DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2026

Administration for a Healthy America

Justification of Estimates for Appropriations Committees

HRSA
Health Resources & Services Administration

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Rockville, MD 20857

MESSAGE FROM THE ADMINISTRATOR

I am pleased to transmit the inaugural Congressional Justification of the Administration for a Healthy America (AHA) request for the Fiscal Year (FY) 2026 Budget. The vision of this new, unified agency is to improve the health and well-being of all Americans. The Administration's FY 2026 Budget request includes $20.6 billion in total funding for AHA, including $14.1 billion in discretionary funding, and $6.5 billion in mandatory funding and other sources.

Supporting Secretary Kennedy's vision to Make America Healthy Again, AHA will be the primary federal agency committed to transforming the health of all Americans by addressing the root causes of chronic disease, promoting preventive care, advancing mental health and substance use services, and increasing access to a healthy environment and foods. Americans should have access to transparent, data-based information to make informed decisions about their health and well-being.

In alignment with the proposed Department of Health and Human Services reorganization, AHA combines several overlapping disease prevention and chronic care programs to increase operational and program efficiency. These programs were previously administered through the Office of the Assistant Secretary of Health (OASH), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute of Environmental Health Sciences (NIEHS), and several centers of the Centers for Disease Control and Prevention (CDC).

This new organization will focus on areas including primary care, environmental health, HIV/AIDS, maternal and child health, mental and behavioral health, and workforce development. AHA will also develop policies and conduct research to support disease prevention and health promotion, as well support the Surgeon General as the nation's doctor providing best scientific information to Americans, overseeing of the U.S. Public Health Service Commissioned Corps, and liaising and supporting the operations of regional health offices.

Supporting Access to Primary Care. The FY 2026 Budget invests in primary care services with an emphasis on health promotion and disease prevention, particularly in medically underserved and rural areas where individuals may not otherwise have access to care. The request supports approximately 1,400 Health Centers operating more than 15,000 service sites nationwide, each working with communities to improve the health and well-being of patients through the prevention and management of chronic diseases, such as diabetes and hypertension. The Budget also supports OPTN system modernization, enhanced oversight, and expanded support for living organ donation. The Budget invests in the continued advancement of telehealth and provides grants to combat opioid use disorders and support the development of health providers in rural areas, and also supports education and resources to assist populations with specific needs including individuals with Hansen's disease and those in need of cell transplantation. These

funds will also support suicide prevention, domestic and sexual violence, rape prevention, opioid overdose prevention and surveillance, and the National Violent Death Reporting System.

Protecting Against Environmental Health Risks. Environmental factors and conditions can lead to negative health impacts and chronic conditions. These effects can be particularly harmful to children. The FY 2026 Budget supports research to improve understanding of the effect of environmental factors, including safe water, on human health. Resources also will continue support of Mining Research, Safe Water, the National Firefighter Registry for Cancer, the National Mesothelioma Registry and Tissue Bank, the World Trade Center Health Program, as well as the Energy Employees Occupational Illness Compensation Program.

Combatting HIV/AIDS. For over 30 years, the Ryan White HIV/AIDS Program has supported states, cities, counties, and community-based organizations in providing comprehensive HIV primary medical care, support services, and treatment for low-income individuals living with HIV. In 2023, the Ryan White Program served more than 576,000 individuals, more than half of those diagnosed with HIV in the United States. In 2023, 90.6 percent of individuals who received HIV medical care through the Ryan White program were virally suppressed, compared to 69.5 percent in 2010. The Budget request continues support for the Ryan White program, as well as for the Ending the HIV Epidemic in the United States Initiative.

Enhancing Maternal and Child Health. An essential component of Making America Healthy Again is to improve access to and the quality of maternal and child health care. The Budget prioritizes programs that provide states and communities with the flexibility to target funding towards the services needed most, such as through the Maternal and Child Health Block Grant and the Maternal, Infant, and Early Childhood Home Visiting Program. AHA will also continue programs that support education and research related to specific health conditions and disabilities, as well as the Maternal Mental Health Hotline and the Embryo Adoption Awareness Campaign.

Strengthening Mental Health and Combating Substance Use. The Budget request emphasizes the importance of mental health and substance use services, including those that support suicide prevention, behavioral health, and substance use disorder, while increasing flexibilities for states to meet their defined needs. The Budget maintains funding for suicide prevention programs, including for the 988 Suicide and Crisis Lifeline to respond to an estimated 9 million contacts in FY 2026. The Budget requests to consolidate the Community Mental Health Services Block Grant; the Substance Use Prevention, Treatment, and Recovery Services Block Grant; and the State Opioid Response grant program into a new Behavioral Health Innovation Block Grant to provide states with increased flexibility to address their local needs. The Budget also funds a new program to provide Behavioral Health resources to tribes. In addition, the Budget request continues to fund Opioid Treatment Programs and Certified Community Behavioral Health Clinics.

Strengthening the Health Workforce. Efforts to strengthen the health workforce must include initiatives to connect providers to communities in need. Through the National Health Service Corps, the Budget will support an estimated 12,800 primary medical care, dental, and behavioral health providers, including through more than 6,600 new scholarships and loan repayment

agreements, in exchange for service in health professional shortage areas. National Health Service Corps participants can serve at more than 22,600 eligible sites and provide care to more than 18 million patients regardless of their ability to pay. The Budget request also supports the Teaching Health Center Graduate Medical Education Program and Behavioral Health Workforce Development Programs.

We look forward to working with Congress to create the Administration for a Healthy America to support the health and well-being of individuals through these vital and innovative programs.

Thomas J. Engels
HRSA Administrator

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Introduction and Mission

The Trump Administration plans to establish the Administration for a Healthy America (AHA) as an outcome-driven institution in public health. Secretary Kennedy plans to place critical, but bureaucratically siloed, programs from across HHS under one organization so that they can coordinate to create streamlined services, show transparent processes, and, ultimately, achieve tangible results for Americans. AHA will be an Operating Division within the U.S. Department of Health and Human Services (HHS).

AHA will work in alignment with the Department's mission and the President's priorities to advance:

- Health care access,
- Disease prevention and health promotion,
- Telehealth,
- Mental health and substance use services,
- Rural health,
- Tribal health,
- Women's, Maternal and child health,
- Health Workforce,
- Healthy environment (clean water, nutritious foods, and physical activity.)

AHA's work will be data-driven, innovative, people-centered, and transparent and will utilize metrics that impact access, quality, and outcomes so that the American people can be empowered to make informed decisions for themselves and their families. By integrating the legacy strengths and expertise of its predecessor agencies, AHA will position itself to lead a unified public health response, enhance patient-centered care and clinical outcomes, and improve and modernize service delivery for all Americans. AHA will prioritize scientific integrity and the patient experience and reflects the voices of those we serve through the services, support, and resources provided by the Administration.

Overview of Budget

The FY 2026 President's Budget request is $20.6 billion for the Administration for a Healthy America. The request includes $14.1 billion in discretionary funding, $6.4 billion from mandatory sources, $135.6 million in PHS Act Evaluation funding, and $35 million in user fees. The Budget prioritizes primary care, strives to improve maternal health outcomes, invests in the health workforce and HIV/AIDS programs, supports mental and behavioral health, and strengthens the nation's environmental health sciences research, aligning with the Administration's priorities.

In alignment with the proposed HHS reorganization, the AHA Budget consolidates and streamlines chronic care and disease prevention programs across the Office of the Assistant Secretary for Health (OASH), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute of Environmental Health Sciences (NIEHS), and several centers and programs of the Centers for Disease Control and Prevention (CDC) creating a more coordinated and efficient structure to serve to serve all Americans, particularly low-income, rural, and medically underserved individuals.

The budgetary accounts of AHA include primary care; environmental health, HIV/AIDS maternal and child health; mental and behavioral health; health workforce; and policy, research, and oversight, which includes the Surgeon General.

Highlights of the FY 2026 Budget request:

Primary Care: total program $7.2 billion ($7.4 billion including +$182 million planned to be transferred from the Policy, Research, and Oversight account)

- *Health Centers: $6.1 billion*

The Budget includes a $6.1 billion investment in the Health Center Program, including $1.8 billion in discretionary funding and $4.3 billion in proposed mandatory resources. This funding supports approximately 1,400 Health Centers operating more than 15,000 service sites nationwide, that provide comprehensive medical care and support services such as health education, transportation, and preventive health screenings to over 31 million people. The request also continues the Health Center Program's support of the Ending HIV Epidemic initiative to provide prevention and treatment services to people at high-risk for HIV.

- *National Center for Injury Prevention and Control: $550.1 million*

The Budget provides $550.1 million to collect data and leverage research to identify pressing health problems and promote evidence-based strategies to inform real-world solutions to address suicide prevention, rape, intimate partner and sexual violence prevention, violent deaths and opioid overdose prevention and surveillance.

- *Rural Health Care: $283.8 million*

The Budget provides funding to continue to build health care capacity and improve health outcomes for the estimated 62 million Americans who live in rural communities. The request

includes $145 million for the Rural Communities Opioid Response program to maintain prevention, treatment, and recovery services for substance use disorder, and $101 million Rural Health Care Outreach program, which provides start-up funding for pilot grants to enhance health care services in rural communities. The outreach program includes $12 million for the Rural Maternity and Obstetrics Management Strategies (RMOMS) program to increase access to maternal and obstetrics care in rural communities. The Budget invests $14.1 million to ensure coal miners and those adversely affected by the mining, transport and processing of uranium receive proper screenings, primary care and other services. In addition, the Budget provides $12.7 million for Rural Residency Planning and Development to expand the number of rural residency training programs with the goal of increasing the number of physicians choosing to practice in rural areas.

- *Prevention Innovation: $119 million (funding for this activity is planned to be transferred from the Policy Research and Oversight account as part of the MAHA Initiative)*

The Budget invests in funding to support the goals of the MAHA initiative by addressing the root causes of America's escalating health crises, focusing on maternal health delivery gaps and chronic conditions that lead to poorer health outcomes in rural areas. This request supports three tracks: one for maternal health, one for chronic disease, and one for Tribes (where applicants could support programs in either maternal health or chronic disease).

- *Organ Transplantation: $54.1 million*

The Budget will continue to modernize the Organ Procurement and Transplantation Network (OPTN). Key priorities will include strengthening patient safety oversight by establishing new systems for monitoring, reporting, and intervening on safety issues; enhancing financial oversight to ensure transparency and accountability in using fees/funds; and continuing the multi-year effort to modernize the IT infrastructure.

- *Telehealth: $42.1 million ($70 million total, including +$28 million planned to be transferred from the Policy Research and Oversight account as part of the MAHA Initiative)*

The Budget includes funding to promote the use of telehealth, particularly in medically underserved areas, for health care delivery, health care information, and education. Funds will support programs to disseminate information regarding telehealth resources, licensure portability, and technology-enabled learning, and maintain the HHS Telehealth Hub.

- *Alzheimer's Disease: $35 million (funding for this activity is planned to be transferred from the Policy Research and Oversight account as part of the MAHA Initiative)*

The Budget includes funding to address Alzheimer's disease and improve brain health by reducing risk, promoting early assessment and diagnosis, and sharing up-to-date data for public health action.

- *Disease Prevention: $25.6 million*

The Budget invests in initiatives that promote healthy activities and expand early detection and prevention to stop disease progression.

- *Minority Health: $45 million*

The Budget includes funding to support grants programs, previously led by OASH's Office of Minority Health, that target underserved, and hard to reach Americans in helping them improve their overall health and wellness.

The Budget proposes to eliminate 23 programs under the Primary Health account to align with the Administrations priorities. A listing can be found under the programs for elimination exhibit on page 365.

<u>Environmental Health: total program $1.7 billion ($1.747 billion including +$56 million planned to be transferred from the Policy Research and Oversight account)</u>

- *Safe Water: $8.6 million*

The Budget provides $8.6 million to strengthen and support services to address the cause of water-related environmental exposures; including preventing exposure to legionellosis and other contaminants found in building plumbing systems, and prioritizing efforts to keep small drinking water systems free from contamination.

- *Childhood Lead Poisoning Prevention: $51 million (funding for this activity is planned to be transferred from the Policy Research and Oversight account as part of the MAHA Initiative)*

The Budget provides $51 million for the Childhood Lead Poisoning Prevention Program to reduce the number of children exposed to lead by improving blood lead testing and reporting systems, leveraging the Childhood Blood Lead Surveillance System to analyze and track trends to identify risk hot spots, and linking lead-exposed children to services.

- *Lead Exposure Registry: $5 million (funding for this activity is planned to be transferred from the Policy Research and Oversight account as part of the MAHA Initiative)*

The Budget provides $5 million to continue support for the Lead Exposure Registry.

- *Occupational Safety and Health: $73.2 million*

The Budget provides $73.2 million in discretionary funding to support select programs in worker safety and health, including the National Mesothelioma Registry and Tissue Bank, National Firefighter Registry for Cancer, and Mining Research.

- *National Institute of Environmental Health Sciences (NIEHS): $594.1 million*

The Budget provides $594.1 million to support scientific research and training through grants and contracts to research organizations and academic institutions, as well as investigator-initiated laboratory and clinical research activities, to understand how the environment affects biological systems across the lifespan and to translate this knowledge to reduce disease and promote human health.

- *NIEHS Superfund-Related Activities: $51.8 million*

The Budget provides $51.8 million to support grants for the Superfund Research Program (SRP) and the Worker Training Program (WTP), Congressionally-mandated programs which address critical environmental health issues facing our nation by bridging laboratory research, worker training, and community interaction to improve health for all. These programs address a wide array of environmental health research and cleanup issues, as well as provide economic benefits to the nation.

- *World Trade Center Health Program: $913.0 million in mandatory funding*

The Budget Request provides $913.0 million in mandatory federal share funding to continue to provide critical care, including cancer screening and treatment to thousands of 9/11 responders and survivors.

- *Energy Employees Occupational Illness Compensation Program Act (EEOICPA): $50.8 million in mandatory funding (post-sequester)*

The Budget request provides $50.8 million in post-sequester mandatory funding to ensure accurate exposure assessments for former Department of Energy (DOE) workers, supporting fair compensation.

The Budget proposes to eliminate 9 programs under the Environmental Health account to align with the Administrations priorities. A listing can be found under the programs for elimination exhibit on page 365.

<u>HIV/AIDS: total program $2.7 billion</u>

The Budget provides $2.3 billion for the Ryan White HIV/AIDS Program, which coordinates with states, localities, and clinics/community-based organizations to provide a comprehensive system of HIV primary medical care, medications, and essential support services for low-income individuals with HIV. The total investment will support HIV care and treatment needs for an estimated 565,000 clients. The request includes $900.3 million for the AIDS Drug Assistance Programs to provide access to life saving HIV related medications and health care services to persons living with HIV in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Pacific jurisdictions.

The Budget includes $385 million within HIV/AIDs to continue the Ending the HIV Epidemic Initiative, including $165 million for the Ryan White HIV/AIDS Program and $220 million for activities formerly carried out by CDC. This investment builds on its successes of connecting and re-connecting high-need people with HIV to high quality care, and efforts in jurisdictions for testing, diagnoses, linkage to treatment, and prevention services.

The Budget proposes to eliminate 5 programs under the HIV/AIDS account to align with the Administrations priorities. A listing can be found under the programs for elimination exhibit on page 365.

Maternal and Child Health: total program $1.7 billion

The Budget invests in a broad array of activities aimed at addressing birth defects, developmental disabilities, and improving maternal health outcomes.

- *Maternal and Child Health Block Grant: $767.3 million*

The Budget includes $593.3 million for formula awards to states to promote and improve the health and well-being of the nation's mothers, children (including children and youth with special health care needs), and their families. Additionally, the request includes $163.7 million in Special Projects of Regional and National Significance (SPRANS) to continue to address critical and emerging issues in maternal and child health.

- *Improving Maternal Health programs: $43.3 million*

The Budget provides funding to improve maternal health and decrease maternal morbidity and mortality. This includes $15.3 million for the Innovation for Maternal Health program to improve maternal health and safety through patient safety bundles—evidence-based practices designed to address specific maternal health conditions. The Budget also includes $10 million for Integrated Services for Pregnant and Postpartum Women to support demonstration projects that integrate care and services across providers to improve maternal health, reduce pregnancy-related deaths, and promote optimal health for all women. Additionally, the Budget provides $7 million to support the Maternal Mental Health Hotline (1-833-TLC-MAMA), which provides free, confidential emotional support, resources, and referrals to pregnant and postpartum women facing mental health challenges, and $11 million for the Screening and Treatment for Maternal Depression program, which supports health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for maternal mental health and substance use disorders.

- *Pediatric Mental Health Care Access Grants: $13 million*

The Budget supports mental health integration in pediatric primary care by developing new, or expanding statewide, or regional pediatric mental health care access programs. The request supports up to 22 statewide or regional pediatric mental health care telehealth access programs, serving an estimated 7,100 children and adolescents.

- *Other Maternal and Child Health programs: $73.3 million*

The Budget provides $38.2 million to maintain support for the Autism and Developmental Disabilities Leadership Education in Neurodevelopmental and Other Related Disabilities program, which trains health professionals to improve access to screening, diagnosis, and services for affected children and youth. The Budget also provides $8.2 million for regional sickle cell disease infrastructure to help individuals with sickle cell disease lead full, productive lives. The Budget provides $26.8 million to continue support for the toll-free Poison Help line, funding 54 Poison Control Centers that provide around-the-clock professional guidance, reduce unnecessary ER visits, and help prevent and manage poisonings and related health concerns.

