MANDATORY

**(***dollars in thousands)*

| OBJECT CLASS | FY 2021 Operating Level | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| Full-time permanent (11.1) | $ 60,685 | $ 62,065 | $ 74,413 | +12,348 |
| Other than full-time permanent (11.3) | 682 | 697 | 726 | +29 |
| Other personnel compensation (11.5) | 1,889 | 1,932 | 2,011 | +79 |
| Military personnel (11.7) | 7,916 | 8,154 | 8,497 | +343 |
| Special personnel services payments (11.8) | - | - | - | - |
| **Subtotal personnel compensation** | **$ 71,172.0** | **$ 72,848.0** | **$ 85,647.0** | **+12,799** |
| Civilian benefits (12.1) | 21,928 | 22,427 | 26,615 | +4,188 |
| Military benefits (12.2) | 817 | 842 | 877 | +35 |
| Benefits to former personnel (13.1) | - | - | - | - |
| **Total Pay Costs** | **$ 93,917** | **$ 96,117** | **$ 113,139** | **+17,022** |
| Travel and transportation of persons (21.0) | - | - | - | - |
| Transportation of things (22.0) | 9 | - | - | - |
| Rental payments to Others (23.2) | 20 | 20 | 20 | - |
| Communication, utilities, and misc. charges (23.3) | 2,238 | 1,844 | 1,844 | - |
| Commercial Reimbursement (23.6) | - | - | - | - |
| Network use data transmission service (23.8) | - | - | - | - |
| Printing and reproduction (24.0) | 1 | 1 | 1 | - |
| **Other Contractual Services: 25.0** | 5,385 | 5,385 | 5,385 | - |
| Advisory and assistance services (25.1) | 117,519 | 23,958 | 23,958 | - |
| Other services (25.2) | 30,446 | 29,698 | 29,698 | - |
| Purchase of goods/services from govt accounts (25.3) | 26,481 | 149,738 | 137,984 | -11,754 |
| Operation and maintenance of facilities (25.4) | - | - | - | - |
| Medical care (25.6) | - | - | - | - |
| Operation and maintenance of equipment (25.7) | 378 | 368 | 368 | - |
| Subsistence and support of persons (25.8) | - | - | - | - |
| Discounts and Interest (25.9) | - | - | - | - |
| Supplies and materials (26.0) | - | - | - | - |
| **Subtotal Other Contractual Services** | **$ 180,209** | **$ 209,147** | **$ 197,393** | **-11,754** |
| **Total Non-Pay Costs** | **$ 182,477** | **$ 211,012** | **$ 199,258** | **-11,754** |
| **Total Budget Authority by Object Class** | **$ 276,394** | **$ 307,129** | **$ 312,397** | **+5,268** |

# Detail of Full-Time Equivalent Employment (FTE)

| Programs | 2021 Actual | | | 2022 Continuing Resolution | | | 2023 President's Budget | | |
|---|---|---|---|---|---|---|---|---|---|
| | Civilian | Military | Total | Civilian | Military | Total | Civilian | Military | Total |
| **Bureau of Primary Health Care:** | | | | | | | | | |
| Direct: | | | | | | | | | |
| Health Centers/Tort | 270 | 29 | 299 | 270 | 29 | 299 | 319 | 26 | 345 |
| Free Clinics Medical Malpractice | | | - | | | - | - | - | - |
| **Total, Direct:** | **270** | **29** | **299** | **270** | **29** | **299** | **319** | **26** | **345** |
| Mandatory: | | | | | | | | | |
| Health Centers | 258 | 27 | 285 | 258 | 27 | 285 | 290 | 27 | 317 |
| **Total, Mandatory** | **258** | **27** | **285** | **258** | **27** | **285** | **290** | **27** | **317** |
| **Total FTE, BPHC** | **528** | **56** | **584** | **528** | **56** | **584** | **609** | **53** | **662** |
| **Health Workforce:** | | | | | | | | | |
| Direct: | | | | | | | | | |
| National Health Service Corps | 16 | - | 16 | 16 | - | 16 | 19 | - | 19 |
| Loan Repayment/Faculty Fellowships | - | - | - | - | - | - | 1 | - | 1 |
| Centers for Excellence | 1 | - | 1 | 1 | - | 1 | 4 | - | 4 |
| Scholarships for Disadvantaged Students | 6 | - | 6 | 6 | - | 6 | 6 | 1 | 7 |
| Health Careers Opportunity Program | - | - | - | - | - | - | 3 | - | 3 |
| Health Care Workforce Assessment | 4 | - | 4 | 4 | - | 4 | 8 | - | 8 |
| Primary Care Training and Enhancement | 5 | - | 5 | 5 | - | 5 | 6 | - | 6 |
| Oral Health Training | 5 | 1 | 6 | 5 | 1 | 6 | 5 | 1 | 6 |
| Area Health Education Centers | 3 | - | 3 | 3 | - | 3 | 3 | - | 3 |
| Geriatric Programs | 3 | 2 | 5 | 3 | 2 | 5 | 6 | 2 | 8 |
| Behavioral Health Workforce Development Programs | 9 | 3 | 12 | 9 | 3 | 12 | 27 | 2 | 29 |
| Public Health/Preventive Medicine | 4 | - | 4 | 4 | - | 4 | 4 | - | 4 |

| Programs | 2021 Actual | | | 2022 Continuing Resolution | | | 2023 President's Budget | | |
|---|---|---|---|---|---|---|---|---|---|
| | Civilian | Military | Total | Civilian | Military | Total | Civilian | Military | Total |
| NURSE Corps Loan Repayment & Scholarship | 24 | 3 | 27 | 24 | 3 | 27 | 25 | 3 | 28 |
| Advanced Education Nursing Program | 9 | - | 9 | 9 | - | 9 | 10 | - | 10 |
| Nurse Workforce Diversity | 3 | - | 3 | 3 | - | 3 | 4 | - | 4 |
| Nurse Education, Practice & Retention | 4 | 1 | 5 | 4 | 1 | 5 | 5 | - | 5 |
| Nurse Faculty Loan Program | 3 | - | 3 | 3 | - | 3 | 4 | - | 4 |
| Children's Hospitals GME Program | 15 | 1 | 16 | 15 | 1 | 16 | 17 | 1 | 18 |
| Graduate Medical Student Education | 1 | - | 1 | 1 | - | 1 | - | - | - |
| Preventing Burnout | - | - | - | - | - | - | 2 | - | 2 |
| **Total, Direct** | **115** | **11** | **126** | **115** | **11** | **126** | **159** | **10** | **169** |
| Reimbursable: | | | | | | | | | |
| National Practitioner Data Bank | 36 | 1 | 37 | 36 | 1 | 37 | 37 | 1 | 38 |
| **Total, Reimbursable:** | **36** | **1** | **37** | **36** | **1** | **37** | **37** | **1** | **38** |
| Mandatory: | | | | | | | | | |
| National Health Service Corps | 202 | 20 | 222 | 202 | 20 | 222 | 236 | 18 | 254 |
| Teaching Health Centers | 5 | 3 | 8 | 5 | 3 | 8 | 11 | 5 | 16 |
| Nurse Corps | 1 | - | 1 | 1 | - | 1 | 11 | - | 11 |
| Behavioral Health Workforce Education and Training | - | - | - | - | - | - | 6 | - | 6 |
| Mental and Behavioral Health | - | - | - | - | - | - | 6 | 1 | 7 |
| Promote Mental and Behavioral Health | - | - | - | - | - | - | 3 | - | 3 |
| Community Health Workforce | - | - | - | - | - | - | 8 | - | 8 |
| Public Health Workforce | - | - | - | - | - | - | 2 | - | 2 |
| **Total, Mandatory** | **208** | **23** | **231** | **208** | **23** | **231** | **283** | **24** | **307** |
| **Total FTE, Health Workforce** | **359** | **35** | **394** | **359** | **35** | **394** | **479** | **35** | **514** |

| Programs | 2021 Actual | | | 2022 Continuing Resolution | | | 2023 President's Budget | | |
|---|---|---|---|---|---|---|---|---|---|
| | Civilian | Military | Total | Civilian | Military | Total | Civilian | Military | Total |
| **Maternal and Child Health Bureau:** | | | | | | | | | |
| Direct: | | | | | | | | | |
| Maternal & Child Health Block Grant | 59 | - | 59 | 59 | - | 59 | 80 | - | 80 |
| Autism and Other Developmental Disorders | 7 | 1 | 8 | 7 | 1 | 8 | 6 | 2 | 8 |
| Sickle Cell Service Demonstrations | 1 | - | 1 | 1 | - | 1 | 2 | - | 2 |
| Early Hearing Detection and Intervention | 4 | - | 4 | 4 | - | 4 | 4 | - | 4 |
| Emergency Medical Services for Children | 6 | - | 6 | 6 | - | 6 | 6 | - | 6 |
| Healthy Start | 14 | 3 | 17 | 14 | 3 | 17 | 20 | 2 | 22 |
| Heritable Disorders | 4 | - | 4 | 4 | - | 4 | 5 | - | 5 |
| Pediatric Mental Health Care Access Grants | 2 | - | 2 | 2 | - | 2 | 2 | - | 2 |
| Screening and Treatment for Maternal Depression | 1 | - | 1 | 1 | - | 1 | 2 | - | 2 |
| Poison Control Centers | 1 | - | 1 | 1 | - | 1 | 3 | - | 3 |
| **Total, Direct:** | **99** | **4** | **103** | **99** | **4** | **103** | **130** | **4** | **134** |
| Mandatory | | | | | | | | | |
| Family to Family Health Info Centers | 1 | - | 1 | 1 | - | 1 | 1 | - | 1 |
| Home Visiting | 38 | 3 | 41 | 38 | 3 | 41 | 52 | 3 | 55 |
| Pediatric Mental Health | - | - | - | - | - | - | 3 | - | 3 |
| **Total, Mandatory** | **39** | **3** | **42** | **39** | **3** | **42** | **56** | **3** | **59** |
| **Total FTE, MCHB** | **138** | **7** | **145** | **138** | **7** | **145** | **186** | **7** | **193** |
| **HIV/AIDS Bureau:** | | | | | | | | | |
| Direct: | | | | | | | | | |
| Ryan White Part A | 40 | 4 | 44 | 40 | 4 | 44 | 43 | 5 | 48 |
| Ryan White Part B | 48 | 4 | 52 | 48 | 4 | 52 | 61 | 5 | 66 |
| Ryan White Part C | 36 | 10 | 46 | 36 | 10 | 46 | 53 | 10 | 63 |
| Ryan White Part D | 7 | 3 | 10 | 7 | 3 | 10 | 11 | 1 | 12 |

| Programs | 2021 Actual | | | 2022 Continuing Resolution | | | 2023 President's Budget | | |
|---|---|---|---|---|---|---|---|---|---|
| | Civilian | Military | Total | Civilian | Military | Total | Civilian | Military | Total |
| Ryan White Part F | 5 | 1 | 6 | 5 | 1 | 6 | 5 | 1 | 6 |
| Ryan White Part F Dental | | | - | | | - | - | - | - |
| Special Project of National Significance (SPNS) | 1 | | 1 | 1 | | 1 | 2 | - | 2 |
| Ending HIV/AIDS | 23 | 2 | 25 | 23 | 2 | 25 | 27 | 2 | 29 |
| **Total, Direct:** | **160** | **24** | **184** | **160** | **24** | **184** | **202** | **24** | **226** |
| **Total FTE, HAB** | **160** | **24** | **184** | **160** | **24** | **184** | **202** | **24** | **226** |
| **Healthcare Systems Bureau:** | | | | | | | | | |
| Direct: | | | | | | | | | |
| Organ Transplantation | 2 | | 2 | 2 | | 2 | 8 | 1 | 9 |
| National Cord Blood Inventory | 3 | 1 | 4 | 3 | 1 | 4 | 3 | 2 | 5 |
| C.W.Bill Young Cell Transplantation Program | 5 | | 5 | 5 | | 5 | 6 | - | 6 |
| Hansen's Disease Center | 33 | 5 | 38 | 33 | 5 | 38 | 40 | 4 | 44 |
| Covered Countermeasures Compensation | 2 | 2 | 4 | 2 | 2 | 4 | 36 | 6 | 42 |
| Vaccine | 14 | 5 | 19 | 14 | 5 | 19 | 26 | 6 | 32 |
| **Total, Direct:** | **59** | **13** | **72** | **59** | **13** | **72** | **119** | **19** | **138** |
| Reimbursable: | | | | | | | | | |
| Hansen's Disease Center | 1 | - | 1 | 1 | - | 1 | 1 | - | 1 |
| **Total, Reimbursable** | **1** | **-** | **1** | **1** | **-** | **1** | **1** | **-** | **1** |
| Mandatory | | | | | | | | | |
| Community Based Workforce Vaccine Outreach | - | - | - | - | - | - | 16 | 2 | 18 |
| Vaccine Confidence Initiative | - | - | - | - | - | - | 4 | - | 4 |
| **Total, Mandatory** | | | | | | | **20** | **2** | **22** |
| **Total FTE, HSB** | **60** | **13** | **73** | **60** | **13** | **73** | **140** | **21** | **161** |

| Programs | 2021 Actual | | | 2022 Continuing Resolution | | | 2023 President's Budget | | |
|---|---|---|---|---|---|---|---|---|---|
| | Civilian | Military | Total | Civilian | Military | Total | Civilian | Military | Total |
| **Federal Office of Rural Health Policy:** | | | | | | | | | |
| Direct: | | | | | | | | | |
| Rural Health Policy Development | 3 | - | 3 | 3 | - | 3 | 3 | - | 3 |
| Rural Health Outreach Grants | 10 | - | 10 | 10 | - | 10 | 10 | - | 10 |
| Rural Hospital Flexibility Grants | 1 | - | 1 | 1 | - | 1 | 3 | - | 3 |
| State Offices of Rural Health | - | - | - | - | - | - | - | - | - |
| Radiation Exposure Screening & Education Program | 1 | - | 1 | 1 | - | 1 | 1 | - | 1 |
| Black Lung | - | - | - | - | - | - | - | - | - |
| Rural Communities Opioid Response | 18 | - | 18 | 18 | - | 18 | 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 |
| **Total, Direct:** | **40** | **-** | **40** | **40** | **-** | **40** | **46** | **-** | **46** |
| Mandatory | | | | | | | | | |
| Rural Health Clinics | - | - | - | - | - | - | 3 | - | 3 |
| Rural and Critical Access Hospitals | - | - | - | - | - | - | 1 | - | 1 |
| Rural Health Clinic Vaccine Confidence | - | - | - | - | - | - | 6 | - | 6 |
| ARP Rural Health Public Workforce | - | - | - | - | - | - | 2 | - | 2 |
| Rural Health Clinic Vaccine Distribution | - | - | - | - | - | - | 4 | - | 4 |
| **Total, Mandatory** | - | - | - | - | - | - | **16** | **-** | **16** |
| **Total, FORHP** | **40** | **-** | **40** | **40** | **-** | **40** | **62** | **-** | **62** |
| **Family Planning (Direct)[334]** | 20 | 2 | 22 | 20 | 2 | 22 | 43 | 1 | 44 |

[334]Due to coding error, Family Planning is reporting lower than the actual 38 FTE.

| Programs | 2021 Actual | | | 2022 Continuing Resolution | | | 2023 President's Budget | | |
|---|---|---|---|---|---|---|---|---|---|
| | Civilian | Military | Total | Civilian | Military | Total | Civilian | Military | Total |
| **Program Management (Direct)** | 734 | 36 | 770 | 734 | 36 | 770 | 849 | 37 | 886 |
| **OGAC Global AIDS (Reimbursable)** | 19 | 2 | 21 | 19 | 2 | 21 | 18 | 2 | 20 |
| **Telehealth (Direct)** | 8 | | 8 | 8 | | 8 | 9 | - | 9 |
| **340B Drug Pricing Program/Office of Pharmacy Affairs (Direct)** | 13 | 6 | 19 | 13 | 6 | 19 | 18 | 7 | 25 |
| **Provider Relief Bureau:** | | | | | | | | | |
| Provider Relief Fund Supplemental Funding | 51 | 2 | 53 | 51 | 2 | 53 | 110 | 2 | 112 |
| Uninsured Supplemental Funding | 3 | - | 3 | 3 | - | 3 | 4 | - | 4 |
| Provider Relief Bureau | - | - | - | | - | - | 2 | - | 2 |
| **Total, Direct** | **54** | **2** | **56** | **54** | **2** | **56** | **116** | **2** | **118** |
| Subtotal Direct (non add) | 1,572 | 127 | 1,699 | 1,572 | 127 | 1,699 | 2,010 | 130 | 2,140 |
| Subtotal Reimbursable (non add) | 56 | 3 | 59 | 56 | 3 | 59 | 56 | 3 | 59 |
| Subtotal Mandatory (non add) | 505 | 53 | 558 | 505 | 53 | 558 | 665 | 56 | 721 |
| **Subtotal, HRSA FTE** | **2,133** | **183** | **2,316** | **2,133** | **183** | **2,316** | **2,731** | **189** | **2,920** |

# Programs Proposed for Elimination

The following list shows the programs proposed for elimination in the FY 2023 Budget Request. Termination of these programs totals $50.0 million in discretionary resources. Following each program is a brief summary and the rationale for its elimination.

*(dollars in millions)*

| Program | FY 2022 Continuing Resolution |
|---|---|
| Medical Student Education[335] | $50.0 |
| **Total Programs Proposed for Elimination** | **$50.0** |

Medical Student Education (-$50.0 million)

No funding is requested in FY 2023. In FY 2023, the FY 2019 grantees will finish their project period. In FY 2023, HRSA will continue to support 5 grants from the FY 2020 cohort with funds appropriated in prior fiscal years.

[335] Program was proposed for elimination in the FY 2021 and FY 2020 budgets.

# FTEs Funded by P.L. 111-148 and Any Supplementals

(*Dollars in Thousands*)

| | | FY 2013 | | FY 2014 | | FY 2015 | | FY 2016 | | FY 2017 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Program** | **Section** | **Total Funding** | **FTE** | **Total Funding** | **FTE** | **Total Funding** | **FTE** | **Total Funding** | **FTE** | **Total Funding** | **FTE** |
| *Community Health Center Fund:* | | | | | | | | | | | |
| P.L. 111-148 Mandatory | H.R. 3590, Section 10503(b)(1) | 1,500,000 | 60 | 2,144,716 | 95 | 3,509,111 | 122 | - | - | - | - |
| Non-P.L. 111-148 Mandatory | | - | - | - | - | - | - | 3,600,000 | 240 | 3.510.661 | 225 |
| 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 |
| *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 |
| *GME Payments Teaching Health Centers:* | H.R. 3590, Section 5508 | | | | | | | | | | |
| P.L. 111-148 Mandatory | | - | 6 | - | 5 | - | 4 | - | - | - | - |
| Non-P.L. 111-148 Mandatory | | - | - | - | - | - | - | 60,000 | 8 | 55,860 | 8 |
| *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 |
| *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 |
| **Total** | | **2,232,100** | **325** | **2,803,956** | **351** | **4,201,481** | **373** | **4,375,000** | **519** | **4,232,186** | **512** |

| | | FY 2018 | | FY 2019 | | FY 2020 | | FY 2021 | | FY 2022 | | FY 2023 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Program** | **Section** | **Total Funding** | **FTE** | **Total Funding** | **FTE** | **Total Funding** | **FTE** | **Total Funding** | **FTE** | **Total Funding** | **FTE** | **Total Funding** | **FTE** |
| *Community Health Center Fund:* | | | | | | | | | | | | | |
| P.L. 111-148 Mandatory | H.R. 3590, Section 10503(b)(1) | - | - | - | - | - | - | - | - | - | - | - | - |
| Non-P.L. 111-148 Mandatory | | 3,800,000 | 174 | 4,000,000 | 177 | 4,000,000 | 203 | 4,000,000 | 285 | 3,905,348 | 285 | 3,905,348 | 317 |
| Health Centers - Facilities Construction | H.R. 3590, Section 10503(c) | - | - | - | - | - | - | - | - | - | - | - | - |
| School-Based Health Centers-Facilities | H.R. 3590, Section 4101 | - | 9 | - | 8 | - | 4 | - | - | - | - | - | - |
| *National Health Service Corps:* | | | | | | | | | | | | | |
| P.L. 111-148 Mandatory | H.R. 3590, Section 10503(b)(2) | - | - | - | - | - | - | - | - | - | - | - | - |
| Non-P.L. 111-148 Mandatory | | 310,000 | 206 | 310,000 | 209 | 310,000 | 205 | 310,000 | 222 | 292,330 | 222 | 292,330 | 254 |
| *GME Payments Teaching Health Centers:* | H.R. 3590, Section 5508 | | | | | | | | | | | | |
| P.L. 111-148 Mandatory | | - | - | - | - | - | - | - | - | - | - | - | - |
| Non-P.L. 111-148 Mandatory | | 126,500 | 10 | 126,500 | 7 | 126,500 | 8 | 126,500 | 8 | 119,290 | 8 | 119,290 | 16 |
| *Family to Family Health Information Centers:* | | | | | | | | | | | | | |
| Non-P.L. 111-148 Mandatory | H.R. 3590, Section 5507 | 6,000 | 1 | 6,000 | 1 | 6,000 | 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 | 42 | 400,000 | 39 | 376,40000 | 38 | 377,200 | 41 | 377,200 | 41 | 467,000 | 55 |
| **Total** | | **4,642,500** | **442** | **4,818,900** | **441** | **4,819,358** | **441** | **4,819,358** | **557** | **4,699,826** | **557** | **4,789,626** | **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.)*

FY21 included (2) Separations of which (1) resigned and (1) retired. The average length of service was 8.5 years.
In FY21, we have (12) vacancies. At this time, (10) vacancies announcement have been posted and (2) vacancies have been filled at this point. Quality applicants have been limited. For example, an average of 29.8 applications are received for a vacancy, however, only (7.4) applicants were considered qualified for the position.
To date there have been (1) Accessions.

3-4) Please complete the table below with details of the PCA agreement for the following years:

| | PY 2021 (Actual) | CY 2022 (Estimates) | BY* 2023 (Estimates) |
|---|---|---|---|
| 3a) Number of Physicians Receiving PCAs | 25 | 35 | 35 |
| 3b) Number of Physicians with One-Year PCA Agreements | 2 | 0 | 0 |
| 3c) Number of Physicians with Multi-Year PCA Agreements | 23 | 35 | 35 |
| 4a) Average Annual PCA Physician Pay (without PCA payment) | $172,883 | $170,800 | $170,800 |
| 4b) Average Annual PCA Payment | $23,174 | $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 FY20 there were (7) Separations of which (3) resigned (2) reassigned and (2) retired. Their average length of service was 9.5 years. PCA in addition to their base salary was needed to meet their current salary or salary expectations.

6) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

n/a

# Drug Control Budget
## Health Resources and Services Administration

## Resource Summary

| | Budget Authority (in millions) | | |
|---|---|---|---|
| | FY 2021 Enacted | FY 2022 Continuing Resolution | FY 2023 President's Budget |
| **Drug Resources by Function** | | | |
| **Prevention** | **$84.350** | **$101.000** | **$157.125** |
| Health Center Program | $54.300 | $54.000 | $54.000 |
| Rural Communities Opioid Response Program | $30.050 | $47.000 | $103.125 |
| **Treatment** | **$712.550** | **$694.000** | **$764.875** |
| Health Center Program | $488.700 | $486.000 | $486.000 |
| National Health Service Corps SUD Workforce Program | $105.000 | $105.000 | $165.000 |
| Addiction Medicine Fellowship Program | $22.900 | $24.000 | $24.000 |
| SUD Treatment and Recovery Loan Repayment | $16.000 | $16.000 | $28.000 |
| Rural Communities Opioid Response Program | $79.950 | $63.000 | $61.875 |
| **Total Drug Resources by Function** | **$796.900** | **$795.000** | **$922.000** |
| **Drug Resources by Decision Unit** | | | |
| Health Center Program | $543.000 | $540.000 | $540.000 |
| National Health Service Corps SUD Workforce Program | $105.000 | $105.000 | $165.000 |
| Addiction Medicine Fellowship Program | $22.900 | $24.000 | $24.000 |
| SUD Treatment and Recovery Loan Repayment | $16.000 | $16.000 | $28.000 |
| Rural Communities Opioid Response Program | $110.000 | $110.000 | $165.000 |
| **Total Drug Resources by Decision Unit** | **$796.900** | **$795.000** | **$922.000** |
| | | | |
| **Drug Resources Personnel Summary** | | | |
| Total FTEs (direct only) | -- | -- | -- |
| | | | |
| **Drug Resources as a percent of Budget** | | | |
| Total Agency Budget (in Billions) | $12.1 | $11.9 | $13.3 |
| Drug Resources percentage | 6.6% | 6.7% | 6.9% |

## METHODOLOGY

Health Center Program

For each of fiscal years 2016 – 2019, HRSA provided new annual ongoing grant funding supporting SUD/MH service expansion in health centers totaling $545.0 million projected to remain in Health Center Program base continuation funding in subsequent fiscal years. Subsequently in FY 2020, HRSA found that 36 health centers were unable to demonstrate

sufficient progress to merit continuing their AIMS awards, resulting in a $2.0 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 $3.0 million total reduction in drug control funding. The remaining $540.0 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.

National Health Service Corps SUD Workforce 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 National Health Service Corps (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% of the amount is scored as treatment funding.

Substance Use Disorder Treatment and Recovery (STAR) 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 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 the Rural Communities Opioid Response Program (RCORP) is through competitive grants and cooperative agreements. The entirety of these programs is scored as drug control funding.

The prevention-treatment split for FY 2021 was revised to match the programs funded based on the enacted budget. The FY 2022 prevention-treatment splits were revised to account for the Continuing Resolution which is $55.0 million below the FY 2022 President's Budget. The FY 2023 prevention-treatment splits was revised to account for the Budget Request that is $55.0 million above the FY 2022 Continuing Resolution.

## BUDGET SUMMARY

The drug control budget for the Health Resources and Services Administration for the FY 2023 President's Budget Request is $922.0 million, which is $127.0 million above the FY 2022 Continuing Resolution.

**Health Center Program**

**FY 2023 President's Budget Request: $540.0 million**
**(level with the FY 2022 Continuing Resolution)**

In FY 2023, the Health Center Program plans to support approximately 1,400 grantees and provide primary health care services to nearly 30 million patients at the Budget Request level, including access to ongoing SUD services. Health centers will continue to provide SUD services for all age groups.

In FY 2019, the Health Center Program awarded $201 million in new SUD/MH ongoing annual awards. The FY 2020 and FY 2021 Health Center Program enacted levels, the FY 2022 Continuing Resolution level and the FY 2023 Budget Request level include no additional targeted drug resources. As a result, the reported amount of estimated drug resources for FY 2019 and FY 2020, and those projected for FY 2021 through FY 2023, reflect the ongoing annual SUD/MH awards initiated in FY 2016 through FY 2019, health center continuation awards made in FY 2020 and FY 2021, and projections for FY 2022 through FY 2023.

**National Health Service Corps SUD Program**

**FY 2023 President's Budget Request: $165.0 million**
**($60.0 million above the FY 2022 Continuing Resolution)**

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.

**Addiction Medicine Fellowship (AMF) Program**

**FY 2023 President's Budget Request: $24.0 million**
**(level with the FY 2022 Continuing Resolution)**

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.

**Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program (LRP)**

**FY 2023 President's Budget Request: $28.0 million**
**($12.0 million above the FY 2022 Continuing Resolution)**

The Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program (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 2023, STAR LRP participants will be fulfilling part of their required SUD treatment service commitments, and HRSA anticipates making 112 awards with approximately $28 million in funding.

**Rural Communities Opioid Response Program (RCORP)**

**FY 2023 President's Budget Request: $165.0 million**
**($55.0 million above the FY 2022 Continuing Resolution)**

The Rural Communities Opioid Response Program (RCORP) initiative aims to reduce the morbidity and mortality associated with substance use disorder (SUD), including opioid use disorder (OUD), in high 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 $404.0 million in grants and technical assistance to rural communities serving more than 1,500 counties across 47 states and two territories. The most recent full-year of performance measurement data collection shows that a cohort of FY 2019 RCORP grantees provided direct SUD/OUD prevention, treatment, and recovery services to 366,871 rural residents, and ensured that 23,605 rural residents received medication assisted treatment (MAT) services.

HRSA supports the following grant and cooperative agreement programs through RCORP:

- **RCORP-Implementation** provides multi-year support to rural communities to reduce the morbidity and mortality associated with SUD/OUD by establishing and/or expanding SUD/OUD services. The core/required activities of this program include, but are not limited to, naloxone training, distribution, and administration; identifying and screening at risk individuals for SUD/OUD and referring them to harm reduction services, treatment, and other support services; building the workforce and infrastructure to

support evidence-based Medication-Assisted Treatment (MAT) provision; and expanding the peer recovery workforce and recovery support services. These activities align with Administration Priorities. The Implementation grants that HRSA fully funded in FY 2021 and FY 2022 will remain active in FY 2023. HRSA anticipates recompeting RCORP-Implementation in FY 2025, when the FY 2022 cohort's period of performance has ended. HRSA does not anticipate recompeting this program in FY 2023.

- **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 2023, HRSA will support the continuation of grants awarded in FY 2022.

- **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. HRSA will recompete these cooperative agreements in FY 2023.

- **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 initiative-wide technical assistance cooperative agreement in FY 2023. HRSA will also recompete the RCORP initiative-wide evaluation cooperative agreement in FY 2023.

- **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 2023.

In FY 2023, HRSA will continue to invest in initiatives and support evidence-based strategies that address the specific substance use disorder issues and behavioral health services needs in rural communities. The FY 2023 Budget Request will fund new and continuing grants and cooperative agreements for RCORP to strengthen the infrastructure and capacity within rural communities at high risk for substance use disorders (SUDs) and provide needed prevention, treatment, and recovery services to rural residents.

This request will also enable HRSA to continue expanding RCORP's focus to include other, emergent behavioral health needs in rural communities. In FY 2022, HRSA piloted a new program—RCORP-Behavioral Health Care Support--targeting rural individuals with SUD/OUD

and/or co-occurring disorders, in recognition of the fact that about half of those who experience an SUD during their lifetime will also experience a mental illness, and vice versa.[336]

In FY 2023, HRSA plans to continue funding for the FY 2022 behavioral health pilot program, existing cooperative agreements that provide needed technical assistance, evaluation, and workforce development support, a new pilot program allowing rural communities to increase access to medication-assisted treatment and training for MAT providers, and a tribal-focused behavioral health care support grant program. 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. Beginning in FY 2021, new RCORP recipients are 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.

## 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 over 14,000 sites, providing comprehensive primary and preventive care on a sliding fee scale to nearly 30 million patients each year. Approximately 91% of health center patients are individuals or families living at or below 200% of the Federal Poverty Guidelines and over 62% of health center patients are racial/ethnic minorities. Health centers also serve nearly 1 million agricultural workers, about 1.3 million individuals experiencing homelessness, and approximately 5.2 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 Program

[336] https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness

The National Health Service Corps (NHSC) Substance Use Disorder (SUD) Workforce Loan Repayment Program (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 (AMF) 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 (STAR) Loan Repayment Program

The Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program (LRP) aims to improve equity by reducing the barriers to access to substance use disorder (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)

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, this budget request for FY 2023 includes funding for an RCORP-Tribal Behavioral Health Support pilot grant program that will allow HRSA to target specific funding to rural Tribal communities. Additionally, 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 2023 CONGRESSIONAL JUSTIFICATION**

**HOUSE REPORT 117-96 (July 19, 2021)**

1) **Alcee L. Hastings Program for Advanced Cancer Screening in Underserved Communities.**—The Committee is extremely concerned about the disparity in cancer screening—and corresponding higher levels of cancer incidence and adverse outcomes—in medically underserved communities. Several studies have demonstrated that this problem has only been made worse by the pandemic. The Committee includes $25,000,000 to fund Health Centers to increase access and address barriers to cancer screening, including patient education, case management, outreach, and other enabling services. Grantees must partner and coordinate closely with NCI-designated cancer centers to deploy cancer-center trained and super-vised outreach specialists and navigators to improve cancer screening and referrals among vulnerable populations in their catchment areas. **(Page 46)**

**Action to be Taken**

HRSA plans to administer programs identified and funded by Congress, as supported in the final FY 2022 Health Center Program appropriation, including the Alcee L. Hastings Program for Advanced Cancer Screening in Underserved Communities.

2) **Health Center Dental Services.**—The Committee recognizes the importance of Health Centers in providing comprehensive primary and preventive health services to the nation's underserved communities. Health Centers provide dental services for many who would otherwise face barriers to dental care. The Committee is aware that some Health Centers have partnered with Community Dental Health Coordinators (CDHCs) to provide patients with greater access to dental care. CDHCs provide community-based prevention, care coordination, and patient navigation to underserved populations in rural, urban, and Native American communities. The Committee encourages HRSA to work with Health Centers to expand their work in this area. **(Page 47)**

**Action to be Taken**

HRSA will continue to support the integration of dental services in the comprehensive primary and preventive health services provided by health centers to underserved communities. HRSA will also continue to encourage health centers to partner with Community Dental Health Coordinators as appropriate in their respective communities.

3) **Health Center Mental Health Services for Children.**—The Committee is concerned about the many challenges faced by children in need of mental health services because of the COVID–19 pandemic. The pandemic has had serious impacts on children's mental, psychological, and emotional well-being, especially in low-income and minority communities. This impact will likely last for an extended period. The Committee strongly

encourages HRSA to provide funding to Health Centers to support vital mental health services for children. **(Page 47)**

**Action to be Taken**

HRSA will continue to provide funding to health centers to address the primary health care priorities in their respective communities, including the need for mental health services among children.