- *Birth Defects, Developmental Disabilities, Disability & Health: $157.8 million*

The Budget provides $157.8 million to measure the impact of birth defects, disabilities, and blood disorders and put research findings and recommendations into public health action to foster a safer, healthier population.

- *Women's Health: $30 million*

The Budget supports expert consultation to the Secretary on women's health, sets departmental goals, and coordinates cross-departmental efforts in prevention, care, research, and education across the female lifespan.

- *Embryo Adoption Awareness Campaign: $1 million*

The request also maintains $1 million for the Embryo Adoption Awareness Campaign to promote embryo donation as a family-building option and to provide medical and administrative support to donors and recipients.

- *Family-to-Family Health Information Centers Program: $6 million*

The Budget proposes to continue mandatory funding to supports 59 Family-to-Family Health Information Centers nationwide, which provide patient-centered information, education, technical assistance, and peer support to families of children and youth with special health care needs. These centers will continue to focus on targeted outreach and leadership development efforts, particularly among underrepresented populations.

- *Maternal, Infant and Early Childhood Home Visiting: $613 million*

The Budget also reflects an increase of $47 million, for a total of $613 million in mandatory resources (post-sequester), for the Maternal, Infant, and Early Childhood Home Visiting program as reauthorized in the Consolidated Appropriations Act, 2023.

The Budget proposes to eliminate 5 programs under the Maternal and Child Health account to align with the Administration's priorities. A listing can be found under the programs for elimination exhibit on page 365.

<u>Mental and Behavioral Health: total program $5.8 billion</u>

Mental health and substance use conditions are part of the chronic disease epidemic plaguing our nation. Research shows that substance use and early health risk behaviors that take root during childhood and adolescence are intimately linked to risk for additional chronic disease, substance use disorders, and mental health conditions later in life and they contribute to a significant proportion of the health and social costs associated with chronic disease. Thus, it is critical that we prioritize preventing substance misuse in the first place, promoting mental health and well-being, expanding crisis intervention services, treating mental and substance use disorders, and help individuals achieve long-term recovery in order to achieve the Administration for a Healthy America's mandate. This budget proposes funding in three categories for mental health and substance use disorder programs that support these priorities.

- *Mental Health: $1.5 billion*

The Budget provides $1.5 billion to address the mental health crisis and to improve the access to quality mental health services. Specifically, the Budget provides $120.5 million for Project

AWARE to continue providing a strong support system for mental health services in schools. Further, it proposes $14.1 million for the Protection and Advocacy for Individuals with Mental Illness. In addition, the Budget funds the Practice Improvement and Training ($7.8 million); Consumer and Consumer Supports Technical Assistance Center ($1.9 million); Disaster Response Programs ($2 million); National Child Traumatic Stress Network ($98.9 million); Certified Behavioral Health Clinics ($385 million); Children's Mental Health Services ($130 million); Projects for the Assistance in Transition from Homelessness ($66.6 million); and Assisted Outpatient Treatment for Individuals with Serious Mental Illness ($21.4 million).

Within Mental Health, the Budget provides $519.6 million for the 988 Suicide and Crisis Lifeline. Funding will continue support for the Lifeline, which offers a direct connection to immediate support and resources for anyone experiencing a mental health, suicide, or substance-use-related challenge. It also provides funding for other suicide prevention resources, including the National Strategy for Suicide Prevention ($28.2 million); Garrett Lee Smith Youth Suicide Prevention Programs (campus $8.5 million; state $43.8 million); the Suicide Prevention Resource Center ($11 million); and the Native American Suicide Prevention Initiative ($3.9 million).

- *Substance Use Prevention: $88.7 million*

This Budget provides funding to support substance use prevention programs, which aim to reach people wherever they are to prevent substance use initiation, prevent the progression of substance use, and prevent and reduce substance use related harms so individuals, families, and communities can thrive. It includes $70 million for the Drug Free Communities program and transfers the program from the Office of National Drug Control Policy to the planned AHA. In addition, the Budget funds the Science and Service Program Coordination, Federal Drug-Free Workplace, and the Center for the Application of Prevention Technologies.

- *Substance Use Treatment: $19.8 million*

The Budget funds Opioid Treatment Activities ($10.7 million) and Addiction Technology Transfer Centers ($9.1 million).

- *Behavioral Health Innovation Grants: $4.1 billion*

The Budget provides $4.1 billion for a new Behavioral Health Innovation Block Grant, which will consolidate the funding for the Community Mental Health Services Block Grant, the Substance Abuse Prevention, Treatment and Recovery Services Block Grant, and State Opioid Response grant and allow states to provide mental health and substance use services while maximizing flexibilities.

- *Behavioral Health and Substance Use Disorder Resources for Native American Grant Programs: $80 million*

The budget is proposing $80 million for a new program that will be used to provide services for the prevention, treatment, and recovery from mental health and substance use disorders among American Indians, Alaska Natives, and Native Hawaiians.

The Budget proposes to eliminate 40 programs under the Mental Health account to align with the Administration's priorities. A listing can be found under the programs for elimination exhibit on page 365.

Health Workforce: total program $948.1 million

- *National Health Service Corps (NHSC): $473.6 million*

The Budget request includes $128.6 million in discretionary funding and $345 million in proposed mandatory resources for NHSC. This investment funds an estimated 6,600 scholarships and loan repayment awards and supports an anticipated field strength of nearly 12,800 primary care, behavioral health, and oral health providers in service in communities of greatest need.

- *Teaching Health Center Graduate Medical Education: $175 million*

The Budget includes $175 million in proposed mandatory resources to train more primary care physicians in community-based settings, such as community health centers, where most primary care is delivered. This investment will support up to 1,273 resident full-time equivalent slots.

- *Other Scholarship and Loan Repayment Programs: $102.6 million*

The Budget provides $92.6 million for the Nurse Corps Scholarship and Loan Repayment Program to support an estimated 238 scholarships (new and continuation) and 450 loan repayments (new and continuation) awards. The investment will increase the number of well-trained nurses available to provide services, such as mental/behavioral health and women's/maternal health services, in communities experiencing a shortage in nurses. In addition, the Budget provides $10 million for the Pediatric Subspecialty Loan Repayment Program to support approximately 85 new loan repayment awards to bolster the pediatric health care workforce.

- *Behavioral Health Workforce Development Programs: $129.3 million*

The Budget requests $129.3 million for the Behavioral Health Workforce Education and Training program. This program establishes and expands internships or field placement programs in behavioral health serving in medically underserved areas. The request includes $40 million for the Substance Use Disorder Treatment and Recovery Loan Repayment program and $25 million for the Addiction Medicine Fellowship Program to support the training of physicians who specialize in the prevention, evaluation, and treatment of substance use disorder.

- *Other Health Workforce programs: $34.1 million*

The Budget provides $28.4 million for Centers of Excellence grants to health professions schools and other public and nonprofit health or educational entities to support programs of excellence in health professions education. These grants will support training for approximately 4,350 individuals in the health career pipeline. The Budget also provides $5.7 million for health workforce data and analysis, including implementation of the 2026 National Sample Survey of Registered Nurses and to provide annual updates and publications on health workforce projections for use by policymakers and researchers.

- *National Practitioner Data Bank (User Fees): $33.5 million*

The Budget funds a workforce tool that helps improve health care quality, enhance patient safety, and prevent fraud and abuse by sharing information on adverse actions of practitioners, providers and suppliers with authorized health care entities.

The Budget proposes to eliminate 14 programs under the Health Workforce account to align with the Administration's priorities. A listing can be found under the programs for elimination exhibit on page 365.

Policy, Research and Oversight: total program $568.5 million ($330.5 million after the planned transfer of $238 million for MAHA initiatives)

The Budget requests $260 million to support Make America Healthy Again (MAHA) initiatives. This funding will be allocated across multiple programs, as discussed in more detail in the appropriate sections above.

The request includes $201.5 million ($223.5 million total, including $22 million allocated from the MAHA Initiative funding) to support AHA operations, covering support staff, business processes, IT, and overhead costs such as rent, utilities, and other expenses.

The Budget provides $65.8 million for the following behavioral health activities: Health Surveillance, Public Health Awareness, and Performance and Quality Information Systems to collect, analyze, and share data on substance use, mental health, and behavioral health trends. The request also provides $15.2 million for administrative funding for the Vaccine Injury Compensation program to continue prompt review of claims and prevent a future backlog of claims awaiting medical review.

The Budget proposes to eliminate 4 programs under the Policy, Research and Oversight account to align with the Administration's priorities. A listing can be found under the programs for elimination exhibit on page 365.

Overview of Performance

The Administration for a Healthy America (AHA) is committed to transforming the health of all Americans by addressing the root causes of chronic disease, promoting preventive care, strengthening mental health and substance use services, and ensuring every community has access to clean water, nutritious foods, and opportunities for physical activity so every American can achieve optimal health and well-being. AHA aims to efficiently coordinate chronic care and disease prevention programs and harmonize health resources to better benefit low-income Americans.

Ultimately, AHA holds itself to high standards by ensuring all its programs maximize their investments to improve health outcomes. Programs will tie their performance measures directly to national health objectives, ensuring that every initiative supports data-informed decision making and drives measurable impact across communities. This alignment will reinforce AHA's commitment to transparency, efficiency, and the delivery of high-quality health outcomes nationwide.

All Purpose Table
Administration for a Healthy America

(dollars in thousands)

	FY 2024	FY 2025	FY 2026	
	Enacted	Operating Level[2]	President's Budget	FY 2026 +/- FY 2025
PRIMARY CARE:				
Health Centers:				
Health Centers	1,737,772	*	1,737,772	*
Health Centers Mandatory	5,345,753	3,186,247	-	-3,186,247
Health Centers Mandatory Proposed	-	-	4,260,000	+4,260,000
Health Center Tort Claims	120,000	*	120,000	*
Subtotal, Health Centers	***7,203,525***	***5,044,019***	***6,117,772***	***+1,073,753***
Free Clinics Medical Malpractice	1,000	*	1,000	*
Organ Transplantation	54,049	*	54,049	*
Cell Transplantation Program and Cord Blood Stem Cell Bank	52,275	*	41,275	*
Hansen's Disease Center	13,706	*	13,706	*
Payment to Hawaii	1,857	*	1,857	*
National Hansen's Disease Program - Buildings and Facilities	122	*	-	*
Rural Health Policy Development	11,076	*	11,076	*
Rural Health Outreach Grants	100,975	*	100,975	*
Rural Hospital Flexibility Grants	64,277	64,277	-	-64,277
State Offices of Rural Health	12,500	12,500	-	-12,500
Radiation Exposure Screening and Education Program	1,889	*	1,889	*
Black Lung	12,190	*	12,190	*
Rural Communities Opioid Response	145,000	145,000	145,000	-
Rural Residency Planning and Development	12,700	12,700	12,700	-
Rural Hospital Stabilization Pilot Program	4,000	*	-	*
Prevention Innovation Program[1]	-	-	-	-
Tribal Set Aside (non-add)[1]	-	-	-	-
Office for the Advancement of Telehealth[1]	42,050	42,050	42,050	-
Chronic Care Telehealth Centers of Excellence (non-add)[1]	-	-	-	-
Telehealth Nutrition Services Network Grant Program (non-add)[1]	-	-	-	-
Office of Disease Prevention and Health Promotion	7,894	7,894	25,594	+17,700
Anti-Doping Activities (non-add)	-	-	*17,700*	+17,700
Office of Minority Health	74,835	74,835	45,000	-29,835
Chronic Disease and Health Prevention:				
Tobacco Prevention and Control	120,650	*	-	*
Tobacco Prevention and Control PPHF	125,850	125,850	-	*
Nutrition, Physical Activity and Obesity	58,420	*	-	*
School Health	19,400	*	-	*

	FY 2024	FY 2025	FY 2026	
	Enacted	Operating Level[2]	President's Budget	FY 2026 +/- FY 2025
Alzheimer's Disease Program[1]	39,500	*	-	*
All other Chronic Disease/Health Promotion	24,600	*	-	*
All other Chronic Disease/Health Promotion PPHF	19,750	*	-	*
Million Hearts PPHF (non-add)	*5,000*	*5,000*	-	*
National Early Child Care Collaboratives PPHF (non-add)	*5,000*	*5,000*	-	*
Hospitals Promoting Breastfeeding PPHF (non-add)	*9,750*	*9,750*	-	*
Prevention Research Centers	28,961	*	-	*
Heart Disease and Stroke	125,850	*	-	*
Heart Disease and Stroke PPHF	29,255	29,255	-	*
Diabetes	89,717	*	-	*
Diabetes PPHF	66,412	66,412	-	*
National Diabetes Prevention Program	37,300	*	-	*
Cancer Prevention and Control	410,049	*	-	*
Oral Health	20,250	*	-	*
Safe Motherhood/Infant Health	110,500	*	-	*
Arthritis	11,000	*	-	*
Epilepsy	11,500	*	-	*
National Lupus Patient Registry	10,000	*	-	*
Racial and Ethnic Approaches to Community Health	68,950	*	-	*
Social Determinants of Health	6,000	*	-	*
Subtotal, Chronic Disease and Health Prevention	**1,433,914**	**1,433,914**	**-**	**-1,433,914**
Injury Prevention and Control:				
Domestic Violence and Sexual Violence, Domestic Violence Community Projects, and Rape Prevention Education Grant	-	-	38,000	+38,000
Intentional Injury	164,550	*	12,000	*
Firearm Injury and Mortality Prevention Research	12,500	*	-	*
National Violent Death Reporting System	24,500	*	24,500	*
Unintentional Injury	13,300	*	-	*
Other Injury Prevention Activities	29,950	*	-	*
Opioid Overdose Prevention and Surveillance	505,579	*	475,579	*
Injury Control Research Centers	11,000	*	-	*
Subtotal, Injury Prevention and Control	**761,379**	**761,379**	**550,079**	**-211,300**
Subtotal, Primary Care[1]	**10,011,213**	**7,851,707**	**7,176,212**	**-675,495**
Subtotal, Primary Care Discretionary BA (non-add)	*4,424,193*	*4,424,193*	*2,916,212*	*-1,507,981*
Subtotal, Primary Care Mandatory(non-add)	*5,345,753*	*3,186,247*	*4,260,000*	*+1,073,753*
Subtotal, Primary Care PPHF(non-add)	*241,267*	*241,267*	-	*-241,267*
ENVIRONMENTAL HEALTH:				
Safe Water	8,600	*	8,600	*
Trevor's Law	3,000	*	-	*

	FY 2024	FY 2025	FY 2026	
	Enacted	Operating Level[2]	President's Budget	FY 2026 +/- FY 2025
Amyotrophic Lateral Sclerosis Registry	10,000	*	-	*
Climate and Health	10,000	*	-	*
Environmental & Health Outcome Tracking Network	34,000	*	-	*
Asthma	33,500	*	-	*
Childhood Lead Poisoning Prevention[1]	-	-	-	-
Childhood Lead Poisoning Prevention PPHF	51,000	51,000	-	-51,000
Lead Exposure Registry[1]	5,000	*	-	*
National Institute for Occupational Safety and Health:				
National Occupational Research Agenda (NORA)	119,500	*	-	*
Education and Research Centers	32,000	*	-	*
Personal Protective Technology	23,000	*	-	*
Mining Research	66,500	*	66,500	*
Other Occupational Safety and Health Research	115,100	*	-	*
National Mesothelioma Registry and Tissue Bank	1,200	*	1,200	*
Firefighter Cancer Registry	5,500	*	5,500	*
Subtotal, National Institute for Occupational Safety and Health	**362,800**	**362,800**	**73,200**	**-289,600**
National Institute for Environmental Health Sciences	993,693	993,693	645,900	-347,793
National Institute for Environmental Health Sciences Labor-HHS (non-add)	*913,979*	*913,979*	*594,086*	*-319,893*
National Institute for Environmental Health Sciences Interior-Superfund (non-add)	*79,714*	*79,714*	*51,814*	*-27,900*
World Trade Center Health Program (Mandatory)	*768,392*	*847,683*	*913,025*	*+65,342*
Energy Employees Occupational Illness Compensation Program Act (Mandatory)	50,763	50,763	50,763	-
Subtotal, Environmental Health[1]	**2,330,748**	**2,410,039**	**1,691,488**	**-718,551**
Subtotal, Environmental Health Discretionary BA (non-add)	*1,460,593*	*1,460,593*	*727,700*	*-732,893*
Subtotal, Mandatory Environmental Health (non-add)	*819,155*	*898,446*	*963,788*	*+65,342*
Subtotal, PPHF Environmental Health (non-add)	*51,000*	*51,000*	-	*-51,000*
HIV/AIDS:				
Emergency Relief - Part A	680,752	*	680,752	*
Comprehensive Care - Part B	1,364,878	*	1,364,878	*
AIDS Drug Assistance Program (non-add)	*900,313*	*900,313*	*900,313*	*
Early Intervention - Part C	208,970	*	208,970	*
Children, Youth, Women & Families - Part D	77,935	*	77,935	*
AIDS Education and Training Centers - Part F	34,886	*	-	*
Dental Reimbursement Program Part F	13,620	*	-	*
Special Projects of National Significance (SPNS)	25,000	*	-	*
Ryan White HIV/AIDS Ending HIV Epidemic Initiative	165,000	165,000	165,000	-
Domestic HIV Prevention and Research	1,013,712	*	220,000	*