4) **School-Based Health Centers (SBHCs) and Health Center Services at School-Based Sites.**—Recognizing the critical role of Health Centers as part of our nation's health care safety net, and that Health Centers providing services at sites located at schools within the communities they serve are currently one of the most effective sources of mental health care for children and adolescents, the Committee includes a total increase of $50,000,000 within the total for Health Centers to support the delivery of health care services at school-based sites. The Committee includes $25,000,000 to make grants to establish new school-based health centers and expand services at SBHCs pursuant to 42 USC 280h-5. SBHCs provide a convenient access point to high-quality, comprehensive primary health care, mental health services, preventive care, social services, and youth development to primarily children and adolescents from low-income families. The Committee also includes $25,000,000, an increase of $20,000,000 above the fiscal year 2021 enacted level, for awards to Health Centers operating at school-based sites to increase their capacity to meet the increasing demand for health services, including mental health services. The Committee encourages HRSA to award grants to applicants that previously submitted fundable applications under HRSA–21–093 but that did not receive such funding. **(Page 47)**

**Action to be Taken**

HRSA plans to administer programs identified and funded by Congress in the final FY 2022 Health Center Program appropriation, including programs providing funding to support increased provision of health care services in school based health centers and health centers operating at school based sites.

5) **HRSA Strategy to Address Intimate Partner Violence and Project Catalyst.**—The Committee includes no less than $2,000,000 for the HRSA Strategy to Address Intimate Partner Violence, an increase of $500,000 over the fiscal year 2021 enacted level and the fiscal year 2022 budget request. The Committee encourages HRSA to support training, technical assistance, and resource development to assist public health and health care professionals to better serve individuals and communities impacted by intimate partner violence. **(Page 48)**

**Actions to be Taken**

HRSA will continue to administer a strategy to address intimate partner violence in FY 2022, at a level supported by the final FY 2022 Health Center Program appropriation.

6) **Health Careers Opportunity Program (HCOP).**—The Committee includes $20,500,000 for HCOP, $5,500,000 above the fiscal year 2021 enacted level and

$2,000,000 above the fiscal year 2022 budget request. The Committee notes that HCOPs assist students from minority and economically disadvantaged backgrounds navigate careers into the health professions. The Committee encourages HRSA to continue its improvement of the diversity and distribution of needed health care professionals through the National HCOP Academies. **(Page 51)**

**Actions to be Taken**

In Academic Year 2020-2021, HCOP grantees reached 3,535 disadvantaged trainees across the country, and partnered with nearly 200 training sites, including academic institutions, community-based organizations, and hospitals. A majority of these training sites were located in medically underserved communities and/or rural settings. The FY 2023 HCOP competition will broaden the Academies' capacity to support the recruitment, training, and retention of disadvantaged students in health and allied health professions programs.

7) **Oral Health Training.**—The Committee includes $42,673,000 for Oral Health Training, $2,000,000 above the fiscal year 2021 enacted level and the fiscal year 2022 budget request. Within the total, the Committee includes not less than $14,000,000 for Pediatric Dentistry Programs, an increase of $2,000,000 above the fiscal year 2021 enacted level. The Committee directs HRSA to provide continuation funding for section 748 post-doctoral training grants initially awarded in fiscal year 2020 and dental faculty loan repayment program (DFLRP) grants initially awarded in fiscal years 2018 and 2021. The Committee directs HRSA to initiate a new pre-doctoral grant cycle, and to initiate a new DFLRP grant cycle with a preference for pediatric dentistry faculty supervising dental students or residents and providing clinical services in dental clinics located in dental schools, hospitals, and community-based affiliated sites. **(Page 52)**

**Actions to be Taken**

In FY 2022, HRSA published Notice of Funding Opportunities (NOFOs), for the Predoctoral Training in General, Pediatric and Public Health Dentistry and Dental Hygiene, and the Dental Faculty Loan Repayment Program with a preference for pediatric dentistry faculty. HRSA also plans to provide continuation funding for the Dental Faculty Loan Repayment Program grants funded in FY 2018 and FY 2021 and for the 27 Postdoctoral Training in General, Pediatric and Public Health Dentistry grantees initially awarded in FY 2020.

8) **Area Health Education Centers (AHEC).**—The Committee includes $50,000,000 for the AHEC program, an increase of $6,750,000 above the fiscal year 2021 level and the fiscal year 2022 budget request. This program links university health science centers with community health service delivery systems to provide education and training networks. The Committee encourages HRSA to support AHEC oral health projects that establish primary points of service and address the need to help patients find treatment outside of hospital emergency rooms. The Committee encourages HRSA to work with programs that have already been initiated by some State dental associations to refer emergency room patients to dental networks. **(Page 52)**

**Actions to be Taken**

HRSA will award the additional $6,750,000 proposed in the President's Budget and included in the House bill to existing AHECs to expand the AHEC Scholars Program, a longitudinal program with interdisciplinary curricula, including clinical, didactic, and community-based training activities. This funding will improve access to community-based oral health providers by increasing access to care and the number of providers trained to deliver these services, with a particular focus on serving high-risk patients living in rural and underserved communities.

9) **Graduate Psychology Education (GPE).**—Within the total for Mental and Behavioral Health Programs, the Committee includes $25,000,000, $6,000,000 above the fiscal year 2021 enacted level and the same as the fiscal year 2022 budget request, for the interprofessional GPE Program to increase the number of health service psychologists trained to provide integrated services to high-need, underserved populations in rural and urban communities. The Committee recognizes the severe impact of COVID–19 on Americans' mental and behavioral health and urges HRSA to strengthen investments in the training of health service psychologists to help meet these demands. **(Page 52)**

**Actions to be Taken**

In FY 2022, the Graduate Psychology Education program ran a new competition to increase the number of doctoral health service psychologists trained in the provision of quality interdisciplinary, integrated behavioral health services to underserved populations in rural and urban communities. HRSA expanded the requirement that trainees spend at least twenty-five (25) percent of the time in the experiential training site(s) in the delivery of not just OUD prevention, treatment and recovery services, but also to include other SUD prevention, treatment, and recovery services as well. This change will increase the type of psychology programs and localities to be eligible for funding. In order to address the impact of COVID-19, HRSA will promote technology integration as a part of psychological services and training programs. GPE grantees will utilize tele-behavioral health services and distance learning options to improve access to health services and address social determinants of health. Additionally, the FY 2022 Notice of Funding Opportunity (NOFO) included a funding priority for programs that have demonstrated the ability to train psychology, psychiatry and social work professionals to work in integrated care settings.

10) **Adolescent Addiction Medicine and Addiction Psychiatry Workforce.**—The Committee applauds HRSA for issuing a funding solicitation for the Addiction Medicine Fellowship (AMF) program and the Mental and Substance Use Disorder Workforce Training Demonstration, as both programs will build the capacity of our nation's addiction medicine physician workforce. However, the Committee remains concerned by the lack of pediatric and adolescent addiction medicine and addiction psychiatry expertise. Currently, there are insufficient opportunities to effectively train a robust mental health and substance use disorder (SUD) workforce. Only 75 of the nation's 179 accredited medical schools offer addiction medicine fellowships, and only one program focuses on fellowship opportunities for pediatric and adolescent addiction medicine and addiction psychiatry. The Committee encourages HRSA to support fellowship programs

focused on increasing the number of board certified pediatric and adolescent addiction medicine and addiction psychiatry subspecialists. **(Page 52)**

**Actions to be Taken**

HRSA will provide funding for 43 non-competing Addiction Medicine Fellowship continuation awards in FY 2023. One of the awards focuses on pediatric and adolescent addiction. HRSA anticipates graduating more than 63 fellows in FY 2023.

In FY 2021, HRSA fully-funded five awards for the Integrated Substance Use Disorder Treatment Program totaling $11.6 million for a period of performance of 5 years. The awards expand the number of nurse practitioners, physician assistants, health service psychologists, and social workers trained to provide mental health and SUD services in underserved community-based settings that integrate primary care and mental health and SUD services.

11) **Registered Nurse Shortages.**—The Committee is concerned about current and projected shortages of registered nurses (RNs) in the U.S. As discussed in the HRSA publication ''Supply and Demand Projections of the Nursing Workforce 2014–2030'', California, New Jersey, South Carolina, and Texas are projected to have a deficit of 10,000 or more full time equivalent RNs by 2030. The Committee directs HRSA to give priority in new funding announcements to public entities for training of additional RNs, specifically for acute care settings. In addition, the Committee directs HRSA to give priority to applicants in States listed by HRSA as having the greatest shortages. **(Page 54)**

**Actions to be Taken**

HRSA has several programs that address the current and projected shortages of registered nurses (RNs) in the U.S. In FY 2022, HRSA released the Nurse Education, Practice, Quality and Retention-Mobile Health Training Program to establish or expand nurse-led mobile units to provide care in rural and underserved areas; In FY 2022, HRSA released the annually-competed Nurse Faculty Loan Program (NFLP) which will continue to increase the number of qualified nursing faculty nationwide. In FY 2022, HRSA continued funding for other Nursing Workforce Development Programs such as the Advanced Nursing Education Workforce Program, the Advanced Nursing Education Sexual Assault Nurse Examiners Program, the Advanced Nurse Education Nurse Practitioner Residency Programs, the Nurse Anesthetist Traineeship Program, the Nurse Education, Practice, Quality and Retention Simulation Education Training Program, the Nurse Education Practice, Quality and Retention Interprofessional Collaborative Practice Program: Behavioral Health Integration, and the Nurse Workforce Diversity Program. These programs focus on transforming nursing education and practice and preparing registered generalist nurses and advanced practice nurses to serve in rural, underserved areas, and high professional shortage areas.

In addition, HRSA's Nurse Corps Programs provide scholarships to students pursuing a nursing degree and loan repayment support to licensed RNs and APRNs working at an eligible healthcare facility with a critical shortage of nurses. Approximately 50 percent of scholarship and 40 percent of loan repayment funds are reserved for RNs serving in Critical

Shortage Facilities (CSFs), including acute care settings. The Nurse Corps will continue dedicating available funding to RNs in FY 2022, providing scholarships to nursing students and nurse faculty to train the future nursing workforce (supply) and loan repayment support to RNs serving at CSFs who are dedicated to working in rural and underserved areas, while prioritizing healthcare facilities experiencing the greatest shortage of nurses.

12) **Nurse Practitioner Optional Fellowship Program.**—The Committee provides $15,000,000, an increase of $10,000,000 above the fiscal year 2021 enacted level and the fiscal year 2022 budget request, for grants to establish or expand community-based nurse practitioner residency and fellowship training programs that are accredited, or in the accreditation process, for practicing postgraduate nurse practitioners (NPs) in primary care or behavioral health, where supported education and training specialties will include family, adult family, adult-gerontology, pediatric, women's health care, nurse midwife, and psychiatric-mental health. The Committee directs HRSA to give preference to FQHCs, as defined by section 1861(aa)(4) of the Social Security Act. The Committee is concerned the Nation is unprepared for health care provider shortages and recognizes that postgraduate programs with this focus, integrating primary care and behavioral health, will help to address this problem. Patients need expert primary care and behavioral health providers prepared to manage the social and clinical complexities experienced in FQHCs. The program provides residency training and fellowships to enable postgraduate NPs to transition to an integrated model of care consistent with current high standards of NP education and practice meeting the needs of our nation's most vulnerable populations. The events of 2020, from the global COVID–19 pandemic to national recognition of the severity of health disparities and health inequities in our country, has made this even more urgent. **(Page 54)**

**Actions to be Taken**

In FY 2020, HRSA funded 10 award recipients under the Advanced Nursing Education Nurse Practitioner Residency Integration Program (ANE-NPRIP). The purpose of ANE-NPRIP is to prepare new nurse practitioners (NPs) in primary care for practice in community-based settings through clinical and academic focused 12-month Nurse Practitioner Residency (NPR) programs, with a preference for those projects that benefit rural or underserved populations. The goal is to increase the supply of and access to primary care and behavioral health providers in integrated community-based settings, while promoting the placement and retention of those providers in rural and underserved settings. The ANE-NPRIP focuses on Enhancement or Expansion of NP residency programs by funding applicants that have existing accredited NP residency programs (or are in the process of NP residency accreditation), and includes a Federally Qualified Health Center (FQHC) preference and behavioral health integration into primary care. Fifty percent of the award recipients are FQHCs, while 30 percent have FQHCs as practice partners, and 10 percent of the award recipients have a rural focus, while 30 percent partner with rural health clinics. The Program ANE-NPRIP. The program provides residency training and fellowships to enable postgraduate NPs to transition to an integrated model of care. NP specialties trained have a primary care focus and include Family, Psychiatric-Mental Health, Adult-

Gerontology, Pediatric, Women's Health Care, and Nurse Midwife. In Academic Year 2020-2021, the program trained 49 new NP graduates; 35 are Family NPs, while 14 are Psychiatric/Mental Health NPs.

In FY 2022, HRSA will fund 10 non-competing continuation awards from the FY 2020 ANE-NPRIP cohort for their final project year. Program activities will continue to promote an increase of skilled NP providers in primary care community based settings that focus on care for rural and underserved populations. Some of these activities include behavioral health integration, cohort collaboration, academic clinical partnerships, curriculum development focusing on HHS/HRSA priorities and underserved populations, preceptor/faculty professional development, and NP residency sustainability.

13) **Medical Student Education.**—The Committee includes $75,000,000, $25,000,000 above the fiscal year 2021 enacted level and the fiscal year 2022 budget request, to support colleges of medicine at public universities located in the top quintile of States projected to have a primary care provider shortage. The Committee directs HRSA to give priority to applications from academic institutions located in States with the greatest number of Federally-recognized Tribes. The Committee also directs HRSA to give priority to applications from public universities with a demonstrated public-private partnership. **(Page 56)**

**Actions to be Taken**

In FY 2022, HRSA will fund ten non-competing continuation awards from the FY 2019 and FY 2020 cohorts. In addition, HRSA proposes to make ten supplemental awards to the ten grantees.

14) **Congenital Syphilis.**—The Committee is concerned with the rise in congenital syphilis as well as the need to expand efforts to prevent this disease and reduce infant mortality. To improve the quality of health care to mothers and their children, the Committee encourages MCHB to support efforts to increase prenatal screening for congenital syphilis and postnatal follow-up for both mothers and babies to ensure that congenital syphilis is detected at the earliest possible stage. **(Page 56)**

**Actions to be Taken**

In FY 2022, HRSA will continue supporting efforts to prevent congenital syphilis. The HRSA-funded Women's Preventive Services Initiative (WPSI) Guidelines include a recommendation for counseling for sexually active adolescent and adult women at an increased risk for sexually transmitted infections (STIs), including congenital syphilis. HRSA updated this guideline in 2021 to reflect current evidence and practices for screening women.

The U.S. Preventive Services Task Force (USPSTF) recommends early screening for syphilis infection in all pregnant women. This recommendation is included in the WPSI clinical summary table, which provides a framework for incorporating preventive health services for women during well woman and routine health care visits.

HSRA-funded programs, such as the Title V Maternal and Child Health (MCH) Block Grant and Healthy Start programs, also support efforts to increase prenatal screening as part of state and community-based strategies to improve health outcomes for women and children. The HRSA-funded Bright Futures guidelines includes screening for sexually transmitted diseases, including syphilis, in adolescents.

15) **Maternal and Child Health (MCH) Block Grant.**—The Committee recommends $868,700,000 for the MCH Block Grant, $156,000,000 above the fiscal year 2021 enacted level and $46,000,000 above the fiscal year 2022 budget request. States use the MCH Block Grant to improve access to care for mothers, children, and their families; reduce infant mortality; provide pre- and post-natal care; support screening and health assessments for children; and provide systems of care for children with special health care needs. The Committee recommends that HRSA continue to support MCH Block Grant partnerships with Federal and State partners to address gaps in services to mothers, children, and their families in all 50 States, the District of Columbia, and the territories; including densely populated Medically Underserved Areas and Medically Underserved Population designated Health Professional Shortage Areas. **(Page 56)**

**Actions to be Taken**

In FY 2022, HRSA will continue to support the Maternal and Child Health (MCH) Block Grant to states and jurisdictions. The State MCH Block Grant program awards formula grants to 59 states and jurisdictions, serving an estimated 60 million pregnant women, infants, and children, including children with special health care needs. The program gives states flexibility in meeting the unique health needs of their children and families, including those individuals residing in Medically Underserved Areas and Medically Underserved Population designated Health Professional Shortage Areas.

16) **State Oral Health Programs.**—The Committee includes $250,000 to continue demonstration projects to increase the implementation of integrating oral health and primary care practice. The projects should model the core clinical oral health competencies for non-dental providers that HRSA published and initially tested in its 2014 report ''Integration of Oral Health and Primary Care Practice''. The Committee encourages the Chief Dental Officer to continue to play a key role in the design, monitoring, oversight, and implementation of these projects. **(Page 57)**

**Actions to be Taken**

In FY 2022, HRSA will continue support for the National Maternal and Child Consortium for Oral Health Systems Integration and Improvement program (COHSII) for the *Integrating Oral Health Care and Primary Care Learning Collaborative: A State and Local Partnership* project with $250,000 in funding. This funding supports the continued provision of technical assistance, training, and other support for demonstration projects. These projects aim to increase the implementation of oral health and primary care practice integration, and are modelled after the 2014 HRSA report, Integration of Oral Health and Primary Care Practice. HRSA is currently recruiting for a new CDO.

17) **Children's Health and Development.**—There is increasing evidence that experiences in early childhood have long-term health consequences over the course of one's life. These experiences are critical in all areas of children's educational, social, and physical development and economic well-being. Children living in persistently high poverty experience more negative health outcomes. The Committee includes $3,500,000 to build upon the work done to address these challenges, and directs HRSA to fund projects bringing systemic change, such as Statewide systems of early childhood developmental screenings and interventions, in States with high levels of or disparities in childhood poverty. The goal of the program is to yield comprehensive and integrated models for other States to utilize in improving child health and development outcomes. **(Page 57)**

**Actions to be Taken**

In FY 2021, HRSA awarded $3.5 million to the University of Mississippi Medical Center to support year five of the Early Childhood Developmental Health System Program. The Early Childhood Developmental Health System Program aims to improve population-level early childhood developmental health outcomes and reduce disparities in a state with significant risk factors for poor child health status. Since the project began in 2017, comprehensive developmental screening and service referral rates have increased, and health providers, early childhood service providers, and parents have improved their knowledge and capacity to promote developmental health. Through this program, HRSA has developed and promoted strategies that can be adapted for other states and communities, particularly those with high levels of childhood poverty. In FY 2022, HRSA will build upon this work by implementing and evaluating strategies to advance systems of early childhood developmental promotion, screenings, and interventions in multiple states with high poverty, and share findings nationally.

18) **Sudden Infant Death Syndrome.**—The Committee includes $5,100,000, an increase of $4,000,000 above the fiscal year 2021 enacted level and the fiscal year 2022 budget request, for the National Fetal, Infant, and Child Death Review (FIDCR) program to expand support and technical assistance to States and tribal communities and improve the availability of data on sudden unexpected infant deaths (SUID). The Committee urges HRSA to consider making grants to support families who have experiences SUID by providing information, referrals, or peer or follow-up support services. **(Page 59)**

**Actions to be Taken**

In FY 2022, HRSA will expand support and technical assistance to states and tribal communities through continued support for the National Fetal, Infant, and Child Death Review (FICDR). The program was recently recompeted with an anticipated project start date in July 2022. The program aims to increase the capacity of community and state Child Death Review (CDR) and Fetal Infant Mortality Review (FIMR) teams to collect high-quality uniform data, translate data into action at the community, state, and national levels, including the availability of data on sudden unexpected infant deaths (SUID). The program also aims to expand fetal, infant, and child death reviews to additional states, territories and tribes.

In addition, HRSA will implement a new program in FY 2022 to increase the capacity of pediatric providers to offer supportive services to families who have experienced SUID by: 1) providing training, information, educational materials, and resources to pediatric providers on providing bereavement support to families; and 2) making awards to professional community-based organizations/agencies to partner with local pediatric providers to provide bereavement education, counseling, and supportive services for families.

19) **Sickle Cell Anemia Demonstration Program.**—The Committee includes $9,205,000 for this program, an increase of $2,000,000 above the fiscal year 2021 enacted level and the fiscal year 2022 budget request. With the start of new five-year grant awards in fiscal year 2022, the Committee is interested in learning how the program is supporting the growth of comprehensive Sickle Cell Disease (SCD) 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. The Committee directs HRSA to provide an update in the fiscal year 2023 Congressional Budget Justification on its plans to meet these goals. **(Page 59)**

**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 developing and supporting 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 in the region, the TDPs collaborate with clinics or practices in at least seven states within a single region in order 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), and will also work and collaborate closely with the 20 CBOs funded in FY 2021 through the Sickle Cell Disease Newborn Screening Follow-up Program, and five community health centers funded through the Hemoglobinopathies National Coordinating Center. Together, these partnerships will 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 system of care.

20) **Severe Combined Immune Deficiency (SCID).**—Within the total amount for Heritable Disorders, the Committee provides $4,000,000, an increase of $1,000,000 above the fiscal year 2021 enacted level and the fiscal year 2022 budget request, to support wider implementation, education, and awareness of newborn screening and follow-up for SCID and other newborn screening disorders. The Committee recognizes the progress that has been made in screening for SCID at birth to enable early interventions, including bone marrow transplantations and emerging investigational gene therapies. This work has been extremely beneficial to families who will soon have access to additional support with the

launch of a virtual, facilitated caregiver support group this year. The Committee directs HRSA to continue supporting this and related work that focuses on helping families understand and navigate the process from diagnosis to treatment and follow-up and to expand access to these resources for providers and families of infants with SCID and other newborn screening disorders with a focus on reaching underserved populations. **(Page 60)**

**Actions to be Taken**

In FY 2022, HRSA will continue to support newborn screening and follow-up for Severe Combined Immunodeficiency (SCID) and other newborn screening disorders. The program works to ensure that newborns and children identified through newborn screening with SCID or other newborn screening disorders achieve the best possible outcomes. The program expands the ability of state public health agencies to provide screening, counseling and services to these newborns and children. The program also supports education, training and collaboration with clinicians, public health agencies and families to create a system of care that can assess and coordinate follow-up and treatment of SCID and other newborn screening disorders. Grantees create follow-up models that provide evidence-based/informed, condition-specific treatments and age-appropriate preventive care for infants and children with SCID or other newborn screening disorders, including using telehealth to link rural and medically underserved populations to knowledgeable clinicians, support, and resources. In addition, grantees collect and analyze long-term follow-up data to evaluate outcomes on infants with SCID and other newborn screening disorders.