	FY 2024	FY 2025	FY 2026	
	Enacted	Operating Level[2]	President's Budget	FY 2026 +/- FY 2025
Ending HIV Epidemic Initiative (non-add)	*220,000*	*	*220,000*	*
Office of Infectious Diseases and HIV/AIDS Policy	7,582	7,582	7,582	-
Minority HIV/AIDS Fund	60,000	60,000	-	*
Subtotal, HIV/AIDS	**3,652,335**	**3,652,335**	**2,725,117**	**-927,218**
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant	813,700	*	767,250	*
Grants to States (non-add)	*593,308*	*	*593,308*	*
SPRANS (non-add)	*210,116*	*	*163,666*	*
CISS (non-add)	*10,276*	*10,276*	*10,276*	-
Innovation for Maternal Health	15,300	*	15,300	*
Integrated Services for Pregnant and Postpartum Women	10,000	*	10,000	*
Maternal Mental Health Hotline	7,000	*	7,000	*
Autism and Other Developmental Disorders	56,344	*	38,245	*
Sickle Cell Service Demonstrations	8,205	*	8,205	*
Early Hearing Detection and Intervention	18,818	*	-	*
Emergency Medical Services for Children	24,334	*	-	*
Healthy Start	145,000	*	-	*
Heritable Disorders	20,883	*	-	*
Pediatric Mental Health Care Access Grants	13,000	*	13,000	*
Screening and Treatment for Maternal Depression	11,000	*	11,000	*
Poison Control Centers	26,846	*	26,846	*
Family-to-Family Health Information Centers (F2F HIC)				
F2F HIC Mandatory	5,658	-	-	-
F2F HIC Mandatory Proposed	-	6,000	6,000	-
Subtotal, F2F HIC	***5,658***	***6,000***	***6,000***	**-**
Maternal, Infant and Early Childhood Home Visiting Mandatory	518,650	565,800	612,950	+47,150
Family Planning	286,479	286,479	-	-286,479
Child Health and Development	75,550	*	68,050	*
Birth Defects (non-add)	*19,000*	*	*19,000*	*
Fetal Death (non-add)	*900*	*	*900*	*
Fetal Alcohol Syndrome (non-add)	*11,500*	*	*11,000*	*
Folic Acid (non-add)	*3,150*	*	*3,150*	*
Infant Health (non-add)	*8,650*	*	*8,650*	*
Autism (non-add)	*28,100*	*	*23,100*	*
Neonatal Abstinence Syndrome (non-add)	4,250	*	2,250	*
Health and Development for People with Disabilities	86,410	*	72,660	*
Disability Health (non-add)	*45,500*	*	*36,000*	*
Tourette Syndrome (non-add)	*2,500*	*	*2,000*	*
Early Heating Detection and Intervention (non-add)	*10,760*	*	*10,760*	*
Muscular Dystrophy (non-add)	*8,000*	*	*6,000*	*

	FY 2024	FY 2025	FY 2026	
	Enacted	Operating Level[2]	President's Budget	FY 2026 +/- FY 2025
Attention Deficit Hyperactivity (non-add)	*1,900*	*	*1,900*	*
Fragile X (non-add)	*2,000*	*	*2,000*	*
Spina Bifida (non-add)	*7,500*	*	*7,000*	*
Congenital Heart Failure (non-add)	*8,250*	*	*7,000*	*
Blood Disorders	21,100	*	17,100	*
Hemophilia (non-add)	*3,500*	*	*8,600*	*
Hemophilia Treatment Centers (non-add)	*5,100*	*	-	*
Public Health Approaches to Blood Disorders (non-add)	*10,400*	*	*6,400*	*
Thalassemia (non-add)	*2,100*	*	*2,100*	*
Office on Women's Health	44,140	44,140	30,000	-14,140
Embryo Adoption Awareness	1,000	1,000	1,000	-
Teen Pregnancy Prevention	107,800	107,800	-	-107,800
Teen Pregnancy Prevention PHS Evaluation (non-add)	*6,800*	*6,800*	-	-
Office of Adolescent Health	443	443	-	-443
Public Health Reports	470	470	-	-470
Subtotal, Maternal and Child Health	**2,318,130**	**2,365,622**	**1,704,606**	**-661,016**
Subtotal, Maternal and Child Health Discretionary BA (non-add)	*1,787,022*	*1,787,022*	*1,085,656*	*-701,366*
Subtotal, Maternal and Child Health PHS Evaluation (non-add)	*6,800*	*6,800*	-	-
Subtotal, Maternal and Child Health Mandatory (non-add)	*524,308*	*571,800*	*618,950*	*+47,150*
MENTAL AND BEHAVIORAL HEALTH:				
Programs of Regional and National Significance and CMHS Block Grant:				
Seclusion & Restraint	1,147	*	-	*
Project AWARE	140,001	*	120,501	*
Mental Health Awareness Training	27,963	*	-	*
Healthy Transitions	28,451	*	-	*
Infant and Early Childhood Mental Health	15,000	*	-	*
Children and Family Programs	7,229	*	-	*
Consumer and Family Network Grants	4,954	*	-	*
MH System Transformation	3,779	*	-	*
Project LAUNCH	23,605	*	-	*
Primary and Behavioral Health Care Integration	55,877	*	-	*
Primary and Behavioral Health Care Integration TTA	2,991	*	-	*
National Strategy for Suicide Prevention	28,200	*	28,200	*
GLS - Youth Suicide Prevention - States BA	31,806	*	43,806	*
GLS - Youth Suicide Prevention - States PPHF	12,000	*	-	*
GLS - Youth Suicide Prevention - Campus	8,488	*	8,488	*
GLS - Suicide Prevention Resource Center	11,000	*	11,000	*
American Indian/Alaska Native Suicide Prevention Initiative	3,931	*	3,931	*

	FY 2024	FY 2025	FY 2026	
	Enacted	Operating Level[2]	President's Budget	FY 2026 +/- FY 2025
988 and Behavioral Health Crisis Services	519,618	*	519,618	*
Specialized Services for LGBTQ Youth (non-add)	*33,100*	*	-	*
Mental Health Crisis Response Partnership Pilot Program	20,000	*	-	*
Homelessness Prevention Programs	33,696	*	-	*
Criminal and Juvenile Justice Programs	11,269	*	-	*
Assertive Community Treatment for Individuals with SMI	9,000	*	-	*
Practice Improvement and Training	7,828	*	7,828	*
Consumer and Consumer Support TA Centers	1,918	*	1,918	*
Disaster Response	1,953	*	1,953	*
Homelessness	2,296	*	-	*
Minority AIDS	9,224	*	-	*
Mental Health Minority Fellowship Program	11,059	*	-	*
Tribal Behavioral Health Grants	22,750	*	-	*
Interagency Task-Force on Trauma Informed Care	2,000	*	-	*
Subtotal, Programs of Regional and National Significance	**1,059,033**	*	**747,243**	*
Assisted Outpatient Treatment for Individuals with SMI	21,420	21,420	21,420	-
National Child Traumatic Stress Network	98,887	98,887	98,887	-
Certified Community Behavioral Health Clinics	385,000	385,000	385,000	-
Children's Mental Health Services	130,000	*	130,000	*
Projects for Assistance in Transition from Homelessness	66,635	*	66,635	*
Protection and Advocacy for Individuals with Mental Illness	40,000	*	14,146	*
Community Mental Health Services Block Grant:				
Community Mental Health Services (CMHS) Block Grant	986,532	*	-	*
CMHS Block Grant PHS Evaluation Funds	21,039	*	-	*
Subtotal, Community Mental Health Services Block Grant	**1,007,571**	*	-	*
Subtotal, Programs of Regional and National Significance and CMHS Block Grant	**2,808,546**	**2,808,546**	**1,463,331**	***-1,345,215***
Substance Use Treatment				
Programs of Regional and National Significance:	574,219	*	19,770	*
Opioid Treatment Programs/Regulatory Activities (non-add)	*10,724*	*	*10,724*	*
Addiction Technology Transfer Centers (non-add)	*9,046*	*	*9,046*	*
PHS Evaluation Funds	2,000	2,000	-	-2,000
Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRSBG)				
Community Mental Health Services (CMHS) Block Grant	1,928,879	*	-	
Substance Abuse Treatment PHS Evaluation Funds	79,200	79,200	-	-79,200
Subtotal, SUPTRSBG	**2,008,079**	**79,200**	**-**	**-79,200**
State Opioid Response Grants	1,575,000	*	-	*
Subtotal, Substance Use Treatment	**4,159,298**	**4,159,298**	**19,770**	***-4,139,528***
Substance Use Prevention				
Federal Drug-Free Workplace	5,139	*	5,139	*

	FY 2024	FY 2025	FY 2026	
	Enacted	Operating Level[2]	President's Budget	FY 2026 +/- FY 2025
Center for Application of Prevention Technologies	9,493	*	9,493	*
Science and Service	4,072	*	4,072	*
Other Substance Abuse Prevention Activities	218,175	*	-	*
Drug Free Communities	-	-	*70,000*	*
Subtotal, Substance Use Prevention	**236,879**	**236,879**	**88,704**	***-148,175***
Behavioral Health Innovation Grants	-	-	4,025,411	*+4,025,411*
PHS Evaluation Funds	-	-	*100,239*	*+100,239*
Behavioral Health and Substance Use Disorder for Native Americans	-	-	80,000	*+80,000*
Subtotal, Mental and Behavioral Health	**7,204,723**	**7,204,723**	**5,777,455**	**-1,427,268**
Subtotal, Mental and Behavioral Health Discretionary BA (non-add)	*7,090,484*	*7,090,484*	*5,677,216*	*-1,413,268*
Subtotal, Mental and Behavioral Health PHS Evaluation Funds (non-add)	*102,239*	*102,239*	*100,239*	*-2,000*
Subtotal, Mental and Behavioral Health PPHF (non-add)	*12,000*	*12,000*	-	*-12,000*
HEALTH WORKFORCE:				
National Health Service Corps (NHSC):				
NHSC	128,600	128,600	128,600	-
NHSC Mandatory	432,904	258,041		-258,041
NHSC Mandatory proposed	-	-	345,000	+345,000
Subtotal, NHSC	***561,504***	***386,641***	***473,600***	***+86,959***
Loan Repayment/Faculty Fellowships	2,310	*	-	*
Health Professions Training for Diversity:				
Centers of Excellence	28,422	*	28,422	*
Scholarships for Disadvantaged Students	55,014	*	-	*
Health Careers Opportunity Program	16,000	*	-	*
Subtotal, Health Professions Training for Diversity	***99,436***	***	***28,422***	***-71,014***
Health Care Workforce Assessment	5,663	*	5,663	*
Primary Care Training and Enhancement	49,924	*	-	*
Oral Health Training Programs	42,673	*	-	*
Medical Student Education	60,000	60,000	-	*-60,000*
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	47,000	*	-	*
Geriatric Programs	48,245	*	-	*
Behavioral Health Workforce Development Programs	157,053	*	89,300	*
Substance Use Disorder Treatment and Recovery Loan Repayment	40,000	*	40,000	*
Subtotal, Interdisciplinary, Community-Based Linkages	***292,298***	***	***129,300***	***-162,998***
Public Health Workforce Development:				
Public Health/Preventive Medicine	18,000	*	-	*

	FY 2024	FY 2025	FY 2026	
	Enacted	Operating Level[2]	President's Budget	FY 2026 +/- FY 2025
Nursing Workforce Development:				
Advanced Nursing Education	95,581	*	-	*
Nurse Education, Practice and Retention	64,413	*	-	*
Nurse Faculty Loan Program	28,500	*	-	*
NURSE Corps Scholarship and Loan Repayment Program	92,635	*	92,635	*
Subtotal, Nursing Workforce Development	***305,472***	*****	***92,635***	***-212,837***
Children's Hospital Graduate Medical Education (CHGME):				
Children's Hospital Graduate Medical Education	390,000	*	-	*
Teaching Health Center Graduate Medical Education (THCGME):				
THCGME Mandatory	219,589	130,890	-	-130,890
THCGME Mandatory Proposed	-	-	175,000	+175,000
Subtotal, THCGME	***219,589***	***130,890***	***175,000***	***+44,110***
National Practitioner Data Bank (User Fees)	*33,500*	*32,910*	*33,500*	*+590*
Pediatric Subspecialty LRP	10,000	10,000	10,000	-
Subtotal, Health Workforce	**2,090,369**	**1,826,217**	**948,120**	**-878,097**
Subtotal, Health Workforce Discretionary BA(non-add)	*1,404,376*	*1,404,376*	*394,620*	*-1,009,756*
Subtotal, Health Workforce User Fees (non-add)	*33,500*	*32,910*	*33,500*	*+590*
Subtotal, Health Workforce Mandatory (non-add)	*652,493*	*388,931*	*520,000*	*+131,069*
POLICY, RESEARCH, AND OVERSIGHT				
Program Management[1]	249,800	*	201,539	*
Community Project Funding (HRSA and SAMHSA)	962,878	-	-	-
Health Surveillance (Mental and Behavioral Health)	50,623	*	50,623	*
Health Surveillance - PHS Evaluation (non-add)	*30,428*	*	*30,428*	*
Data Request and Publication User Fees	*1,500*	*	*1,500*	*
Awareness and Support	13,260	*	5,000	*
Substance Abuse & MH Performance and Quality Information Systems	10,200	*	10,200	*
Drug Abuse Warning Network	10,000	*	-	*
Behavioral Health Workforce Data and Development	1,000	*	-	*
Behavioral Health Workforce Data and Development PHS Evaluation (non-add)	*1,000*	*	-	*
Subtotal, Health Surveillance	**87,583**	**87,583**	**67,323**	***-20,260***
Immediate Office of Assistant Secretary of Health/Surgeon General Activities	22,560	22,560	24,473	+1,913
Assistant Secretary of Health PHS Evaluation (non-add)	*4,885*	*4,885*	*4,885*	-
Kidney X	5,000	5,000	-	-5,000
Sexual Risk Avoidance	35,000	35,000	-	-35,000
Vaccine Injury Compensation:				
Vaccine Injury Compensation Trust Fund (Claims)	261,497	266,727	272,061	+5,334

	FY 2024	FY 2025	FY 2026	
	Enacted	Operating Level[2]	President's Budget	FY 2026 +/- FY 2025
VICTF Direct Operations	15,200	15,200	15,200	-
Subtotal, Vaccine Injury Compensation	**276,697**	**281,927**	**287,261**	**+5,334**
Countermeasures Injury Compensation Program	7,000	7,000	-	-7,000
Make America Healthy Again Initiative	-	-	260,000	+260,000
Alzheimer's Program (non-add)	-	-	*35,000*	*+35,000*
Prevention Innovation Program(non-add)	-	-	*119,000*	*+119,000*
Chronic Care Telehealth Centers of Excellence (non-add)	-	-	*20,000*	*+20,000*
Telehealth Nutrition Services Network Grant Program (non-add)	-	-	*8,000*	*+8,000*
Childhood Lead Poisoning Prevention Program (non-add-BA)	-	-	*51,000*	*+51,000*
Childhood Lead Poisoning Prevention Program (non-add-PPHF)	-	-	-	-
Lead Exposure Registry (non-add)	-	-	*5,000*	*+5,000*
Program Management (non-add)	-	-	*22,000*	*+22,000*
Subtotal, Policy, Research, and Evaluation	**1,384,021**	**421,143**	**568,535**	**+147,392**
Subtotal, Policy, Research, and Evaluation User Fees (non-add)	*1,500*	*1,500*	*1,500*	-
Subtotal, Policy, Research, and Evaluation PHS Evaluation (non-add)	*36,313*	*36,313*	*35,313*	*-1,000*
Subtotal, Policy, Research, and Evaluation Discretionary BA (non-add)	*1,346,208*	*383,330*	*531,722*	*+148,392*
AHA Program Level	**28,991,539**	**25,731,786**	**20,591,533**	**-5,140,253**
Less Programs Funded from Other Sources:				
User Fees	*-35,000*	*-34,410*	*-35,000*	*-590*
Evaluation Funding	*-145,352*	*-145,352*	*-135,552*	*+9,800*
Mandatory Programs	*-7,341,709*	*-5,045,424*	*-6,362,738*	*-1,317,314*
PPHF[3]	*-304,267*	*-304,267*	-	*+304,267*
Total, AHA Discretionary Budget Authority	**21,165,211**	**20,202,333**	**14,058,243**	**-6,144,090**
Total, Interior Budget Authority	*-79,714*	*-79,714*	*-51,814*	*+27,900*
Total, Labor/HHS Budget Authority	**21,085,497**	**20,122,619**	**14,006,429**	**-6,116,190**

1\This activity also will receive funds from the Make America Healthy Again Initiative under Policy Research and Oversight

2\Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for 2025, and is rolled up within the account