21) **Remote Blood Pressure Monitoring Initiative.**—Preeclampsia/eclampsia is the most dangerous form of hypertension that can develop during pregnancy or the postpartum period, affecting as many as one in twelve pregnancies and resulting in 15 percent of premature infant deaths. While new preeclampsia diagnostics are being evaluated by the Food and Drug Administration (FDA), the Committee understands that medical providers continue to rely on regular blood pressure monitoring to identify pregnant and postpartum people at highest risk of developing preeclampsia. The Committee also understands that preeclampsia disproportionately affects racial and ethnic minorities and those living in rural communities, and supports efforts to improve blood pressure monitoring for people lacking access to consistent prenatal care, particularly efforts to support remote blood pressure monitoring of pregnant people through use of blood pressure cuffs and easy-to-understand patient information to identify the signs and symptoms of preeclampsia and allow patients to proactively engage their health providers. The Committee urges the Healthy Start Program to work with States, health care providers, and nonprofit patient organizations to design and support an initiative that will strengthen remote blood pressure monitoring programs among high-risk vulnerable populations and communities. **(Page 61)**

**Actions to be Taken**

Regular blood pressure monitoring is essential to maternal and infant health. HRSA's Healthy Start Program has taken steps to support and improve blood pressure monitoring among its clients, which include high-risk vulnerable populations and communities. Through clinical support funds provided to grantees, Healthy Start awardees monitor and track clients' blood pressure, as well as provide and refer for follow-on care where appropriate. The purchase of and training on the use of remote blood pressure monitors is an allowable grant expense.

22) **Screening and Treatment for Maternal Depression and Related Disorders State Grants.**—The Committee provides $10,000,000 for the Screening and Treatment of Maternal Depression and Related Behavioral Disorders Program (MDRBD), an increase of $5,000,000 above the fiscal year 2021 enacted level and the same as the fiscal year 2022 budget request. Maternal mental health (MMH) conditions are the most common pregnancy and postpartum complication; however, 75 percent of mothers go untreated. The COVID–19 pandemic has exacerbated maternal mental health conditions, with pregnant and new mothers experiencing anxiety and depression at a three to four times higher rate than prior to the pandemic. MDRBD trains health care providers to screen, assess, and treat for MMH conditions and provide specialized psychiatric consultation to assist the providers. The Committee directs HRSA to make grants to establish new State programs, and improve or maintain existing State programs. Grants shall include culturally competent approaches to assist in the reduction of maternal health inequities. The Committee recognizes the high need amongst States and directs MDRBD to provide technical assistance to non-grantee States. **(Page 62)**

**Actions to be Taken**

In FY 2022, HRSA is planning a Notice of Funding Opportunity (NOFO) to make grants to establish new Screening and Treatment of Maternal Depression and Related Behavioral Disorders Program (MDRBD) State programs, and improve or maintain existing MDRBD State programs. HRSA will issue the NOFO in 2022 with an anticipated project start date in September 2022. Grants will include culturally and linguistically appropriate training and approaches to assist in the reduction of maternal health inequities. Technical assistance to non-grantee States will be available through HRSA's Maternal and Child Health Tele-Behavioral Health Programs Technical Assistance Innovation Center.

23) **Maternal, Infant, and Early Childhood Home Visiting Program.**—The Committee recognizes that good oral health is an important component for improving the health and well-being of children and families. The Committee encourages HRSA to explore opportunities to facilitate linkages between the agency's Home Visiting Program and Community Dental Health Coordinators, where available. The Committee also encourages HRSA to work with oral health initiatives such as Community Dental Health Coordinators that have already been initiated by dental organizations to provide dental

education, community-based prevention, care coordination, and patient navigation to children and vulnerable families. **(Page 62)**

**Actions to be Taken**

In FY 2022, HRSA continues to integrate oral health into the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program by requiring awardees to establish appropriate linkages and referral networks to community resources, as specified in statute. HRSA has initiated collection of additional data on whether children enrolled in home visiting programs have a usual source of dental care by 12 months of age. In FY 2021, approximately 66 percent of children 12 months or older enrolled in home visiting had a usual source of dental care. HRSA continues to promote linkages with Community Dental Health Coordinators to MIECHV awardees, where available, and to the extent practicable.

24) **Ryan White Part A Formula Disparities.**—The Committee directs HRSA to take action to revise and improve the funding formula disparities under Part A of the Ryan White HIV/AIDS Program. Funding allocations utilized under the Ryan White HIV/AIDS Treatment Extension Act of 2009 are largely based on a formula which considers the place of residence of persons at the time of initial diagnosis when making formula-based grants. Under current law, if a person diagnosed with HIV in one area of the country moves to another part of the country, the funding for the case is not transferred to the new location. Therefore, the Committee directs HRSA to develop methods for calculating RWHAP formula funds to reflect the number of persons living with HIV in eligible jurisdictions, as well as other factors that reflect variability in funds and other resources. **(Page 63)**

**Actions to be Taken**

HRSA is exploring the feasibility of utilizing most recent address and other factors in both the Ryan White HIV/AIDS Program Part A base award and supplemental award.

25) **Maximizing Deceased Donor Organ Recovery, Acceptance, and Utilization.**—The Committee supports swift implementation of the CMS final rule for Organ Procurement Organizations (OPOs) Conditions for Coverage (CMS–3380–F), including efforts to decertify underperforming OPOs. OPO failures are disproportionately borne by patients of color, which means OPO reform is an urgent health equity issue. The Committee believes swift and effective implementation of the Final Rule is a first step toward ensuring OPOs perform their public duties to secure more organs in an inclusive and equitable manner. The Committee supports regulatory and enforcement efforts to minimize excessive and frivolous expenses reimbursed by Medicare, including the CMS proposed rule on Medicare reimbursement for organ acquisition costs (CMS–1752–P). The Committee also encourages HHS to make all efforts to promote competition for the Organ Procurement and Transplantation Network (OPTN) contract, and to use the announced movement of the Division of Transplantation to the Office of the Assistant Secretary for Health to facilitate coordinated organ donation reforms. **(Page 64)**

**Actions to be Taken**

HRSA has always held full and open competitions for the OPTN contract. Since the last competition in 2018, HRSA has undertaken efforts to promote competition in future procurements. HRSA conducted market research on potential ways to modernize the OPTN IT system and published a Request for Information (RFI) in November 2019. The market research/RFI engaged industry on the possibilities for modern IT architecture to perform the primary functions of a national organ allocation system. HRSA held an "Industry Day" and responded to questions from interested offerors. HRSA also utilized the expertise of the U.S. Digital Services (USDS) to better understand the submissions received in response to the RFI.

26) **340B Drug Discount Program.—**The Committee is aware that in 2011, GAO issued a report outlining five recommendations for HRSA to improve performance and accountability within the 340B program. The Committee commends HRSA for implementing three of those recommendations and directs HRSA to report to the Committee within 120 days of enactment of this Act on plans to implement the remaining two recommendations, which focus on clarifying eligibility criteria for 340B patients and providers. The Committee also directs GAO to update the 2011 report on the performance of the 340B program. **(Page 66)**

**Actions to be Taken**

The 340B Program spans the country and serves as a critical safety-net drug discount program that is an integral component of the success of the safety-net system in our country and has grown to nearly $40 billion in discounted drugs sales in 2020. While none of that amount is directly tied to taxpayer dollars, the growth of the Program has brought down the cost of prescription drugs in the safety net community to the tune of a 25 – 50% discount off the regular cost of the drugs.

Despite the broad reach and impact of the Program, HRSA's regulatory authority in this area is limited. This has led to disputes over compliance and oversight in the Program as evidenced by ongoing litigation making this issue even more urgent. Court decisions completed have outlined the need for Congress to act in this space. While HRSA appreciates the work of the GAO in providing recommendations to improve the oversight of the 340B Program and as described in the President's Budget for the past 6 years, HRSA does not have explicit regulatory authority to implement, further define or enforce most aspects of the 340B statute, including the compliance elements cited in the 2011 GAO Report. HRSA only has explicit regulatory authority in three areas of the 340B statute (ceiling price calculation, civil monetary penalties for manufacturers, and establishing an alternative dispute resolution process).

Safety-net clinics and hospitals are foundational to our country's health system, focusing on our most vulnerable, underserved, and isolated patient populations and the pandemic has illustrated just how essential these providers are in serving those in need. Over the years, HRSA has received significant feedback from Congress urging HRSA to take action under the authority it has in the statute, which we have done to the fullest extent. However that authority is not sufficient. Legislative action is necessary to provide the kind of transparency,

accountability, and oversight needed to ensure that the intent of the program is met to stretch scarce federal resources for safety net providers and the safety net has access to discounted drugs for their patients.

27) **Urban Focused Telehealth Network Grant Program.**—The Committee believes that a fundamental element to ensuring our health care system is prepared for pandemic events is the development of robust telehealth services and integrated systems that can provide a continuum of care across State and regional lines. This is especially true in the nation's urban areas, where a pandemic event has the potential to disproportionately impact and overwhelm the health care and delivery system. The Committee believes increased investments in urban telehealth services could have a tremendous impact on the health and well-being of the nation's most vulnerable citizens and medically underserved populations, especially during times of national public health emergencies. The Committee encourages HRSA to establish a pilot program to expand academic health system telehealth programs aimed at addressing the health inequities of urban populations. **(Page 68)**

**Actions to be Taken**

HRSA's Office for the Advancement of Telehealth (OAT), through Section 330I of the Public Health Service Act, has the ability to fund telehealth networks in rural areas, frontier, communities, and medically underserved areas, and for medically underserved populations.

28) **Rural Health Residency Program.**—The Committee includes $12,700,000 for the Rural Health Residency Program, an increase of $2,200,000 above the fiscal year 2021 enacted level and the same as the fiscal year 2022 budget request. This program funds physician residency training programs that support physician workforce expansion in rural areas. The COVID–19 pandemic has exacerbated the challenges in access to care faced by Americans in rural areas, particularly when they require specialty care. The Committee commends the Federal Office of Rural Health Policy for its efforts to expand the physician workforce in rural areas and supports continuation and expansion of the program to develop new rural residency programs, or Rural Training Tracks (RTTs). This Committee encourages HRSA to expand the current program to include RTTs in obstetrics and gynecology, as women in rural communities are more likely to begin prenatal care late and are more likely to experience maternal mortality and severe maternal morbidity. The Committee requests a report in the fiscal year 2023 Congressional Budget Justification on the progress made to date and efforts to expand RTTs in obstetrics and gynecology. **(Page 69)**

**Actions to be Taken**

HRSA recognizes the need for rural training in obstetrics and gynecology. Studies show that health care providers who train in rural areas are more likely to practice in rural areas. In FY 2020 HRSA issued a new Rural Residency Planning and Development (RRPD) program funding opportunity soliciting applications to start residency programs in family medicine, internal medicine, public health and general preventive medicine, psychiatry, general surgery, and obstetrics and gynecology. From this competition, HRSA made awards in FY

2020 and FY 2021 to 20 organizations across 15 states to develop new rural residency programs in family medicine, internal medicine, psychiatry, and general surgery.

HRSA continues to investigate barriers to rural training in obstetrics and gynecology. HRSA has funded a study through its Rural Health Research Center Program to investigate barriers to providing rural obstetrical training for physicians. HRSA expects the results of this research to be available by the end of FY 2022.

HRSA issued a new RRPD program funding opportunity for FY 2022 in October 2021 (HRSA-22-094) which was due in January 2022. HRSA plans to issue awards from this competition on or before August 1, 2022. Eligible residency types for the FY 2022 funding opportunity are rural residency programs in family medicine, internal medicine, preventive medicine, psychiatry, general surgery, and obstetrics and gynecology. With this funding opportunity HRSA further emphasized obstetrics and gynecology as an eligible residency specialty and highlighted the importance of obstetrics training for rural physicians.

29) **Telehealth Guidance.**—The Committee recognizes that the COVID–19 pandemic has increased the importance of access to telehealth services across the health care system, including for Title X providers and patients. The Committee urges the OPA to release telehealth guidance and best practices for Title X projects that reiterate the importance of telehealth in providing quality family planning services. **(Page 70)**

**Actions to be Taken**

OPA made available $35 million to support Title X telehealth enhancement and expansion for award in May 2022. The office anticipates releasing telehealth guidance, best practices, and training to its Title X grantees that reinforces the importance of telehealth, as a viable method for providing equitable access to quality family planning services to communities and individuals who may not otherwise receive these services throughout FY 2023.