3\The FY 2026 Budget proposes to eliminate the Prevention and Public Health Fund

BUDGET EXHIBITS TAB

Appropriations History Table
Administration for a Healthy America

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2017				
General Fund Appropriation:	-	-	-	-
FY 2018				
General Fund Appropriation:	-	-	-	-
FY 2019				
General Fund Appropriation:	-	-	-	-
FY 2020				
General Fund Appropriation:	-	-	-	-
FY 2021				
General Fund Appropriation:	-	-	-	-
FY 2022				
General Fund Appropriation:	-	-	-	-
FY 2023				
General Fund Appropriation:	-	-	-	-
FY 2024				
General Fund Appropriation:	-	-	-	-
FY 2025				
General Fund Appropriation:	-	-	-	-
FY 2026				
General Fund Appropriation:	$14,058,243,000	-	-	-

Summary of Changes
Administration for a Healthy America

(dollars in thousands)

	Dollars	FTEs
FY 2025 Estimate		
Total estimated budget authority.....	-	-
FY 2026 President's Budget		
Total estimated budget authority.....	14,058,243	TBD
Net Change.....	**14,058,243**	**TBD**

	FY 2025 Estimate		FY 2026 President's Budget		FY 2026 +/- FY 2025	
	BA	FTE	BA	FTE	BA	FTE
Increases:						
B. Program:						
1. Primary Care	-	-	2,916,212	TBD	+2,916,212	TBD
2. Environmental Health	-	-	727,700	TBD	+727,700	TBD
3. HIV/AIDS	-	-	2,725,117	TBD	+2,725,117	TBD
4. Maternal and Child Health	-	-	1,085,656	TBD	+1,085,656	TBD
5. Mental Health	-	-	5,677,216	TBD	+5,677,216	TBD
6. Health Workforce	-	-	394,620	TBD	+394,620	TBD
7. Policy, Research, and Oversight	-	-	531,722	TBD	+531,722	TBD
Subtotal, Program Increases.....					*+$14,058,243*	--
Total Increases.....					**+14,058,243**	**--**
Decreases:						
A. Built-in:	-	-	-	-	-	-
B. Program:	-	-	-	-	-	-
Subtotal, Program Decreases.....					-	-
Total Decreases.....					**--**	**--**
Net Change.....					**+14,058,243**	**--**

PRIMARY CARE TAB

PRIMARY CARE

Health Centers

	FY 2024 Final[1]	FY 2025 Enacted	FY 2026 President's Budget
BA	$1,737,772,000	*	$1,737,772,000
Current Law Mandatory	$5,345,753,424	$3,186,246,575	---
Proposed Law Mandatory	---	---	$4,260,000,000
FTCA	$120,000,000	*	$120,000,000
FTE	**	**	502[2]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

**FY 2024 and FY 2025 FTE included in HRSA FTE totals.

1\ Through sequential FY 2024 funding measures, including the Consolidated Appropriations Act, 2024 (P.L. 118-42), program received total mandatory appropriation of $5,345,753,424, available through December 31, 2024.

2\FY 2026 FTE represents entire Primary Care FTE total.

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

Program Description

For nearly 60 years, health centers have delivered affordable, accessible, high-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 medically underserved, low-income people across the country, using a coordinated, comprehensive, and patient-centered approach. Today, approximately 1,400 health centers operate over 15,000 service delivery sites that provide care to over 31 million patients across every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

Health centers serve a wide range of patients. In 2023:

- Approximately 90 percent of health center patients are individuals or families living at or below 200 percent of the Federal Poverty Guidelines as compared to approximately 27.5 percent of the U.S. population.
- Approximately 80 percent of health center patients were uninsured or covered by Medicaid, Medicare, or other public insurance programs.
- Approximately 29 percent of patients were children (age 17 and younger); approximately 12 percent were 65 or older. Over 59 percent were adult patients (18-64).

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 to 4 years). New Health Center Program grant opportunities are announced nationally, and applications are reviewed and rated by objective review committees (ORCs), 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, AHA applies statutory awarding factors including funding priority for applications serving a sparsely populated area; consideration of the rural and urban distribution of awards (e.g. at least 40 percent of awardees must serve rural areas); and continued proportionate distribution of funds to the special populations served under the Health Center Program.

Federal Tort Claims Act (FTCA) Program: The Health Center Program also administers the FTCA Program, under which participating health centers, their employees and eligible contractors may be deemed to be Federal employees qualified for medical malpractice liability protection under the FTCA. As Federal employees, they are immune from suit for medical malpractice claims while acting within the scope of their employment. The Federal Government assumes responsibility for such claims. In addition, the FTCA Program supports risk mitigation activities, including reviews of risk management plans and sites visits as well as risk management technical assistance and resources to support health centers. The enactment of the 21st Century Cures Act in December of 2016 extended liability protections for volunteers at deemed health centers under the FTCA Program.

Budget Request

The FY 2026 Budget Request for the Health Center Program is $6.12 billion. This total consists of $1.86 billion in discretionary resources, which includes $120 million for the FTCA program, and $4.26 billion in mandatory funding. This grant funding will enable health centers to provide high quality, cost-effective primary health care services to 31.9 million medically underserved, low-income patients across the country. The request also supports costs associated with the grant review and award process, operational site visits, information technology, and other program support costs.

Health centers are at the forefront of efforts to Make America Healthy Again through increasing access to chronic disease prevention and management (e.g. hypertension, diabetes), nutrition counseling and patient health education services, cancer screenings, and comprehensive primary health care services, including preventive services, mental health, and wellness activities. In 2023, 66 percent of adult health center patients with diagnosed hypertension had blood pressure under adequate control (less than 140/90), and 71 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 were able to better control hypertension and diabetes for their patients compared to the NCQA/HEDIS 2022 Medicaid HMO averages.

Seventy-two percent of child and adolescent health center patients received a weight assessment and counseling for nutrition and physical activity. The proportion of health center patients that received screenings for colorectal cancer (41 percent), cervical cancer (55 percent), and breast cancer (52 percent) all increased in 2023. Seventy-two percent of health center patients were screened for depression and had a follow-up plan documented, when appropriate.

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. In 2024, a study published in BMC Pediatrics found that Medicaid fee for service child patients seen at a health center had a 7 percent lower chance of hospitalization and total expenditures 8 percent lower than non-health center patients.[1] Additionally, a recent study noted that the health center model of care was associated with lower use of specialty, emergency department, and hospitalization visits compared with other primary care providers serving Medicaid managed care beneficiaries.[2]

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

AHA 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. AHA accomplishes this monitoring through a variety of available resources, including the review of health center data reports, independent annual financial audits reports, ongoing communication with grantees, and site visits. AHA will work to ensure that Health Center Program grantees are continuing to serve as a safety net for low-income and medically underserved populations and that its low-income patients benefit from discounts health centers receive from participating in the 340B Drug Program.

Funding History

FY	Amount
FY 2022 Final	$1,627,772,000
FY 2022 Mandatory Final	$3,905,348,000[3]
FY 2023 Final	$1,857,772,000

[1] Volerman et al. "Utilization, quality, and spending for pediatric Medicaid enrollees with primary care in health centers vs non-health centers" BMC Pediatrics, Jan 2024

[2] Pourat, N., Chen, X., Lu, C., Zhou, W., Yu-Lefler, H., Benjamin, T., Hoang, H., & Sripipatana, A. (2024). Differences in Health Care Utilization of High-Need and High-Cost Patients of Federally Funded Health Centers Versus Other Primary Care Providers. Medical care, 62(1), 52–59.

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

FY	Amount
FY 2023 Mandatory Final	$3,905,348,000[4]
FY 2024 Final	$1,857,772,000[5]
FY 2024 Mandatory Final	$5,345,753,000
FY 2025 Enacted	*
FY 2025 Mandatory Enacted	$3,186,247,000
FY 2026 President's Budget	$1,580,522,000
FY 2026 President's Budget Mandatory	$4,260,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In 2023, health centers served 31.3 million patients, an increase of approximately 800,000 patients from Calendar Year (CY) 2022. Health centers provided over 132 million patient visits (an increase of over 5.5 million visits from CY 2022). In 2023, about 41 percent of all health centers served rural areas providing care to nearly 9.8 million patients.

Patient Care: Health centers focus on integrating care for their patients across the full range of services – not just medical but services like mental health, oral health, vision, and pharmacy as well. Health centers also deliver crucial services such as case management, transportation, and health education, which better enable patients to access and utilize care services. In 2023, health centers provided mental health services to 2.8 million patients, an increase of 155 percent since 2013 and oral health services to nearly 6.4 million patients, an increase of nearly 44 percent since 2013.

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. AHA-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.

Appropriate prenatal care management has a significant effect on the incidence of low birth weight (LBW), the risk factor most closely associated with neonatal mortality. In 2023, 71 percent of pregnant health center patients began prenatal care in the first trimester. In addition, effectively 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

[4] FY 2023 reflects the post-sequestration amount of current law mandatory funding.
[5] Through sequential FY 2024 funding measures, including the Consolidated Appropriations Act, 2024 (P.L. 118-42), program received total mandatory appropriation of $5,345,753,424, available through December 31, 2024.

total health center patient population served in 2023. In 2023, the health center rate was 8.59 percent, and has consistently been lower than the national rate in prior years, despite health centers serving a higher risk prenatal population than represented nationally in terms of socio-economic status, health status, and other factors. In 2023, the CDC low birth weight rate was 8.58 percent, virtually equal to the health center rate.

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. AHA'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 2023, more than three-fourths of AHA-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 98 percent of all health centers reported having a certified EHR in 2023 and approximately 13 percent of all patient visits were conducted virtually, including over 40 percent of mental health visits.

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. Recent findings include:

- Health centers that receive supplemental substance use disorder-specific AHA grants had increased substance abuse disorder service capacity and utilization.[6]

- Co-locating mental health staff, particularly psychiatrists, at health centers increases patients' likelihood to receive timely, on-site mental health treatment.[7]

- Effective 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.[8]

[6] 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

[7] 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

[8] 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.

- Organizational advances in health information technology have led to improved quality of care in health centers that augments patient care capacity for disease prevention, health promotion, and chronic care management.[9]
- Enabling services were associated with higher probability of getting a routine checkup, a higher likelihood of having had a flu shot, and a higher probability of patient satisfaction.[10]

- Total spending on adult Medicaid patients was $1,411 lower in health centers than for other primary care providers.[11]

- Total spending on pediatric Medicaid patients was $741 lower in health centers than for other primary care providers.[12]

Federal Tort Claims Act (FTCA) Program: In accordance with the statute, AHA implemented FTCA coverage for volunteers in FY 2018. Nearly 221 volunteers were covered under the FTCA Program in FY 2024. Overall, for the Health Center FTCA Program, in FY 2021, 115 claims were paid totaling $72.5 million; in FY 2022, 151 claims were paid totaling $158.3 million; in FY 2023, 145 claims were paid totaling $104.8 million; and in FY 2024, 107 claims were paid totaling $83.2 million.

[9] 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.
[10] 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.
[11] Pourat, N., Chen, X., Lu, C., Zhou, W., Yu-Lefler, H., Benjamin, T., Hoang, H., & Sripipatana, A. (2024). Differences in Health Care Utilization of High-Need and High-Cost Patients of Federally Funded Health Centers Versus Other Primary Care Providers. *Medical care*, *62*(1), 52–59.
[12] Volerman, A., Carlson, B., Wan, W., Murugesan, M., Asfour, N., Bolton, J., Chin, M. H., Sripipatana, A., & Nocon, R. S. (2024). Utilization, quality, and spending for pediatric Medicaid enrollees with primary care in health centers vs non-health centers. *BMC pediatrics*, *24*(1), 100.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
1010.01 Number of patients served by health centers (Output)	FY 2023: 31.3 million Target: 30.4 million (Target Exceeded)	*	31.9 million	*
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 2023: 8.59% Target: Below national rate (8.58%) (Target Not met)	*	Below national rate	*
1010.07 Percentage of adult health center patients with diagnosed hypertension whose blood pressure is under adequate control (less than 140/90) (Outcome)	FY 2023: 66% Target: 61% (Target Exceeded)	*	66%	*
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 2023: 70% Target: 67% (Target Exceeded)	*	70%	*
1010.09 Percentage of pregnant health center patients beginning prenatal care in the first trimester (Output)	FY 2023: 71% Target: 73% (Target Not Met)	*	72%	*
1010.10 Percentage of health center patients who are at or below 200 percent of poverty (Output)	FY 2023: 90% Target: 90% (Target Met)	*	91%	*

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
1010.11 Percentage of health centers with at least one site recognized as a patient centered medical home (Output)	FY 2023: 78% Target: 75% (Target Exceeded)	*	78%	*
1010.13 Percentage of health center patients 12 years of age and older screened for depression and had a follow up plan documented as appropriate (Output)	FY 2023: 72% Target: 67% (Target Exceeded)	*	72%	*
1010.15 Percentage of health center patients seen within 30 days of first HIV diagnosis (Outcome)	FY 2023: 80% Target: 83% (Target Not Met)	*	81%	*
1010.16 Percentage of health center patients 3-16 years of age receiving weight assessment and counseling (Output)	FY 2023: 71% Target: 69% (Target Exceeded)	*	71%	*
1010.17 Percentage of health center patients 18 years of age and older screened for tobacco use and provided intervention if appropriate (Output)	FY 2023: 85% Target: 82% (Target Exceeded)	*	85%	*

* Performance targets under development.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	1,366	*	1,359
Average Award	$3.9 million	*	$3.9 million
Range of Awards	$400,000 – $23 million	*	$400,000 – $26 million

* Grant award estimates under development.

Free Clinics Medical Malpractice

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$1,000,000	*	$1,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Allocation Method ..... Other

Program Description

The Free Clinics Medical Malpractice Program encourages health care providers to volunteer their time at qualified free clinics by providing medical malpractice protection at sponsoring health clinics, thus expanding the capacity of free clinics. 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 to expand access to health care services for low-income individuals in medically underserved areas.

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

Budget Request

The FY 2026 Budget Request for the Free Clinics Medical Malpractice Program is $1 million. In FY 2023 and FY 2024 there were no paid claims under the Free Clinics Medical Malpractice Program. The Program Fund has a current balance of approximately $5 million. The request will support the Program's continued achievement of its performance targets, addressing its goal of maintaining access and capacity in free clinics. The funding request also includes costs associated with the application review and approval process, follow-up performance reviews, information technology and other program support costs.

Targets for FY 2026 focus on the number of patient visits provided by free clinic health care providers deemed eligible for FTCA malpractice coverage.

The FY 2026 Budget will also support the Program's continued coordination and collaboration with related Federal programs to further leverage and promote efforts to increase the capacity of the health care safety net. Areas of collaboration include coordination with the Health Center FTCA Program, also administered by AHA, 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) to assist in drafting items including deeming applications and related policies.

Funding History

FY	Amount
FY 2022 Final	$1,000,000
FY 2023 Final	$1,000,000
FY 2024 Final	$1,000,000
FY 2025 Enacted	*
FY 2026 President's Budget	$1,000,000

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

Increasing Access: In FY 2023, 11,769 health care providers received Federal malpractice insurance through the Free Clinics Medical Malpractice Program, exceeding the Program target. In FY 2023, 236 clinics participated, exceeding the program target. Free clinics had nearly 480,000 patient visits in FY 2023.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
1020.02 Patient visits provided by free clinics sponsoring Federal Tort Claims Act deemed clinicians. (Output)	FY 2023: 479,715 Target: 500,000 (Target Not Met)	*	500,000	*

* Performance targets under development.

Organ Transplantation

	FY 2024 Enacted	FY 2025 Enacted	FY 2026 President's Budget[1]
BA	$54,049,000	*	$54,049,000
FTE	**	**	502[2]

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025 and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\Does not include estimated user fees
2\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Method:

- Contracts, Competitive Grants
- Cooperative Agreements
- Other (Interagency Support)

Program Description

The National Organ Transplant Act of 1984 requires the Department of Health and Human Services (HHS), to oversee a national Organ Procurement and Transplantation Network (OPTN) to allocate and distribute donor organs to individuals awaiting transplant. The bipartisan Securing the U.S. Organ Procurement and Transplantation Network Act (P.L. 118-14) enhances HHS's tools to carry out this critical mission. Given the high demand and limited supply of organs, OPTN policies are continually refined to improve patient outcomes, maximize benefit across waitlist candidates, and promote equitable and efficient organ use.

The Organ Transplantation Program improves and extends the lives of individuals with end-stage organ failure for whom transplant is the most appropriate treatment. OPTN policies are informed by data and analysis from the Scientific Registry of Transplant Recipients (SRTR), which also supports policy development and performance evaluation. Public dashboards improve transparency and help patients and families make informed decisions.

In 2023, the OPTN Modernization Initiative was launched to improve accountability, transparency, governance, technology, and patient safety. For more than 40 years, OPTN had been operated by a single vendor. The modernization effort introduces a competitive, multi-vendor model and modernizes the IT platform for organ matching and data analytics. A contract to support a newly incorporated OPTN Board of Directors, with a special election taking place in 2025 to establish an independent, conflict-free Board. This new governance structure is supported by a dedicated contract and efforts to prevent conflicts of interest. Additionally, temporary authority provided in the FY 2025 appropriation allows for the collection and allocation of OPTN user fees to fund essential operations and infrastructure.

The organ transplantation program provides grants to support the Living Organ Donation Reimbursement Program (LODRP), which provides financial assistance to eligible living donors. Recent expansions include higher income thresholds and reimbursement of lost wages and

dependent care expenses, helping increase access and reduce wait times for kidney transplants. The Public Education for Living Organ Donation Reimbursement Program (PE-LODRP) complements these efforts by raising awareness through outreach and education. Both the LODRP and PE-LODRP operate on a three-year cycle, from September 1, 2025, through August 31, 2028.

Budget Request

The FY 2026 Budget Request for the Organ Transplantation Program is $54 million. AHA will continue implementing the OPTN Modernization Initiative through a competitive process that enables top-tier vendors to manage specific aspects of the system and operations. This approach fosters innovation, enhances accountability, and aligns OPTN components with vendor expertise.

Building on prior progress, FY 2026 activities will focus on strengthening oversight mechanisms, updating policies, and modernizing the regulatory framework. This includes implementing provisions of the Securing the U.S. OPTN Act, which provides the flexibility to manage the OPTN more effectively.

Key priorities include:

- Establishing new systems for monitoring and addressing patient safety issues;
- Enhancing financial oversight to ensure transparency and proper use of funds; and
- Continuing IT infrastructure modernization.

These efforts will help ensure the OPTN serves patients, families, and providers with improved efficiency, equity, and trust—advancing the broader goal of saving lives.

Temporary user fee authority supports critical system operations and infrastructure. Per OPTN regulations, the Board will recommend the FY 2026 registration fee to the HHS Secretary prior to the start of the fiscal year. As this determination is pending, the FY 2026 budget request does not reflect the estimated fee revenue.

AHA will continue overseeing multiple contracts under the modernization effort, with a strong emphasis on ensuring governance and operations uphold patient safety. The newly elected, independent OPTN Board of Directors will play a key role in advancing operational, technological, and accountability improvements. The request supports contract and grant awards, performance monitoring, IT systems, and other essential program activities.

Funding History

Fiscal Year	Amount
FY 2022 Final	$30,049,000
FY 2023 Final	$31,549,000
FY 2024 Final	$54,049,000
FY 2025 Enacted	$56,549,000
FY 2026 President’s Budget	$54,049,000

Program Accomplishments

In FY 2024, solicitations were issued, under new legislative authority, that would improve transparency, efficiency, and safety across the national organ transplant system. This included awarding contracts to multiple vendors to support core OPTN operations and modernize system functions. These actions aim to enhance competition, performance, and patient outcomes, with continued implementation in FY 2025 and FY 2026 focused on modern data systems, stronger governance, and patient-centered policies.

A major milestone in this effort was the separation of the OPTN Board of Directors from the incumbent vendor's board, creating a fully independent governance structure to eliminate conflicts of interest. The new OPTN Board is now a distinct legal entity, better positioned to act transparently and prioritize patients and the integrity of the system. Following this reform, a nationwide special election was held, resulting in the installation of a newly elected, representative Board in summer 2025—fulfilling a key modernization objective.

Governance reforms also included establishing direct channels for patients, families, clinicians, and other stakeholders to report misconduct, patient harm, or system concerns. This bypasses legacy contractor structures and enables timely action, reinforcing accountability and public trust in the transplant system. HHS is also developing infrastructure to implement new authority to collect OPTN user fees, ensuring transparent and sustainable funding for core system operations and future innovation.

The OPTN's primary goal, as defined in its performance measure (5010.01), is to maximize the number of organs transplanted from deceased and living donors. In FY 2024, the number of donor organs transplanted reached 47,577, surpassing the annual target and representing the highest number ever recorded. This progress builds on years of sustained organ procurement and transplantation growth and reflects continued national commitment to saving lives. By increasing transplants and reducing waitlist deaths, the OPTN's work helps more patients gain a second chance at life through the gift of organ donation.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
5010.01: Annual number of donor organs transplanted (Outcome)	FY 2024: 47,577 Target: 43,000 (Target Exceeded)	*	48,500	*

*Performance target under development

Grants Awards Table (living donor program):

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	1	*	2
Average Award	$2,400,000	*	$4,000,000
Range of Awards	$2,400,000	*	$500,000 - $7,500,000

*Grant award estimates under development

Blood Stem Cell Transplantation Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
C.W. Bill Young Cell Transplantation BA	$33,009,000	*	$33,009,000
National Cord Blood Inventory BA	$19,266,000	*	$8,266,000
FTE	**	**	502[1]

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Method ..... Contract

Program Description

The Blood Stem Cell Transplantation Program (BSCTP) includes the C.W. Bill Young Cell Transplantation Program (CWBYCTP) and the National Cord Blood Inventory (NCBI).The program is dedicated to increasing the number of transplants for patients who need life-saving treatments using biologically unrelated bone marrow or umbilical cord blood donors.

Blood stem cell transplantation, which includes the use of bone marrow and cord blood, is a critical therapy for patients with leukemia, lymphoma, sickle cell disease, and other serious blood and genetic disorders. For many, a stem cell transplant offers the best or only chance of survival. Each year, nearly 18,000 people in the U.S. are diagnosed with life-threatening conditions that may be treated with stem cell transplants. Although the ideal donor is often a close relative, only about 30 percent of patients have a fully matched family member. The remaining 70 percent must search for a matched unrelated adult donor or cord blood unit (CBU).

The program operates through four key functions that require close coordination and oversight:

- Single Point of Access – Coordinating Center (SPA-CC): Provides a centralized system for healthcare professionals to electronically search for and access bone marrow and cord blood units from unrelated donors.
- Office of Patient Advocacy (OPA): Supports a system that offers individualized patient services for finding bone marrow and cord blood donors. It also assists patients with understanding their treatment options, payment matters, and other critical support needs.
- Stem Cell Therapeutic Outcomes Database (SCTOD): Maintains an electronic database of clinical outcomes related to blood stem cell transplants. It supports researchers and healthcare professionals by collecting, analyzing, and storing donor and recipient data and transplant outcomes.
- Cord Blood Inventory Support: Provides funding through competitive contracts to public cord blood banks. These banks collect and store high-quality, genetically

diverse CBUs, with preference given to those with FDA biological licenses and proven capability to serve diverse populations.

Budget Request

The FY 2026 Budget Request for the BSCTP program is $41.3 million. This request will fund the program's inventory goal of 150,000 CBUs.

Support services for patients and donors, including case management and the sharing of critical information, will remain focused on delivering meaningful support. Key advocacy functions and patient assistance efforts will continue, ensuring individuals receive the help they need throughout the transplant process.

Data collection and analysis under the SCTOD will emphasize the most relevant outcomes to strengthen the evidence base for transplant success, while streamlining repository functions and management to enhance overall impact.

Funding History

FY	Amount
FY 2022 Final	$50,275,000
FY 2023 Final	$52,275,000
FY 2024 Final	$52,275,000
FY 2025 Enacted	*
FY 2026 President's Budget	$41,275,000

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

At the end of FY 2024, more than 9.4 million potential adult volunteer donors were registered in the United States through the CWBYCTP, of which 285,400 were new registrants from FY 2024. The total number of unrelated blood stem cell transplants facilitated by the CWBYCTP increased to 7,550 in FY 2024, an eight percent increase from nearly 6,970 in FY 2023. This increase is attributed to optimizing media and marketing activities and educational efforts to build trust and reach communities and health care professionals more effectively.

In FY 2024, the NCBI registry was able to add 3,700 more CBUs, increasing the overall total to nearly 126,000 CBUs (see Table 1). The program awarded $16.5 million to cord blood banks to support the NCBI and expand and maintain high-quality CBUs ready for transplant.

Table 1. Cord Blood Collections

Fiscal Year	AHA-funded NCBI CBU	CBU Collected and Made Available[1] for Patient Searches	Cumulative CBU Made Available
2020	4,567	4,049	111,512
2021	4,117	5,418	116,930
2022	3,937	3,556	120,486
2023	4,675	2,026	122,512
2024	3,961	3,700	125,873

The total number of CBUs released for transplantation has shown a steady decline since FY 2020 due to the increasing use of alternative curative therapies, as shown in Table 2. Despite the downward trend, cord blood banking remains critical in providing care for genetically diverse populations. In FY 2024, 289 AHA-funded cord blood units were used for transplants.

Table 2. Cord Blood Units Released for Transplantation

Fiscal Year	AHA-funded CBUs Released for Transplantation	Total CBUs (AHA-funded and Non-AHA funded) released for Transplantation through the BSCTP
2020	344	702
2021	313	589
2022	342	576
2023	281	506
2024	289	489

In 2024, the Advisory Council met two times to review issues related to the CWBYCTP and the NCBI program and made three recommendations to the Secretary.
AHA uses two performance measures (5020.02 and 5020.10) to evaluate the efficiency of AHA's primary role in administering the BSCT. These measures capture the efficiency of (1) the number of NCBI-funded cord blood units banked and available through the program, and (2) the number of unrelated blood stem cell transplants facilitated by the program.

In FY 2024, AHA set a measure target (5020.02) of 118,600 AHA-funded cord blood units banked and available through the C.W. Bill Young Cell Transplantation Program. NCBI exceeded this goal with 125,873 AHA-funded cord blood units banked and available through the program.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
5020.02: The number of AHA-funded cord blood units banked and available through the C.W. Bill Young Cell Transplantation Program (Outcome)	FY 2024: 125,873 Target: 118,600 (Target Exceeded)	*	127,500	*
5020.10: The annual number of domestic blood stem cell transplants facilitated by the Program.	FY 2024: 6,457 Target: Not Defined	*	6,500	*

*Performance targets under development.

National Hansen's Disease Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$13,706,000	*	$13,706,000
FTE	**	**	502[1]

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
******FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Method..... Direct Federal/Intramural, Contracts

Program Description

The National Hansen's Disease Program (NHDP) was established to create a national leprosarium in Carville, Louisiana. NHDP is the nation's leading resource for medical care, research, and education related to Hansen's disease (leprosy).

These services include diagnosis, multi-drug treatment, consultations, clinical laboratory services, and hand and foot rehabilitation. More complex cases are treated at NHDP's outpatient referral clinic in Baton Rouge, Louisiana, which provides short-term intensive care and rehabilitation. In addition to direct patient care, NHDP supports private-sector physicians by offering diagnostic, laboratory, and consultative services to strengthen the broader health system's capacity to manage this rare disease.

A key component of NHDP's mission is educating healthcare professionals, particularly in regions where Hansen's disease is less familiar and may be misdiagnosed. The program addresses these gaps through targeted outreach, clinical training, and provider support, helping to reduce delays in diagnosis and related disabilities.

Since its inception, NHDP has advanced the standard of care for Hansen's disease. It is the sole provider of reagent-grade viable Mycobacterium leprae (leprosy bacilli), essential for research. The program conducts laboratory research using modern genomics and molecular biology techniques to improve diagnosis, monitor drug resistance, and better understand transmission. This includes drug resistance testing, strain typing, and methods to determine the origin of infection.

The program collaborates with researchers worldwide to support scientific progress in Hansen's disease and works with federal, state, local, and private partners to enhance care and outcomes for those affected.

NHDP continues to improve health outcomes through scientific research. Early diagnosis and effective treatment are critical to reducing Hansen's disease-related disability. Current research focuses on improving testing methods, understanding drug resistance, and identifying transmission sources to inform effective care.

Through patient-centered care, research, and partnerships, NHDP remains dedicated to reducing the impact of Hansen's disease in the United States and ensuring patients receive timely, effective, and stigma-free treatment.

Budget Request

The FY 2026 Budget Request for the National Hansen's Disease Program is $13.7 million. This request will support the Program's primary focus of direct patient care activities and improving health outcomes for patients with Hansen's disease. In FY 2026, the program will continue to offer comprehensive, no-cost services to patients in the United States and its territories and will fund twelve ambulatory care contracts in FY 2026, with continuing efforts to align resources with levels of care. Funding will also allow Hansen's disease patients with severe complications who are advanced along the Hansen's disease spectrum or who have Hansen's disease-related disabilities to be referred to the primary clinic in Baton Rouge, free of charge. The Program provides free Hansen's disease medication to all providers upon request for the care and treatment of Hansen's disease patients in the U.S. and its territories.

The FY 2026 funding request will provide for purchasing and maintaining state-of-the-art laboratory equipment and consumables to support research activities focused on early diagnostics, new treatment modalities, understanding nerve damage, and disease transmission in a low-endemic setting. The program serves as the reference laboratory for many Hansen's Disease-specific laboratory tests essential for patient care, case management, and disease surveillance in the US. Finally, the request will allow the program to continue timely, high-quality Polymerase Chain Reactions (PCR) testing for HD diagnosis in US patients.

The funding request includes contracts, information technology, and other program support costs.

Funding History

FY	Amount
FY 2022 Final	$13,706,000
FY 2023 Final	$13,706,000
FY 2024 Final	$13,706,000
FY 2025 Enacted	*
FY 2026 President's Budget	$13,706,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

The National Hansen's Disease Program (NHDP) has significantly expanded its use of telehealth. This has allowed patients, especially those in remote areas or with limited resources, to access expert care without traveling. Many face barriers such as a lack of health insurance,

low health literacy, or jobs that do not allow time off. Others prefer the convenience of virtual visits. As a result, telehealth encounters increased from 423 in FY 2021 to 1,104 in FY 2024.

In FY 2024, NHDP renewed 12 ambulatory care clinic contracts, dispensed over 4,300 prescriptions, supplied 85 billion viable Mycobacterium leprae bacteria for international research, and evaluated 11 drugs for effectiveness in armadillo models. The program continued using Polymerase Chain Reaction (PCR) testing on all received tissue samples. PCR remains the only reliable method to distinguish between M. leprae and M. lepromatosis, essential for accurate and timely diagnosis. NHDP exceeded its target by completing PCR tests on 282 human samples, surpassing its goal of 200.

Education and outreach efforts also saw growth. NHDP expanded training opportunities for healthcare providers through virtual sessions, a learning management system, and approved YouTube videos. The program aimed to train 700 providers in FY 2024 and reached 688, a near-complete achievement that underscores NHDP's commitment to building awareness and improving the quality of care for individuals affected by Hansen's disease.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
5050.01 Number of health care providers who have received training from NHDP (Output)	FY 2024: 688 Target: 700 (Target Not Met)	*	800	*
5050.02 Number of human tissue samples on which clinically diagnostic Polymerase Chain Reactions were performed (Output)	FY 2024: 282 Target: 200 (Target Exceeded)	*	225	*

* Performance targets under development.

National Hansen's Disease Program - Payment to Hawaii

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$1,857,000	*	$1,857,000
FTE	**	**	502[1]

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Method ..... Direct Federal

Program Description

The Hawaii Hansen's Disease Community Program (HDCP) was established in 1982. Hawaii had its own leprosarium on the island of Kalaupapa, which is now part of the Kalaupapa National Historical Park.

The Hawaii HDCP began receiving federal funds as part of a reimbursement program for Hawaii's Hansen's disease care in 1988. The program currently has 260 active cases in treatment and a total of 642 cases, including active treatment, contact patients, chronic care (rehabilitation), disability monitoring/screening post-treatment, and outreach efforts.
The Hawaii Department of Health administers the Hawaii HDCP; the State monitors and treats Hansen's disease throughout Hawaii. Expenses above the level of the Federal funds appropriated for the support of medical care are borne by the State of Hawaii.

Budget Request

The FY 2026 Budget Request for the National Hansen's Disease Program – Payment to Hawaii program is $1.9 million This request will fund the payment made to the State of Hawaii for the medical care and treatment of persons with Hansen's disease.

Funding History

FY	Amount
FY 2022 Final	$1,857,000
FY 2023 Final	$1,857,000
FY 2024 Final	$1,857,000
FY 2025 Enacted	*
FY 2026 President's Budget	$1,857,000

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

The program continues to conduct ongoing contact investigations, tracing, and education through their assigned Hansen's disease Public Health Nurses (PHNs). This contact, outreach, and screening involve staff travel to neighboring islands. Individuals who are screened and show symptoms of Hansen's disease are referred for further medical evaluation, and the program covers the cost of biopsies and testing for uninsured individuals.

The program continues to find community health center programs on Oahu and the Neighbor Islands to ensure access to referrals from the Program and keep the care of Hansen's disease mainstreamed in the medical care system, along with specialist providers following cases. Infectious disease physicians are utilized in North Hawaii and Kona, establishing access to Hansen's disease care as well. Neighbor Island trips to coordinate visits for newly diagnosed patients in this area have helped with continuity of care and building case management with local PHNs.

More intensive case management continues to be required for the formerly institutionalized Hansen's disease patients who elected to live in the community on their own. This population is steadily aging and requires additional services and assistive aid to keep them safe in their own homes.

National Hansen's Disease Program – Buildings and Facilities

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
BA	$122,000	$122,000	---	-$122,000
FTE	**	**	502[1]	

****FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Method ..... Direct Federal

Program Description

This activity provides for facility-related expenses for the buildings and facilities of the National Hansen's Disease Center in the vicinity of Baton Rouge, Louisiana, to eliminate deficiencies according to applicable laws, and in keeping with accepted standards of safety, comfort, human dignity, efficiency, and effectiveness. Projects ensure safe facilities and functional environments for patients, research animals, the public, and staff.