30) **Recommendations for Quality Family Planning Services.**—The Committee directs the Secretary to begin the process of revising ‘‘Providing Quality Family Planning Services,’’ evidence-based recommendations from the CDC and OPA that were last updated in 2017. Revisions should incorporate new evidence and support holistic reproductive and sexual health needs. The Committee requests a briefing on the status of this process no later than 180 days of enactment of this Act. **(Page 70)**

**Actions to be Taken**

OPA anticipates revising the Quality Family Planning Services evidenced-based recommendations that were developed jointly with CDC. The revisions will incorporate new evidence and support holistic reproductive and sexual health needs through a health equity frame. To this end, OPA will conduct systematic reviews of the current and emerging reproductive and sexual health topics and lead a series of technical panel discussions about best practices and recommendations with experts in the field of sexual and reproductive health to inform the guidelines development.

31) **Estimated Need for Services.**—The Committee requests the Secretary conduct a study, within 270 days of enactment of this Act, reflecting the current estimated need for Title X services and cost required to provide such updating the 2016 study published in the American Journal of Public Health. **(Page 70)**

**Actions to be Taken**

OPA anticipates conducting an updated study which examines the current estimated need for Title X services and its associated costs.

32) **HRSA Chief Dental Officer.**—The Committee is disturbed to learn that despite its directive in House Report (116–450) to have HRSA ensure that the Chief Dental Officer (CDO) is functioning at an executive level authority with resources and staff to oversee and lead all oral health programs and initiatives across HRSA, no such authority has been delegated. The Committee directs HRSA to restore the authority of HRSA CDO with executive level authority and resources to oversee and lead HRSA dental programs and initiatives as well as have a role within oral health 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 2023 Congressional Budget Justification on how the CDO is serving as the agency representative on oral health issues to international, national, State and/or local government agencies, universities, and oral health stakeholder organizations. **(Page 70)**

**Actions to be Taken**

In a recent 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. The CDO position at HRSA is responsible for: coordinating oral health activities across HRSA programs and advising HRSA oral health priorities throughout the various programs in the agency. Over the past year, specific activities have included: reviewing and advising on proposed oral health-related investments across the agency; representing the agency at professional conferences and meetings; providing presentations on the agency's oral health portfolio and key topics of interest to a variety of stakeholders; and developing and directing a cross-agency project to improve the oral health literacy of HRSA constituent populations. HRSA is currently recruiting for a new CDO.

33) **Action for Dental Health.**—With the enactment of the Action for Dental Health Act of 2018, the Committee encourages HRSA to expand oral health grants for innovative programs under PHS Act Section 340G (42 USC Section 256g) to include Action for Dental Health activities. The Action for Dental Health program helps reduce barriers to dental care through oral health education, prevention, and the establishment of dental homes for underserved populations. **(Page 71)**

**Actions to be Taken**

In FY 2022, HRSA issued a Notice of Funding Opportunity for "Grants to States to Support Oral Health Workforce Activities". The purpose of this program is to help States develop and implement innovative programs to address the dental workforce needs of designated dental health professional shortage areas (Dental HPSAs) in a manner appropriate to each State's individual needs. This NOFO expanded the allowable activities under the program to include the language from the Action for Dental Health Act of 2018. The estimated total program funding is $12.8 million; expected number of awards is 32; estimated award date is September 1, 2022.

34) **Oral Health Literacy.**—The Committee includes $500,000 to continue the development of an oral health awareness and education campaign across relevant HRSA divisions, including the Health Centers Program, Oral Health Workforce, Maternal and Child Health, Ryan White HIV/AIDS Program, and Rural Health. The Committee directs HRSA to identify oral health literacy strategies that are evidence-based and focused on oral health care prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer. The Committee urges HRSA to ensure that the Chief Dental Officer plays a key role in the design, monitoring, oversight, and implementation of this project. **(Page 71)**

**Actions to be Taken**

HRSA will launch an evidence-based oral health literacy campaign incorporating messaging around early detection, disease prevention, and oral health promotion by the end of FY 2022. The Chief Dental Officer will be involved in the design, planning, development and monitoring of an oral health awareness and education campaign for health center patients, people living with HIV/AIDS, parents and children, and rural or underserved populations.

35) **Targeted Investments in Impoverished Areas.**—The Committee supports targeted investments in impoverished areas, particularly in persistent poverty counties and in other high-poverty census tracts. The Committee directs HRSA to develop and implement measures to increase the share of investments its programs in persistent poverty counties, high-poverty areas, and any other impoverished communities that HRSA determines to be appropriate areas to target. The Committee appreciates the report HRSA provided in response to the Committee's request in House Report 116–450 and directs the Department to provide an update to the Committee within 180 days of enactment of this Act on how HRSA is carrying out this directive. **(Page 71)**

**Actions to be Taken**

While some of HRSA's statutory authorities allow programs to target rural areas or medically underserved communities such as Health Professional Shortage Areas and Medically Underserved Areas/Populations, HRSA's current program authorities do not allow HRSA to limit competitive awards to locations in persistent poverty counties or other high-poverty census tracts.

36) **Prenatally and Postnatally Diagnosed Conditions Awareness Act (P.L. 110–374).**—As a response to the growth in prenatal screening and testing, Congress passed this Act to

ensure women receive ac-curate information on genetic testing, community support, and out-comes of care for their children when they receive a prenatal or postnatal diagnosis for Down syndrome or similar conditions. The Committee requests an update on the efforts to implement the Act in the fiscal year 2023 Congressional Budget Justification. **(Page 94)**

**Actions to be Taken**

HRSA acknowledges the importance of accurate information on genetic testing, community support, timely screening and referral to services for children with Down syndrome and other similar genetic conditions. HRSA supports these activities through a variety of programs, including the Regional Genetics Networks that provide health care professionals with education to assess and coordinate genetic testing, follow-up and treatment relating to genetic conditions by linking patients to genetic services. In addition, HRSA supports the Family-to-Family Health Information Centers (F2F HICs) Program. Each state has an F2F HIC that provides information, education, technical assistance, and peer support to families of children and youth with special health care needs, including those diagnosed with Down syndrome and other similar conditions, and the professionals who serve them.

# Legislative Proposals

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# Legislative Proposals

1. **Expand HRSA's Rulemaking Authority for the 340B Drug Pricing Program and Establish Requirements for the Use of Savings for Program Integrity**
   HRSA is seeking to establish rulemaking authority and require covered entities to report both the 340B savings and their uses to HRSA. The 340B Program helps to ensure safety-net providers are able to provide access to care to the vulnerable populations that they serve. The 340B Program was authorized by the Veterans Health Care Act of 1992 and amended by sections 7101 and 7102 of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), which expanded eligibility for the 340B Program and significantly increased HHS's oversight responsibility and authority. Under the current law, HHS has explicit authority to regulate in only three areas; other areas are operated under guidance documents. The proposal would provide HRSA with general rulemaking authority to strengthen the 340B Program by allowing HRSA to issue binding and enforceable regulations for all aspects of the 340B Program.

2. **Update HRSA's Health Center Construction Authority**
   HRSA is seeking to modify the authority for facility alteration, renovation, and construction grants for health centers. Currently, there are specific limits on how grant funding can be used, and this proposal would expand the potential uses and increase flexibility. The proposed modification of the authority would allow the use of funds for health centers to: 1) increase facility capacity to provide additional primary care services; 2) maintain current facilities; 3) improve or build new facilities that support evolving face-to-face and virtual patient-centered care delivery models; and 4) build, improve, or modify facilities to support continuity of access to high quality primary care services for underserved and vulnerable populations during and after public health emergencies and disasters.

3. **Permanent extension of HRSA's Health Center Volunteer Health Professional (VHP) Federal Tort Claims Act (FTCA) Program**
   HRSA is seeking to permanently extend the statutory authority for HRSA's Health Center VHP FTCA program (which is set to expire on October 1, 2022). The program supports health centers' ability to recruit and retain volunteer health professionals by providing federal liability protections. During the COVID-19 pandemic, VHP providers are a key resource in providing critical COVID-19 related services and general health care services that meet the needs of underserved populations. Health centers have recognized the value of maintaining and expanding their use of a volunteer workforce to better meet the preventive and primary health care needs of their patients. If FTCA coverage for VHPs ends, health centers will have to determine whether they can afford private malpractice insurance for their VHPs, or they would have to turn away these volunteer services. The loss of VHPs would negatively impact health centers' ability to provide primary health care services to underserved and vulnerable patient populations.

4. **Update HRSA's Legislative Authority for the Office for the Advancement of Telehealth**
   HRSA is seeking to update the Office for the Advancement of Telehealth's (OAT) legislative authority to include a broader focus to take on an advisory role to the HHS Secretary on

policy, research, and programmatic activities. The proposed amendments to OAT's authorizing legislation would formalize the office's policy role and provide more flexible grant authority for OAT. Current legislative authority is program specific, with limited language focusing on coordination and outreach. These changes would update the statute to reflect OAT's current role and provide a more flexible grant authority to keep pace with changes in the telehealth environment. This proposal would strengthen HHS' overall efforts in improving access to health care for rural communities by strengthening policies, informing research, and targeting programmatic activities that seek to increase and expand utilization of telehealth services.

5. **Improving HRSA's Ryan White HIV/AIDS Program Data at the Client Level**
HRSA is seeking to modify the restriction on its ability to collect individually identifiable health information in the Ryan White HIV/AIDS Program. HRSA requests statutory authority to collect ZIP codes for residential addresses of clients in order to improve the agency's ability to analyze the resources available by the geographic location of clients, resulting in improved ability to assess and improve health equity. Collecting just this one variable will allow HRSA to conduct important public health analyses, while still protecting at the federal level the privacy and identity of people living with HIV. This proposal would allow HRSA to better understand where clients live versus where they receive HIV care and treatment and address disparities in HIV care and treatment by geographic location.