Budget Request

The FY 2026 Budget Request for the National Hansen's Disease Program – Buildings and Facilities is $0. There are carryover balances available to continue to support facility expenses.

Funding History

Fiscal Year	Amount
FY 2022	$122,000
FY 2023	$122,000
FY 2024	$122,000
FY 2025	$122,000
FY 2026	---

Rural Health Policy Development

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$11,076,000	*	$11,076,000
FTE	**	**	502[1]

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
******FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Methods .....Competitive grant/co-operative agreement

Program Description

The Department of Health and Human Services (HHS) is required by statute to analyze the possible effects of HHS programs and regulations, particularly those related to Medicare and Medicaid, on the quality and availability of health care for people living in rural communities. HHS is also required to administer grants, cooperative agreements, and contracts to provide technical assistance and other activities necessary to improve health care in rural areas. Rural Health Policy Development funds several programs that provide information and technical assistance to support the improvement of health care for the 61 million residents of rural communities. The research studies and information resources made available by these programs provide critical information about the status of rural health that can help HHS, as well as the public, understand the unique challenges and impacts on rural communities and health systems to improve health. These resources were accessed by the public over 4.8 million times in 2024. In FY 2025 and FY 2026 these programs will continue to provide accessible information and rural-focused research to rural stakeholders and the public, including community members and leaders of rural health care organizations. Components of the Rural Health Policy Development program include:

- National Rural Health Information Clearinghouse Program supports an award that serves as a clearinghouse for information and resources to empower stakeholders and the public to improve rural health, including data-driven best practices and innovative approaches to enhance rural health care delivery.
- National Rural Health Policy, Community, and Collaboration Program supports an award to educate and engage rural stakeholders to collaborate on rural health issues and promising practices to improve the health of people living in rural communities nationwide.
- Rural Health Clinic (RHC) Technical Assistance Program supports an award to identify and analyze key regulatory, programmatic, and clinical issues facing RHCs and provide tools, resources, and strategies to RHCs and other rural stakeholders to improve care.
- Rural Health Innovation and Transformation Technical Assistance Program supports a technical assistance award to support rural health care through innovative payment

models and to promote the value-based care landscape in the context of rural health care.

- Rural Maternal Health Data Support and Analysis Program supports an award that provides data support to rural maternal health care networks to assist them in their efforts to improve maternal health care at the community- and regional-levels. It also supports the analysis of data to inform the improvement of maternal health care in rural areas nationwide.

Funding also supports publicly available studies on rural health issues:

- Rural Health Research Center (RHRC) Program funds eight core research centers to conduct rural health services research. The RHRCs produce research briefs and peer-reviewed journal manuscripts and make their publications rural stakeholders at the Federal, state, and community levels.
- Rapid Response Rural Data Analysis and Issue Specific Rural Research Studies Program, supports an award to conduct rapid data analyses and short-term rural research studies.
- Rural Health Research Dissemination Program supports an award that 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.

Budget Request

The FY 2026 Budget Request for Rural Health Policy Development is $11.1 million. This request will fund awards in FY 2026 to provide technical assistance and other activities necessary to improve health care in rural areas.

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

Funding History

FY	Amount
FY 2022 Final	$11,076,000
FY 2023 Final	$11,076,000
FY 2024 Final	$11,076,000
FY 2025 Enacted	*
FY 2026 President's Budget	$11,076,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

FORHP continues to monitor and track rural hospital financial distress and outcomes including hospital closures and conversions that eliminate inpatient services through the Rapid Response

Rural Data Analysis and Issue Specific Rural Research Studies Program.[1] This data collection tracks the number of rural hospital closures every year since 2005 and is heavily used by rural health stakeholders at the local, state, and federal levels to understand the trends and factors contributing to rural hospital closures nationwide. FORHP also tracks growth of the new outpatient-only Rural Emergency Hospital (REH) provider type that started in 2023.[2] This data collection shows that 19 rural hospitals converted to REHs in 2023, and 18 rural hospitals converted to REHs in 2024. FORHP-funded researchers use cost reports and other publicly available data to expand the evidence base regarding financial and community factors that affect closures and conversions, and the effects of those events on rural communities. This work has informed the development of rural hospital technical assistance programs, including the Delta Region Community Health Systems Development Program and the Appalachian Region Healthcare Support Program. FORHP grants offer technical assistance and provide support to rural hospitals to enhance or expand services lines and to keep health care, such as obstetric services, locally available.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
6010.01 Number of rural health research products released during the fiscal year (Output)	FY 2024: 55 Target: 47 (Target Exceeded)	*	47	*

* Performance targets under development.

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	16	*	15
Average Award	$830,000	*	$896,000
Range of Awards	$100,000 - $3,000,000	*	$100,000 - $3,500,000

*Grant award estimates under development.

Rural Health Outreach Grants

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$100,975,000	*	$100,975,000
FTE	**	**	502[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

**FY 2024 and FY 2025 FTE included in HRSA FTE totals.

1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Methods .....Competitive grant/co-operative agreement

Program Description

The Rural Health Care Services Outreach, Network and Quality Improvement Grants (Outreach programs) improve rural community health by focusing on quality improvement, increasing health care access, coordination of care, and integration of services. This program was created in recognition of the unique challenges faced by rural communities in accessing quality healthcare 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 metropolitan communities with greater resources. The Outreach programs are structured to allow applicants and grantees to determine the best ways to meet local needs. This flexibility responds to the unique health care challenges in rural communities and enables communities to determine the best approaches for addressing their specific needs. Eligible entities for these programs are community-based organizations serving rural areas. The grants provide initial start-up funding and recipients then identify and implement strategies to continue the projects after federal funding ends.

The programs administered have been shown to increase access to and coordination of rural community-based programs in the United States and territories. In FY 2023, over 500,000 individuals received direct services through these programs, which increased access to services in over 345 rural counties.

In FY 2024, these programs were able to improve rural community health by focusing on quality improvement, increasing health care access, coordination of care, and integration of services. These programs support collaborative approaches to deliver basic healthcare services to rural areas, tailored to local needs. Activities that support these goals will continue in FY 2025 and FY 2026.

- Rural Health Care Services Outreach Program focuses on improving access to health care in rural communities through community coalitions and evidence based and promising practice models. These grants focus on disease prevention, health

promotion, and can support the expansion of services around primary care, opioid use disorder treatment and prevention, behavioral health, and oral health care.

- Rural Health Network Development Program supports formalized partnerships among health care providers and social and community service organizations collaborating to improve access and enhance the quality of health care in rural areas. The program focuses on demonstrating improved health outcomes resulting from network collaboration, as well as positioning health care 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.
- Rural Health Network Development Planning Program provides support to rural communities to identify local health care challenges and develop potential solutions for emerging local public health issues, such as care coordination, patient engagement, rural hospital closure/conversion, telehealth, mental health, and substance use disorder.
- Small Health Care Provider Quality Improvement Grants help improve patient care and chronic disease outcomes by assisting rural primary care providers with the implementation of quality improvement activities. Specifically, program objectives include increased care coordination, enhanced chronic disease management, and improved health outcomes for patients. An additional program goal is to prepare rural health care providers for quality reporting and pay-for-performance programs.
- Rural Maternity and Obstetrics Management Strategies (RMOMS) grants provide start-up funding to test out new approaches to supporting, enhancing, and expanding maternal and obstetrics care in rural communities.
- Rural Health Care Coordination Program supports rural health consortiums/networks aiming to achieve the overall goals of improving access, delivery, and quality of care through the application of care coordination strategies in rural communities.

The challenges facing rural communities often involve regional patterns and common concerns that cut across state boundaries. The Federal government has used regional commissions and authorities as a strategy to address unique circumstances. Several rural health programs are administered in collaboration with these commissions that focus on regional concerns.

- The Delta States Rural Development Network Grant Program provides grants to the eight states in the Mississippi Delta for network and rural health infrastructure development. The program supports health promotion, chronic disease prevention and management, disease management, health promotion, 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 implement programs based on promising practices or evidence-based models.
- The Delta Region Community Health Systems Development Program provides technical assistance to help under-resourced health care providers (hospitals and clinics) that serve rural populations. Through this program, hospitals and clinics can access high-level technical support that they otherwise would not be able to access to improve their financial and operational performance. As a result, these facilities are

able to remain economically viable and preserve access to care for essential services. This program is implemented in coordination with the Delta Regional Authority.

- The Delta Health Systems Implementation Program provides the opportunity for Critical Access Hospitals and small rural hospitals in rural areas of the Mississippi Delta Region that have shown mastery and success of their technical assistance projects through the Delta Region Community Health Systems Development program to receive direct funding to address finances and operations, quality improvement, telehealth, and workforce development activities.
- The Delta Maternal Care Coordination Program aims to enhance and expand access to care for pregnant women and new mothers in the Delta Region. This is achieved through care coordination strategies that incorporate evidence-based, promising practices, and value-based care models in the planning and delivery of perinatal services. The program addresses barriers to maternal health care by developing and implementing sustainable care coordination strategies into policies, procedures, staffing, services, and communication systems, which includes appropriate service billing and partnering with private and public payers.
- Rural Northern Border Region Outreach Program supports the delivery of health care services to rural underserved populations in the rural Northern Border Regional Commission (NBRC) Region of Maine, New Hampshire, New York, and Vermont. Through a consortium of local health care and social service providers, communities can develop innovative approaches to challenges related to specific health needs that expand clinical and service capacity.
- The Appalachian Region Healthcare Support Program provides technical assistance to help health care providers (hospitals and clinics) that serve rural populations. Through this program, hospitals and clinics can access high-level technical support that they otherwise would not be able to access to improve their financial and operational performance. As a result, these facilities are able to remain economically viable and preserve access to care for essential services. This program is implemented in coordination with the Appalachian Regional Commission.

Budget Request

The FY 2026 Budget Request for the Rural Health Outreach Grants program is $101 million. This request will fund grants that will positively affect health care service delivery for rural communities. This funding request will support services and capacity-building activities for rural communities in improving rural community health by focusing on quality improvement, increasing health care access, chronic disease management, coordination of care, and integration of services. The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology, and other program support costs.

Funding History

FY	Amount
FY 2022 Final	$85,975,000
FY 2023 Final	$92,975,000

FY	Amount
FY 2024 Final	$100,975,000
FY 2025 Enacted	*
FY 2026 President's Budget	$100,975,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

The most recent data show that over 522,000 unique individuals received services through the Outreach Programs. The sustainability of their projects has been a critical element of these grants and AHA expects the majority of projects to continue after Federal funding. In FY 2023, the Rural Health Network Development Program grantees reported that 98% will sustain all or part of their projects. This is partly accomplished by the technical assistance provided by FORHP to the grantees during their grant cycle.
Grantees use the RHI Hub's Economic Impact Analysis tool to assess the economic impact of Federal investments. The tool translates project impacts into community-wide benefits, such as the number of jobs created, new spending, and impacts of new and expanded services. The most recent data shows that Rural Health Network Development Program grantees generated an average of $2.00 of economic impact into their rural communities for every Outreach program dollar spent.

Additionally, beginning in FY 2021, FORHP assessed grantees that showed improvement in one or more clinical quality measures. Clinical measures include reductions in diabetic hemoglobin A1c scores (HgbA1c), blood pressure scores, tobacco use, and body mass index (BMI) calculations. For FY 2023, the Delta States Rural Network Development Grants showed that 100% of grantees who reported on clinical measures showed improvement in at least one or more clinical measures. These grantees are operating in a challenging environment given that rural communities have higher rates of chronic disease and higher rates of avoidable or excess death from the five leading causes of death as identified by the Centers for Disease Control and Prevention (respiratory disease, injury, heart disease, cancer, and stroke).3 Historically, the results for this performance measure have been over 90% and the FY 2023 results mark the first time this performance measure has been 100 %. Accordingly, FORHP has increased the FY 2026 target to 92 % to align with previous results and will continue to realign the target based on available data.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
6020.01 Number of unique individuals who received direct services through Federal Office of Rural Health Policy Outreach grants (Output)	FY 2023: 522,753 Target: 516,000 (Target Exceeded)	*	525,000	*
6020.02 Percent of Outreach Authority grantees that will continue to offer services after the Federal grant funding ends (Output)	FY 2023: 98% Target: 80% (Target Exceeded)	*	90%	*
6020.03 Percentage of grantees that showed improvement in one or more clinical quality measures (Outcome)	FY 2023: 100% Target: Not Defined (Baseline)	*	92%	*

*Performance targets under development.

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	169	*	178
Average Award	$385,960	*	$442,433
Range of Awards	$100,000 - $10,000,000	*	$100,000 - $10,000,000

*Grant award estimates under development.

Radiation Exposure Screening and Education Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$1,889,000	*	$1,889,000
FTE	**	**	502[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Methods .....Competitive grants

Program Description

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. RESEP grantees also assist clients with appropriate medical referrals and engage in public information development and dissemination.

In FY 2024, this program supported organizations to screen and educate people exposed to radiation related to the mining of uranium and U.S. nuclear weapons testing by providing information and education to the public about prevention, detection and treatment of radiogenic cancers and disease, medical screenings, referrals and follow-up services.

In FY 2025 and FY 2026, program activities will continue to support the program goal by supporting organizations to provide information and education to populations exposed to radiation from uranium mining and U.S. nuclear weapons testing to understand radiogenic exposure and related disease process, recommendations for preventive screenings and the importance of preventive factors including healthy lifestyle behaviors such as smoking cessation, healthy weight management and preventive screenings as well as the significance of early detection and intervention for treatment of radiogenic cancer and disease on related disease prevention and progression.

Budget Request

The FY 2026 Budget Request for the Radiation Exposure Screening and Education Program is $1.9 million. This request will continue to support activities such as: disseminating information on radiogenic diseases and the importance of early detection, developing education programs, screening eligible individuals for cancer and other radiogenic diseases, and providing appropriate referrals for medical treatment.

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

Funding History

FY	Amount
FY 2022 Final	$1,889,000
FY 2023 Final	$1,889,000
FY 2024 Final	$1,889,000
FY 2025 Enacted	*
FY 2026 President's Budget	$1,889,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

RESEP grantees have continued to implement cancer screening and education programs, share information on radiogenic diseases and the importance of early detection, screen eligible individuals for cancer and other radiogenic diseases, and provide appropriate referrals for medical treatment.

All 8 RESEP grantees use evidence-based practice strategies to accomplish their work, incorporating elements including clinical expertise, current best evidence, and patient perspectives. Performance has remained consistent compared with previous years, continuing to provide program services to eligible individuals exposed to radiation from uranium mining and U.S. nuclear weapons testing annually.

Over 900 eligible individuals screened by RESEP grantees in FY 2023 reflected an outlying increase in response to the approaching sunset of the Radiation Exposure Compensation Act (RECA), (42 U.S.C. 2210 and Public Law 106-245, formerly a part of activities provided by RESEP grantees, which included assisting eligible individuals with filing RECA claims following screenings in RESEP grantee clinics. RECA sunset in June 2024, after RECA's initial sunset anticipated in July 2022 was extended. In future years, the number of individuals screened per year through RESEP is expected to return to prior screening estimates of over 700 individuals will be screened per year by RESEP grantees.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
6050.01 Total number of individuals screened per year through the Radiation Exposure Screening and Education Program (Output)	FY 2023: 931 Target: 300 (Target Exceeded)	*	750	*

*Performance targets under development.

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	8	*	8
Average Award	$212,510	*	$212,510
Range of Awards	$110,446 - $231,132	*	$110,446 - $231,132

*Grant award estimates under development.

Black Lung

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$12,190,000	*	$12,190,000
FTE	**	**	502[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Methods .....Competitive grant and /co-operative agreement

Program Description

The Black Lung Clinics Program (BLCP) funds eligible public, private, and state entities that provide medical, outreach, educational, and benefits counseling services to active, inactive, retired, and disabled coal miners throughout the United States. Black Lung Clinics work to reduce the morbidity and mortality associated with occupationally related coal-mine dust lung disease. To support the longer-term need faced by miners with severe disability due to black lung disease, grantees may also assist coal miners and their families in preparing the detailed application for Federal Black Lung benefits from the Department of Labor (DOL). In recent years, grantees have been able to use funds to upgrade equipment, enhance their workforce capacity, and increase behavioral health screenings and care integration.

In FY 2024, this program supported BLCP grantees to providing medical services, outreach services, educational services and benefits counseling services to active, inactive, retired and disabled coal miners to reduce the morbidity and mortality associated with occupation related coal mine dust lung disease (CMDLD), also known as black lung disease.

In FY 2025 and FY 2026, program activities will continue to support BLCP services that improve health outcomes for active, inactive, retired and disabled coal miner populations. These activities include services such as patient education and outreach services, lung function testing, chest imaging, pulmonary rehabilitation, lung disease treatment and benefits counseling.

The Black Lung Data and Resource Center (BLDRC) supports the operations of BLCP awardees and strengthens their ability to examine and treat respiratory and pulmonary impairments in active and inactive coal miners. The BLDRC supports Black Lung Clinics through improved patient-level data collection, analysis, and expansion of the body of knowledge related to the health status and needs of coal miners nationally.

Budget Request

The FY 2026 Budget Request for the Black Lung Clinics Program is $12.2 million. This request will fund 15 Black Lung Clinic Program awards and will continue to support primary care and other services to coal miners and one cooperative agreement with the Black Lung Data and

Resource Center to enhance the quality of services provided by BLCP grantees and work closely with AHA to strengthen the quality of data collection and analysis.