# Vaccine Injury Compensation Program

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# VACCINE INJURY COMPENSATION PROGRAM

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# Appropriation Language

## VACCINE INJURY COMPENSATION PROGRAM TRUST FUND

*For payments from the Vaccine Injury Compensation Program Trust Fund (the ''Trust Fund''), such sums as may be necessary for claims associated with vaccine-related injury or death with respect to vaccines administered after September 30, 1988, pursuant to subtitle 2 of title XXI of the PHS Act, to remain available until expended: Provided, That for necessary administrative expenses, not to exceed $26,200,000 shall be available from the Trust Fund to the Secretary.*

## Amounts Available for Obligation

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| Discretionary Appropriation: | $38,100,000 | $38,100,000 | $67,843,000 |
| Transfer to Other Accounts | -$11,200,000 | | |
| Transfer from Other Accounts | $11,200,000 | | |
| **Subtotal, adjusted Discretionary Appropriation** | **$38,100,000** | **$38,100,000** | **$67,843,000** |
| Mandatory Appropriation | $246,415,000 | $251,343,000 | $256,370,000 |
| Transfer to Other Accounts | -$246,415,000 | | |
| Transfer from Other Accounts | $246,415,000 | | |
| **Subtotal, adjusted Mandatory Appropriation** | **$246,415,000** | **$251,343,000** | **$256,370,000** |
| Spending Auth Offsets | -- | | |
| Administrative Expenses | 38,100,000 | 38,100,000 | 67,843,000 |
| Total HRSA Claims | 246,415,000 | 251,343,000 | 256,370,000 |
| **Total New Obligations** | **284,515,000** | **289,443,000** | **324,213,000** |

## Budget Authority by Activity

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| Trust Fund Obligations: Post-10/1/88 claims | $246,415,000 | $251,343,000 | $256,370,000 |
| Administrative Expenses: HRSA Direct Operations | $11,200,000 | $11,200,000 | $26,200,000 |
| Total Obligations | $257,615,000 | $262,543,000 | $282,570,000 |

## Budget Authority by Object

| | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2022 +/- FY 2021 |
|---|---|---|---|
| Insurance claims and indemnities | $251,343,000 | $256,370,000 | +$5,027,000 |
| Salaries & Expenses/Other Services | $11,200,000 | $26,200,000 | +$15,000,000 |
| Total | $262,543,000 | $282,570,000 | +$20,027,000 |

# Authorizing Legislation

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| (a) PHS Act, Title XXI, Subtitle 2, Parts A and D: | | | |
| Pre-FY 1989 Claims | --- | --- | --- |
| Post-FY 1989 Claims | $246,415,000 | $251,343,000 | $256,370,000 |
| (b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239): | | | |
| HRSA Operations | $11,200,000 | $11,200,000 | $26,200,000 |

# Appropriation History Table

(Pre-1988 Claims Appropriation)

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 1996 | 110,000,000 | 110,000,000 | 110,000,000 | 110,000,000 |
| 1997 | 110,000,000 | 110,000,000 | 110,000,000 | 110,000,000 |
| 1998 | --- | --- | --- | --- |
| 1999 | --- | --- | 100,000,000 | 100,000,000 |
| 2000 | --- | --- | --- | --- |
| 2001 | --- | --- | --- | --- |
| 2002 | --- | --- | --- | --- |
| 2003 | --- | --- | --- | --- |
| 2004 | --- | --- | --- | --- |
| 2005 | --- | --- | --- | --- |
| 2006 | --- | --- | --- | --- |
| 2007 | --- | --- | --- | --- |
| 2008 | --- | --- | --- | --- |
| 2009 | --- | --- | --- | --- |
| 2010 | --- | --- | --- | --- |
| 2011 | --- | --- | --- | --- |
| 2012 | --- | --- | --- | --- |
| 2013 | --- | --- | --- | --- |
| 2014 | --- | --- | --- | --- |
| 2015 | --- | --- | --- | --- |
| 2016 | --- | --- | --- | --- |
| 2017 | --- | --- | --- | --- |
| 2018 | --- | --- | --- | --- |
| 2019 | --- | --- | --- | --- |
| 2020 | --- | --- | --- | --- |
| 2021 | --- | --- | --- | --- |
| 2022 | --- | --- | --- | --- |
| 2023 | --- | --- | --- | --- |

# Vaccine Injury Compensation Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **Claims BA** | $246,415,000 | $251,343,000 | $256,370,000 | +$5,027,000 |
| **Admin BA** | $11,200,000 | $11,200,000 | $26,200,000 | +$15,000,000 |
| **Total BA** | $257,615,000 | $262,543,000 | $282,570,000 | +$20,027,000 |
| **FTE** | 19 | 19 | 32 | +13 |

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 2023 Authorization……...…....Indefinite

Allocation Method ..... Other

**Program Description and Accomplishments**

Serving as an alternative to the traditional tort system, the National Vaccine Injury Compensation Program (VICP) compensates individuals or families of individuals, who have been injured by vaccines recommended by the Centers for Disease Control and Prevention (CDC) for routine administration to children or pregnant women. HRSA administers the VICP, and the Department of Justice (DOJ) represents HHS in the U.S. Court of Federal Claims (Court), which ultimately decides to provide compensation or dismiss claims.

HRSA receives claims requesting compensation for vaccine injuries or deaths, which the petitioner has served against the HHS Secretary and filed with the Court. HRSA medical officers with special expertise in pediatrics and adult medicine review these claims, 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 healthcare 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 compensates 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. Table 1 shows the number of petitioners awarded compensation and vaccine injury compensation provided over the last five years.

**Table 1. Growth in Families and Individuals Receiving Compensation**

| Fiscal Year | No. of Petitioners | Compensation ($ in millions) |
|---|---|---|
| **2016** | 689 | $253 |
| **2017** | 706 | $282 |
| **2018** | 521 | $227 |
| **2019** | 653 | $226 |
| **2020** | 733 | $218 |
| **2021** | 719 | $245 |

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 2.

In FY 2017, HRSA began 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 HRSA funding to administer the VICP increased by $1 million from $10.2 in FY 2020 to $11.2 million in FY 2021, the backlog grew to 1,580 by the end of FY 2021, results in compensation delays since claims are on the waiting list for about 13 months pending review.

**Table 2. 10-Year Trend in Number of Claims Filed and Administrative Costs**
(*dollars in millions)*

| Fiscal Year | Number of Claims Filed | Administrative Funding |
|---|---|---|
| **2012** | 401 | $6.50 |
| **2013** | 504 | $6.50 |
| **2014** | 633 | $6.50 |
| **2015** | 803 | $7.50 |
| **2016** | 1,120 | $7.50 |
| **2017** | 1,243 | $7.75 |
| **2018** | 1,238 | $9.20 |
| **2019** | 1,282 | $9.20 |
| **2020** | 1,192 | $10.20 |
| **2021** | 2,057[1] | $11.20 |

1/Significant influx of 800 claims in January 2021 due to expected implementation of the final rule proposed to remove Shoulder Injury Related to Vaccine Administration (SIRVA)

**Funding History – VICP Claims Compensation**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $225,900,000 |
| FY 2020 | $260,400,000 |
| FY 2021 Final | $246,415,000 |
| FY 2022 CR | $251,343,000 |
| FY 2023 President's Budget | $256,370,000 |

**Funding History - VICP Administration**

| Fiscal Year | Amount |
|---|---|
| FY 2019 | $9,200,000 |
| FY 2020 | $10,200,000 |
| FY 2021 Final | $11,200,000 |
| FY 2022 CR | $11,200,000 |
| FY 2023 President's Budget | $26,200,000 |

**Budget Request**

VICP Claims Compensation

The FY 2023 Budget Estimate for the VICP Claims Compensation Program of $256.3 million is $5.0 million more that the FY 2022 Continuing Resolution level. This request will help provide adequate funds to compensate petitioners and pay their attorneys' fees and costs. These funds will also allow the VICP to continue to meet its zero percent target for eligible claimants who opt to reject awards and elect to pursue civil action. Prior to the existence of the VICP, civil actions

against vaccine manufacturers threatened to cause vaccine shortages and reduce vaccination rates.

VICP Administration

The FY 2023 Budget Request for the VICP Administration Program of $26.2 million is $15.0 million more than the FY 2022 Continuing Resolution level. This request will support administrative expenses to process approximately 2,560 claims, which includes reducing the backlog by 480 claims or approximately 27 percent. 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.

**Outputs and Outcomes Tables**

| Measure | Year and Most Recent Result/ Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 9000.01 Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed. (Outcome) | FY 2021: 0% Target: 0% (Target Met) | 0% | 0% | Maintain |
| 9000.02 Average time settlements are approved from the date of receipt of the DOJ settlement proposal. (Outcome) | FY 2021: 1 day Target: 10 days (Target Exceeded) | 10 days | 5 days | -5 days |
| 9000.03 Average time that lump sum only awards are paid from the receipt of all required documentation to make a payment. (Outcome) | FY 2021: 3 days Target: 4 days (Target Exceeded) | 4 days | 3 days | -1 day |

| Measure | Year and Most Recent Result/ Target for Recent Result (Summary of Result) | FY 2022 Target | FY 2023 Target | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| 9000.04 Percentage of cases in which court-ordered annuities are funded within the carrier's established underwriting deadline. (Outcome) | FY 2021: 100% Target: 98% (Target Exceeded) | 98% | 99% | +1 percentage point |
| 9000.05 Percentage of medical reports that are completed within 90 days of receipt of any medical records. (Outcome and Developmental) | FY 2021: 92% Target: 75% (Target Exceeded) | 75% | 80% | +5 percentage points |
| 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 2021: 31% Target: 65% (Target Not Met) | 65% | 65% | Maintain |

**Discussion of Outputs and Outcomes**

In FY 2018, HRSA developed a performance measure to monitor whether claims with medical records are assigned for medical review within four months of the claim being received from the Court. For FY 2023, the proposed target is 65% of claims with any medical records will be assigned for medical review within 4 months of receipt from the Court. Adequate funding to conduct medical reviews of newly filed and backlog claims will help the VICP to meet or exceed this target.

# Countermeasures Injury Compensation

# TAB

# COUNTERMEASURES INJURY COMPENSATION PROGRAM

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COVERED COUNTERMEASURE PROCESS FUND

*For carrying out section 319F-4 of the PHS Act, $15,000,000 shall remain available until expended.*

## Amounts Available for Obligation

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| Discretionary Appropriation: | | | |
| Direct Appropriation | --- | --- | $15,000,000 |
| Unobligated Balance: | | | |
| Unobligated Balance, start of year | $1,492,838 | $2,992,689 | --- |
| Unobligated Balance, Transfer from Other Accounts | $4,350,509 | $6,277,692 | --- |
| **Subtotal, Unobligated Balance** | **$5,843,347** | **$9,270,381** | --- |
| Administrative Expenses | $4,891,421 | $4,025,000 | $9,000,000 |
| Compensation Funding | $951,926 | $5,245,381 | $6,000,000 |
| **Total New Obligations** | **$5,843,347** | **$9,270,381** | **$15,000,000** |

## Budget Authority by Activity

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget |
|---|---|---|---|
| Countermeasures Injury Compensation Program[337] | --- | --- | $15,000,000 |

## Authorizing Legislation

| | FY 2022 Amount Authorized | FY 2022 Amount Appropriated | FY 2023 Amount Authorized | FY 2023 Amount Appropriated |
|---|---|---|---|---|
| Countermeasures Injury Compensation Program: PHS Act, Sections 319F-3 and 319F-4, as added by P.L. 109-148, as amended by P.L. 113-5 (to Section 319F-3) | Not Specified | --- | Not Specified | $15,000,000 |

[337] Since October 2009, CICP has received funding from the Public Health and Social Services Emergency Fund (PHSSEF).

# Countermeasures Injury Compensation Program

| | FY 2021 Final | FY 2022 Continuing Resolution | FY 2023 President's Budget | FY 2023 +/- FY 2022 |
|---|---|---|---|---|
| **BA** | --- | --- | $15,000,000 | +$15,000,000 |
| **FTE** | --- | --- | 42 | +42 |

Authorizing Legislation: Public Health Service Act, Sections 319F-3 and 319F-4, as amended by Public Laws: 109-148 Sec. 3, 113-5 Sec. 402, 116-123, 116-127, Sec. 6005 and 116-136.

FY 2023 Authorization ..... Not Specified

Allocation Method ..... Other

**Program Description and Accomplishments**

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. PREP Act declarations identify the countermeasures covered by CICP. Since October 2009, CICP has received funding from the Public Health and Social Services Emergency Fund (PHSSEF).

**Funding History**

| FY | Amount |
|---|---|
| FY 2019 | --- |
| FY 2020 | --- |
| FY 2021 Final | --- |
| FY 2022 CR | --- |
| FY 2023 President's Budget | $15,000,000 |

**Budget Request**

The FY 2023 Budget Request for the Countermeasures Injury Compensation Program (CICP) is $15.0 million. This funding will be used to initiate the review of an estimated 1,500 medical reviews of claims and provide compensation to eligible individuals for injuries and deaths directly resulting from the use of covered countermeasures