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

Funding History

FY	Amount
FY 2022 Final	$11,845,000
FY 2023 Final	$12,190,000
FY 2024 Final	$12,190,000
FY 2025 Enacted	*
FY 2026 President's Budget	$12,190,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2020, patient-level data collection was officially integrated into the Black Lung Clinics program. In FY 2023, Black Lung Clinics were operating at markedly increased levels when compared to the previous year's patient-level data with regard to both medical services and benefits counseling services. The patient-level data reporting system demonstrates a 5% increase in the number of miners served between FY 2022 and FY 2023, as well as a 10% increase in medical screenings and an 11% increase in medical encounters between FY 2022 and FY 2023. Other program accomplishments that are not included in the Outputs and Outcomes table below include a 9% increase in the number of Federal Black Lung Program claims filed through Black Lung Clinics. Black Lung Clinics provided myriad services, including over 5,000 chest x-rays and over 4,000 benefits counseling service encounters related to workers' compensation claims.

As well as supporting internal data management for BLCP, the Black Lung Data and Resource Center has utilized AHA funding, and BLCP data, to improve the quantity and quality, of available data related to the health status of the miners they serve and ensure ease of reporting into the patient-level data system.

All reported measures increased in FY 2023. This upward trend aligns with grantee-reported observations of increased numbers of young miners presenting with Progressive Massive Fibrosis (PMF), the more severe stage of Black Lung, in addition to interest from older miners who had delayed seeking care.

The number of miners being screened each year through BLCP is dependent on the size of the active, inactive, retired and disabled coal miner population. Changes in the coal miner population such as coal mining employment rates, mine closures and miner death rates can significantly impact the number of miners screened each year through the BLCP. As such, in future years, the number of miners screened annually through the BLCP is expected to vary.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
6060.01 Number of miners served each year through the Black Lung Clinics Program (Output)	FY 2023: 7,381 Target: 12,200 (Target Not Met)	*	7,800	*
6060.02 Number of miners screened each year through the Black Lung Clinics Program (Output)	FY 2023: 5,217 Target: Not Defined (Historical Actual)	*	4,000	*

*Performance targets under development.

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	16	*	16
Average Award	$743,962	*	$744,587
Range of Awards	$125,000 - $2,162,010	*	$135,000 - $2,162,010

*Grant award estimates under development.

Rural Residency Planning and Development

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$12,700,000	$12,700,000	$12,700,000
FTE	**	**	502[1]

****FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Methods .....Competitive grant/co-operative agreement

Program Description

The Rural Residency Planning and Development (RRPD) program seeks to expand the number of rural residency training programs, increase the number of physicians training in rural settings, and subsequently increase the number of physicians choosing to practice in rural areas. Rural residency programs are accredited physician residency programs that primarily train residents in rural training sites for greater than 50 percent of their total time in residency and focus on producing physicians who will practice in rural communities. Rural residencies include Rural Track Programs (RTPs), a specific model of rural residency training in which residents gain both urban and rural experience with more than half of the training taking place in rural areas. This program provides start-up funding to grant recipients to create accredited rural residency programs. These residency programs are designed to become self-sustaining through viable and stable long-term funding mechanisms, such as public or private funding graduate medical education (GME) funding.

Research has shown that residents often practice near where they complete their residency training. Spending more than half of training time in rural locations during family medicine residency is associated with a five- to six-fold increase in subsequent rural practice.[4] Rural training is more strongly associated with rural practice for physicians than having a rural background.[5] The RRPD funds two activities that support the creation of new rural residencies:

- The Rural Residency Planning and Development (RRPD) program creates new physician residency training programs that support physician workforce expansion in rural areas and that are sustainable beyond the grant period of performance through public or private funding. Recipients may use grant funds to cover planning and development costs incurred while achieving program accreditation and recruiting their early classes of residents. Since FY 2019, the program has made ten to sixteen new awards each fiscal year and plans a new competition for FY 2026.
- The Rural Residency Planning and Development Technical Assistance (RRPD-TA) program funds one cooperative agreement that creates for a technical assistance center to support organizations, such as RRPD grant recipients, that are creating and sustaining rural residency programs. Eligible entities include domestic organizations with the capability to be national in scope to reflect the distribution of current and future RRPD cohorts.

Budget Request

The FY 2026 Budget Request for the Rural Residency Planning and Development Program is $12.7 million, which is equal to the FY 2025 Enacted level. This request will fund approximately 15 new awards under RRPD and one non-competing continuation award for technical assistance under RRPD-TA.

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

Funding History

FY	Amount
FY 2022 Final	$10,500,000
FY 2023 Final	$12,500,000
FY 2024 Final	$12,700,000
FY 2025 Enacted	$12,700,000
FY 2026 President's Budget	$12,700,000

Program Accomplishments

Since FY 2019, the RRPD program has supported 85 grantees starting rural residency programs in 38 states and 1 territory. As of March 2025, 54 award recipients have achieved accreditation on or ahead of schedule, for a total of 683 new approved residency positions at full complement in the following specialties:

- 39 New Family Medicine Residency Programs and 471 Residency Positions
- 8 New Psychiatry Medicine Residency Programs and 92 Residency Positions
- 6 New Internal Medicine Residency Programs and 105 Residency Positions
- 1 New General Surgery Residency Program and 15 Residency Positions

In 2024, residency programs started through RRPD had approximately 430 residents in training. These programs graduated 51 residents in 2024. As residency programs that began in prior years start graduating residents, which takes three to five years depending on the specialty, the annual number of graduates will continue to increase with approximately 85 graduates anticipated in 2025 and 135 in 2026.

In FY 2024, a total of 12 grant recipients from RRPD Cohort 1 (FY 2019), Cohort 2 (FY 2020), and Cohort 3 (FY 2021) finished their periods of performance and 75% of them successfully achieved new rural residency program accreditation.

Two grant recipients that completed their period of performance in FY 2024 were still in the process of applying for accreditation due to delays by their sponsoring institutions. A third grant recipient was unable to develop a residency program due to its inability to sustain the partnerships with inpatient training sites required for accreditation. AHA is applying lessons learned from this effort to inform future program development and working closely with the

technical assistance center to document lessons learned from grantee successes and challenges to inform future rural residency development.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
6080.01 Percentage of Rural Residency Planning and Development grantees who achieve Accreditation Council for Graduate Medical Education accreditation by the end of the period of performance (Outcome)	FY 2024: 75% Target: 90% (Target not met)	90%	85%	-5 percentage points

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	16	16	16
Average Award	$749,767	$781,250	$781,250
Range of Awards	$747,150 - $750,000	$750,000 - $1,250,000	$750,000 - $1,250,000

Rural Communities Opioid Response

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$145,000,000	$145,000,000	$145,000,000
FTE	**	**	502[1]

****FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Methods .....Competitive grant/co-operative agreement

Program Description

Established in response to a Public Health Emergency, the Rural Communities Opioid Response Program (RCORP) seeks to reduce the factors that result in increased morbidity and mortality associated with substance use disorder (SUD), including opioid use disorder (OUD). It serves high need rural communities by establishing, expanding, and sustaining prevention, treatment, and recovery services at the county, state, and/or regional levels. In FY 2024, HRSA launched the results-driven and outcomes-based RCORP-Impact program, which provided funds to 198 award recipients to establish new and expand existing access to treatment services and enhance long-term recovery for rural individuals. In total, RCORP grant recipients provided services in rural areas of 1,010 counties across 45 states and two territories in FY 2024.

The investments in FY 2024 and FY 2025 included continuation of a portfolio of programs to enhance service access, behavioral health workforce, and community networks to address SUD and OUD needs, as described below. The RCORP-Overdose Response program was also re-competed in FY 2025 and open to all rural communities to address their most pressing challenges related to substance use disorder.

RCORP supports the following grant and cooperative agreement programs:

- The RCORP-Impact program provides funding to rural communities to improve access to integrated and coordinated treatment and recovery services for SUD and OUD with the aim to reduce morbidity and mortality and promote long-term, sustained recovery.
- The RCORP-Overdose Response program provides one-year funding to rural communities to meet their immediate needs related to the overdose crisis, including the distribution of naloxone.
- RCORP-Planning is a two-year program which provides support to organizations in rural communities to build the foundational capacity that is needed to develop and implement substance use disorder services.
- The RCORP-Child and Adolescent Behavioral Health program provides funding to rural communities to establish and expand behavioral health care services, including

mental and substance use disorder, across the prevention, treatment, and recovery continuum for rural children and adolescents aged 5-17 years.

- The RCORP-Rural Centers of Excellence on Substance Use Disorders provides funding to support the dissemination of best practices related to the treatment and prevention of substance use disorders within rural communities, with a focus on the current opioid crisis.
- The RCORP-Pathways program provides funding to rural communities to support rural youth with behavioral health care challenges while also bolstering the behavioral health care workforce in rural communities, by building innovative new youth-focused, peer-driven behavioral health care support programs and strengthening career pathway opportunities.
- The Northern Border Rural Workforce provides funding to address the ongoing critical need for behavioral health care professionals in rural communities by supporting behavioral health care training and job placement in the Northern Border Regional Commission service area
- RCORP-Technical Assistance and Evaluation provides funding to support technical assistance and evaluation efforts encompassing the entire RCORP initiative.

Budget Request

The FY 2026 Budget Request for the Rural Communities Opioid Response Program of $145 million is equal to the FY 2025 Enacted level. This request will support the development and continuation of community-based grant programs and technical assistance that provide needed behavioral health services, including those for substance use disorder/opioid use disorder (SUD/OUD), directly to rural residents. From 2002 to 2022, the drug overdose death rate increased nearly four-fold from 8.2 deaths per 100,000 population to 32.6 deaths. In 2023, the U.S. saw a decrease in overdose deaths (31.3 deaths per 100,000 population), and provisional data suggests that these declines continued through 2024. Although rates are decreasing nationally, there are smaller year-over-year decreases in rural compared to urban.[6] [7]

RCORP award recipients and other rural stakeholders have described continually evolving and emerging threats related to SUD/OUD (e.g., fentanyl and xylazine), and the need for additional resources to address co-occurring use of substances beyond opioids (e.g., alcohol) and mental health disorders specific to rural areas.

In FY 2026, AHA plans to continue funding activities that provide hands-on and on-demand technical assistance, access to AHA program staff, evaluation resources, and support for rural behavioral health care workforce development. The focus will be on emphasizing local control of the funding, reducing burden on the applicants and grant recipients, and promoting a cross-sector approach to addressing the behavioral health and substance use disorder needs of rural communities in a sustainable manner. This funding request also will enable AHA to strengthen RCORP's commitment to improving health outcomes and increasing access to health care services for underserved rural populations and ensure that essential SUD/OUD resources continue to reach people who are geographically isolated and reside in the highest-need rural communities. This investment will fund 1,956 competing and continuing grant recipients in FY 2026. These grants will support the establishment of new and sustainable prevention, treatment,

and recovery services; the addition of new behavioral health care providers; and the ability to address the continually evolving landscape of the opioid epidemic in rural communities.

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

Funding History

FY	Amount
FY 2022 Final	$135,000,000
FY 2023 Final	$145,000,000
FY 2024 Final	$145,000,000
FY 2025 Enacted	$145,000,000
FY 2026 President's Budget	$145,000,000

Program Accomplishments

In FY 2023, RCORP award recipients provided direct prevention, treatment, and recovery services to 1,966,586 rural individuals across the country, including medication-assisted treatment (MAT) services to 85,718 rural individuals. Further, 322 active RCORP award recipients (85.2%) operated newly established medication-assisted treatment services in their rural service area, with a total of 1,402 service sites.[8] Additionally, RCORP award recipients newly hired 425 behavioral health and substance use disorder providers to build the rural workforce as a direct result of their RCORP funding.[9] The targets for measures 6090.01 and 6090.03 have decreased from FY 2023 results due to a number of RCORP grant programs previously front-funded in earlier fiscal years completing their periods of performance.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
6090.01 Number of individuals screened for Substance Use Disorder (Output)	FY 2023: 1,437,238 Target: Not Defined (Historical Actual)	910,000	950,000	+40,000

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
6090.02 Percentage of Rural Communities Opioid Response Program (RCORP) grantees with other sources of funding for sustainability (aside from RCORP grant) (Output)	FY 2023: 87.8% Target: Not Defined (Historical Actual)	80%	80%	Maintain
6090.03 Number of providers who have provided Medication-Assisted Treatment (Output)	FY 2023: 3,319 Target: 2,100 (Target Exceeded)	1,615	1,650	+35

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	173	197	195
Average Award	$782,964	$682,685	$680,932
Range of Awards	$300,000 - $10,000,000	$300,000 - $10,000,000	$100,000 - $10,000,000

Prevention Innovation Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	---	---	$119,000,000[1]
FTE	---	---	502[2]

1\Funding is planned to be transferred from the Policy, Research and Oversight account as part of the MAHA Initiative.
2\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Method ..... Competitive Grants/Co-operative Agreements

Program Description:

The Prevention Innovation (PI) program provides communities with new and practical ways to support the goals of the Administration to Make America Healthy Again (MAHA). The PI program supports the goals of the MAHA initiative by addressing the root causes of America's escalating health crises, focusing on maternal health delivery gaps and chronic conditions that lead to poorer health outcomes in rural areas. This request supports three tracks: one for maternal health, one for chronic disease, and one for Tribes (where applicants could support programs in either maternal health or chronic disease).

The intent of the PI program is to improve overall health, reduce dependence on medications and other treatments, and ensure that people have access to resources such as nutrition services, physical activity venues, and other clean and healthy environmental and lifestyle options. These grants would provide initial start-up funding to support innovative and collaborative efforts within each community to build solutions to achieve the goals. Award recipients will identify and implement strategies to continue the projects after federal funding ends. To ensure access to needed services, applicants are encouraged to explore ways to integrate telehealth services. Additionally, award recipients will track outcomes data allowing AHA and communities to capture and share data to strengthen efforts and begin building an evidence base for this approach.

Chronic Conditions Track

Chronic disease impacts the costs associated with health care, morbidity and mortality, and overall quality of life for those living in rural communities. This program is intended to address the root causes of chronic disease and support communities as they implement promising practices or evidence-based models and develop innovative strategies in order to ensure rural residents build healthy practices to prevent chronic diseases from occurring. Approaches to prevent chronic diseases among rural communities include sponsoring screening fairs, supporting physical activity, and offering access to healthy foods.[13]

[13] 2025. RHIHub. Chronic Disease in Rural America. https://www.ruralhealthinfo.org/topics/chronic-disease.

This proposal would allow flexibility for rural award recipients to determine the partners and strategies that best meet their community's needs to address the challenges associated with chronic conditions. The PI program will drive measurable health outcomes through implementing nutrition-driven, chronic disease prevention programs in schools and other community organizations and promoting broadband access and technology integration.

Maternal Health Track

Rural areas also face specific challenges in maternal health, including limited access to specialists, higher rates of pregnancy-related mortality, and inadequate infrastructure. When maternal health care is not available, it can lead to negative outcomes such as premature birth, low birthweight, maternal morbidity and mortality, and postpartum depression. Access and utilization of health care services for maternal health are key to ensuring the wellness of mothers and their babies.[14]

To address maternal health challenges, the PI program will seek to strengthen maternal health services in rural communities through improved health care access to preventative and specialty care, health education and promotion and ensuring reliable broadband and technology integration. Activities supporting this effort include addressing transportation barriers and increasing the maternal health workforce to combat maternity care deserts.

Tribal Track

In the United States there are currently 574 federally recognized American Indian and Alaska Native (AI/AN) tribes that are sovereign entities with 40 percent of these populations residing in rural areas. Tribal communities in rural areas face significant health challenges compared to urban populations due to geographic barriers, limited health care infrastructure, and workforce shortages. Rural AI/AN populations have an increased risk of chronic conditions and the highest incidence of severe maternal morbidity and mortality.[15]

To address these issues, the PI program includes a $19 million Tribal set aside for tribes, tribal organizations, urban Indian health organizations, and health service providers to tribes serving rural communities experiencing poor chronic disease and maternal health outcomes.

Technical Assistance and Evaluation

This activity provides funding to support technical assistance and evaluation efforts for all of the awardees, including support for data collection and transparency efforts.

Budget Request

The FY 2026 Budget requests $119 million request, planned to be transferred from the Policy, Research and Oversight account as part of the MAHA Initiative. Funding will support approximately 102 awardees. Awardees for the chronic care, maternal health, or Tribal awards

[14] 2025. RHIHub. Rural Maternal Health. https://www.ruralhealthinfo.org/topics/maternal-health.

[15] https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/rural-tribal-health_printfinal.pdf

will receive $1 million each for a three-year project period. Beginning in year one, the awardees will increase access to either chronic disease or maternal health care services through partnering with agencies and assessing opportunities to increase access to care and resources within their community. In years two and three, award recipients will be expected to implement and/or expand access to chronic disease or maternal health care services. Additionally, to support technical assistance, data collection and evaluation efforts, AHA plans to award up to 2 awards for a combined of $15 million across four years (to provide support to awardees as they close out their projects.)

This funding is essential to improve the overall health of individuals living in rural areas, both at the community and population levels. By targeting the root causes of chronic diseases and maternal care challenges through preventive measures, the program aims to enhance health outcomes and reduce the long-term economic burden of healthcare in rural communities.

Funding History

FY	Amount
FY 2022 Final	---
FY 2023 Final	---
FY 2024 Final	---
FY 2025 Enacted	---
FY 2026 President's Budget	$119,000,000

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
Number of unique individuals from your target population who received direct services during the reporting period.	N/A	N/A	TBD	N/A
Number of individuals who received timely prenatal or postpartum care, within the reporting period, across number of grantees with appropriate measures, and funds dispersed.	N/A	N/A	TBD	N/A
Number of participants enrolled in health promotion or disease prevention programs.	N/A	N/A	TBD	N/A

Number of program participants with modified or adopted healthy behaviors	N/A	N/A	TBD	N/A

Performance Narrative

This program has not previously been funded or operated; therefore, there is not data to project future targets for these measures.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	---	---	102
Average Awards	---	---	$1,000,000
Range of Award	---	---	$1,000,000-$15,000,000

Office for the Advancement of Telehealth

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$42,050,000	$42,050,000	$42,050,000[1]
FTE	**	**	502[2]

****FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\An additional $28 million in FY 2026 is planned to be transferred from the Policy, Research and Oversight account as part of the MAHA Initiative, for a total of $70.1 million
2\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Method ..... Competitive Grants/Co-operative Agreements/Contracts

Program Description

The Office for the Advancement of Telehealth (OAT) was established in 1998 to promote 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 improve access to health care services in rural and underserved communities.
    - **Telehealth Nutrition Services Network Grant Program** supports telehealth networks that improve access to quality health care services through telehealth technology. This program will focus on chronic disease prevention and chronic disease management through comprehensive telehealth nutrition services.
    - **Behavioral Health Integration (BHI) Evidence Based Telehealth Network Program (EB-TNP)** increases access to integrated behavioral health services in primary care settings in rural and underserved communities by using telehealth technology. This program supports expanding and improving the quality of health information available to health care providers by evaluating the effectiveness of integrating telebehavioral health services into primary care settings and establishing an evidence-based model that can assist health care providers.

- **Telehealth Resource Centers (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.
- **Telehealth Centers of Excellence** program supports academic medical centers to implement innovative telehealth services in rural and urban areas and disseminates the findings through research publications. These centers serve as national models for implementing telehealth solutions that improve health outcomes and enhance access to care, especially in medically underserved areas.
- **Chronic Care Telehealth Centers of Excellence Program** supports academic medical centers to integrate innovative telehealth technologies into the full spectrum of services included in chronic care models, including but not limited to, chronic disease prevention and management, and the treatment for acute episodes that result from long-term morbidity. These centers will disseminate findings through research publications and will serve as national models for integrating telehealth technology into chronic care services.
- **Telehealth Research Center Program** supports clinically informed and policy-relevant health services research to expand the evidence base and evaluate nationwide telehealth investments in rural and urban underserved populations. This program will work with the EB-TNP awardees to analyze their results and prepare summaries and publications of their impact.
- **Telehealth Rapid Response Center Program** supports rapid telehealth data analyses and short-term, issue-specific telehealth research studies to provide the public with resources to understand the impact of telehealth policies and regulations.
- **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.
- **Technology-enabled Collaborative Learning Program** supports the use of technology-enabled collaborative learning to improve retention of health care providers and increase access to health care services in rural and underserved areas.
- **HHS Telehealth Hub** continues support for the coordination of the Telehealth.HHS.gov site, which is a one-stop resource for patients, providers, and states for information about telehealth such as telehealth best practices, policy and reimbursement updates, funding opportunities, and events.

Budget Request

The FY 2026 Budget Request for OAT is $42.1 million. An additional $28 million is planned to be transferred from the Policy, Research, and Oversight account as part of the MAHA Initiative, for a total of $70.1 million. This request funds the continued utilization of telehealth to provide access to healthcare in rural and underserved areas. In FY 2026, AHA will support the continuation of 55 existing grantees, and 41 new competitive grants through the Telehealth Nutrition Services Network Grant Program, Telehealth Centers of Excellence Program, Chronic Care Telehealth Centers of Excellence and Technology-enabled Collaborative Learning

Program. Specifically, the Telehealth Nutrition Services Network Program and Chronic Care Telehealth Centers of Excellence are new programs that will support the MAHA initiative. Overall, these programs increase access to healthcare services utilizing telehealth technologies and establish an evidence-base assessing the effectiveness of telehealth.

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

Funding History

FY	Amount
FY 2022 Final	$35,050,000
FY 2023 Final	$38,050,000
FY 2024 Final	$42,050,000
FY 2025 Enacted	$42,050,000
FY 2026 President's Budget \1	$42,050,000

1\An additional $28 million in FY 2026 is planned to be transferred from the Policy, Research and Oversight account, for a total of $70.1 million

Program Accomplishments

The Office for the Advancement of Telehealth had several outcomes and accomplishments through its program activities and collaborative efforts.

- The telehealth programs that provide direct services had over 35,000 telehealth encounters in FY 2023 for services such as tele-emergency and direct-to-consumer services.

- The TRCs have provided over 6,600 technical assistance requests in FY 2023 to assist providers with implementing telehealth and understanding evolving telehealth policy. The TRCs also develop key resources such as state Medicaid telehealth updates, Medicare billing guides, and toolkits and webinars on a range of topics.

- The Telehealth Centers of Excellence and Telehealth Research Centers have contributed to the evidence-base for telehealth with over 100 published articles to date on topics such as telehealth technology implementation, cost, utilization, and remote patient monitoring.

- Since the inception of the collaborative learning programs, grantees of the Technology-enabled Collaborative Learning Program (TCLP), previously known as TTELP, have had over 8,800 providers participating in Extension for Community Healthcare Outcomes (ECHO) or ECHO-like learning sessions that have focused on topics such as behavioral health, chronic disease management, and pediatric care.

- The Licensure Portability Grant Program was expanded in FY 2024 to include the Social Work Licensure Compact and Podiatry Interstate Licensure Compact along with continuing support for the Interstate Medical Licensure Compact (IMLC) and Psychology Interjurisdictional Compact (PSYPACT). There are approximately 15,000 providers participating in IMLC and over 15,700 providers participating in PSYPACT.

- The HHS Telehealth Hub had over 10 million users for Telehealth.hhs.gov since its launch. The website shares valuable telehealth resources to empower patients and health care providers including best practices for remote patient monitoring, interstate licensure resources, and information to improve access to high-speed internet.

- Supported by Telehealth.hhs.gov, OAT hosted its third virtual National Telehealth Conference in 2024, with over 2,700 registered participants and covering a wide range of topics such as tele-behavioral health, broadband, healthcare innovation, and health policy.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
6070.02 Increase the number of telehealth encounters provided through telehealth grant programs (Output)	FY 2023: 35,392 Target: Not Defined (Historical Actual)	23,000	24,000	+1000
6070.03 Increase the number of unduplicated patients receiving care via telehealth through telehealth grant programs (Output)	FY 2023: 16,422 Target: Not Defined (Historical Actual)	9,450	9,500	+50
6070.04 Increase the number of clients receiving technical assistance from the Telehealth Resource Centers Program (Output)	FY 2023: 6,683 Target: Not Defined	6,600	6,700	+100

	(Historical Actual)			

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	77	76	96
Average Award	$476,623	$478,289	$618,229
Range of Awards	$100,000 - $4,250,000	$100,000 - $4,250,000	$100,000 - $4,250,000

Office of Disease Prevention and Health Promotion

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$7,894,000	*	$25,594,000
FTE	**	**	502[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in OASH FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Methods:

- Contracts
- Direct federal

Program Description

The Office of Disease Prevention and Health Promotion (ODPHP), previously in the Office of the Assistant Secretary for Health:

- Coordinates all activities within the Department which relate to disease prevention, health promotion, preventive health services, and health information and education with respect to the appropriate use of health care;
- Coordinates such activities with similar activities in the private sector;
- Establishes a national information clearinghouse to facilitate the exchange of information concerning matters relating to health information and health promotion, preventive health services (which may include information concerning models and standards for insurance coverage of such services), and education in the appropriate use of health care, to facilitate access to such information, and to assist in the analysis of issues and problems relating to such matters; and
- Supports projects, conduct research, and disseminate information relating to preventive medicine, health promotion, and physical fitness and sports medicine.

Budget Request

The FY 2026 Budget Request for the ODPHP program is $25.6 million. This includes $17.7 million for domestic anti-doping activities and World Anti-Doping Agency (WADA) dues.

The request includes funding for ODPHP to create measures with up-to-date data to address the chronic disease epidemic in both adults and children. These measures will be based on gold standard science and be transparent so that Americans can understand how they can prevent and reverse chronic disease.

The request includes efforts to prevent doping (the use of banned substances to enhance athletic performance), especially among young athletes. ODPHP will work with the Office of Global Affairs, within the Assistant Secretary for External Affairs, to assist HHS in its efforts related to World Anti-Doping Agency (WADA). WADA is an international organization that promotes, coordinates, and monitors the fight against drugs in sports.

Funding History

FY	Amount
FY 2022 Final	$7,956,000
FY 2023 Final	$7,894,000
FY 2024 Final	$7,894,000
FY 2025 Enacted	*
FY 2026 President's Budget	$25,594,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

- In FY 2024, ODPHP collaborated with CDC's National Center for Health Statistics to expand nationally representative data on life satisfaction to include data on loneliness and social isolation which, together with the Healthy People 2030's key elements, will provide a complete framework for assessing progress in achieving the nation's health and well-being goals.
- In FY 2024, ODPHP launched the first HHS Food is Medicine (FIM) website, a key deliverable of the HHS FIM initiative to unify and advance collective action. As part of this initiative, ODPHP engaged a broad range of external partners to understand challenges and opportunities to advance FIM, cultivated partnerships with cross-sector leaders, and developed an interactive web environment with resources to help communities design and implement effective FIM.
- In FY 2025, ODPHP developed an action plan to revitalize the Presidential Youth Fitness Program to promote and measure physical fitness through school-based programming and recognition.

ODPHP will create measures with up-to-date data to address the chronic disease epidemic. These measures will be based on gold standard science and be transparent so that Americans can understand how they can prevent and reverse chronic disease.

Office of Minority Health

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$74,835,000	*	$45,000,000
FTE	**	**	502[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in OASH FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Methods:

- Contracts
- Competitive grants/cooperative agreements
- Direct federal

Program Description

The Office of Minority Health (OMH), formerly within the Office of Assistant Secretary of Health

- Establishes short-range and long-range goals and objectives and coordinate all other activities within the Public Health Service that relate to disease prevention, health promotion, service delivery, and research concerning such individuals. The heads of each of the agencies of the Service shall consult with the Deputy Assistant Secretary to ensure the coordination of such activities.
- Enters into interagency agreements with other agencies of the Public Health Service.
- Supports research, demonstrations and evaluations to test new and innovative models.
- Increases knowledge and understanding of health risk factors.
- Develops mechanisms that support better information dissemination, education, prevention, and service delivery to individuals from disadvantaged backgrounds, including individuals who are members of racial or ethnic minority groups.
- Ensures that the National Center for Health Statistics collects data on the health status of each minority group.
- With respect to individuals who lack proficiency in speaking the English language, enter into contracts with public and nonprofit private providers of primary health services for the purpose of increasing the access of the individuals to such services by developing and carrying out programs to provide bilingual or interpretive services.
- Supports the national minority health resource center to carry out the following:
    - Facilitate the exchange of information regarding matters relating to health information and health promotion, preventive health services, and education in the appropriate use of health care.
    - Facilitates access to such information.

    - Assist in the analysis of issues and problems relating to such matters.
    - Provides technical assistance with respect to the exchange of such information (including facilitating the development of materials for such technical assistance).
- Carries out programs to improve access to health care services for individuals with limited proficiency in speaking the English language. Activities under the preceding sentence shall include developing and evaluating model projects.
- Advises in matters related to the development, implementation, and evaluation of health professions education in decreasing disparities in health care outcomes, including cultural competency as a method of eliminating health disparities.

Budget Request

The FY 2026 Budget request for OMH is $45 million. OMH will lead the Department's priorities to advance Make America Healthy Again. OMH will focus on the prevention and treatment of chronic disease; promote culturally and linguistically appropriate services; enhance and develop strategic partnerships and collaborations across the federal government and with other public and non-profit entities; and support the minority health resource center.

Funding History

Fiscal Year	Amount
FY 2022 Final	$64,835,000
FY 2023 Final	$74,835,000
FY 2024 Final	$74,835,000
FY 2025 Enacted	*
FY 2026 President's Budget	$45,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

- OMH expanded health providers' access to cultural competency resources by sponsoring nine e- learning programs on culturally and linguistically appropriate services in health and healthcare. In FY 2024, OMH released two updated e-learning programs. In FY 2025 there were at least 21,244 program completions, and health professionals and students earned 105,450 continuing education credits.

- Through the Hear Her® campaign, a communications campaign launched to prevent pregnancy-related deaths, OMH and the Centers for Disease Control and Prevention (CDC) increased awareness of urgent maternal warning signs and the importance of culturally appropriate maternal health care. In FY 2024, OMH expanded the language accessibility and translated urgent maternal warning signs posters, palm cards, and conversation guides into Cherokee, Choctaw, Yupik, and Navajo.

- Central Oklahoma American Indian Health Council Inc. - Family-Centered Approaches to Improving Type 2 Diabetes Control and Prevention - The awardee implemented a 12-week intervention that provided Continuous Glucose Monitors (CGM) to all patient

participants and utilized paper charts completed by the patients. Participants that completed the 12-week program lost weight and improved their HgbA1c levels.

OMH will create measures with up-to-date data to address the chronic disease epidemic in minority populations. These measures will be based on gold standard science and be transparent so that Americans can understand how they can prevent and reverse chronic disease.

Alzheimer's Disease

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$39,500,000	*	$35,000,000[1]
FTE	**	**	502[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in CDC FTE totals.
1\Funding is planned to be transferred from the Policy, Research and Oversight account as part of the MAHA Initiative
2\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Methods:

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

Program Description

Alzheimer's disease seriously impairs a person's ability to carry out activities of daily living and to live independently. In 2024, approximately 6.9 million Americans were living with Alzheimer's disease, and this number is expected to increase to nearly 14 million by 2060. In FY 2024, the program increased the number of public health departments funded through the Building our Largest Dementia Infrastructure (BOLD) program from 23 to 43. BOLD recipients bolster the public health infrastructure by improving early detection, risk reduction, hospitalization prevention, and caregiving support. To support their efforts, the program funds four organizations through the National Healthy Brain Initiative to implement and evaluate the updated Healthy Brain Initiative (HBI) Road Map. The HBI road map actions provide a guide for state, local and tribal public health practitioners to address brain health in communities. The program also funds three organizations through the BOLD Public Health Centers of Excellence (PHCOE) to identify, translate, and disseminate promising research findings and evidence-informed best practices. This work supports the goal in the National Plan to Address Alzheimer's Disease; goal 6 emphasizes risk reduction for Alzheimer's disease and related dementias.

Budget Request

The FY 2026 Budget Request for Alzheimer's Disease is $35 million. The FY 2026 request supports the planned HHS realignment of these activities from CDC to AHA.

In FY 2026, this program will continue to support funded programs and update its Alzheimer's Disease and Healthy Aging Data Portal, infographic series, and Healthy Brain Resource Center to share up-to-date data for public health action.

Funding History

FY	Amount
FY 2022 Final	$30,500,000
FY 2023 Final	$38,500,000
FY 2024 Final	$39,500,000
FY 2025 Enacted	*
FY 2026 President's Budget	$35,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

- In 2023, funding for the BOLD public health program supported 143 public health workers to reduce dementia risk, increase early detection and diagnosis, and support dementia caregiving.
- With funding from BOLD program and the Virginia Department of Health, the Virginia Commonwealth University (VCU) launched The Virginia Memory Project in 2022. This expansive brain health registry for Alzheimer's disease and related dementias is one of only four in the nation and allows researchers to collect and analyze critical data. Policy makers and public health workers use The Virginia Memory Project to make informed decisions about the allocation of scarce resources for dementia and caregiving in the state.
- In 2024, Healthy Brain Initiative partnered with the Alzheimer's Association to release an updated version of the Road Map for American Indian and Alaska Native Peoples. The second edition of the Road Map builds on lessons learned from the implementation of the first, improving public health for tribes, nations, pueblos, urban Indian organizations while respecting sovereignty and traditions of AI/AN peoples.

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	43 (BOLD) 3 (PHCOE) 5 (HBI)	*	*
Average Award	$450,000 (BOLD) $500,000 (PHCOE) $400,000 (HBI)	*	*
Range of Awards	$250,000 - $450,000 (BOLD) $500,000 (PHCOE) $200,000 - $1,500,000 (HBI)	*	*

*Grant award estimates under development

Injury Prevention and Control

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$761,379,000	$761,379,000	$550,079,000
Comprehensive Suicide Prevention (non-add)	*$30,000,000*	*	*$12,000,000*
Preventing Intimate Partner and Sexual Violence Program Grant (non-add)	*N/A*	*	*$38,000,000*
National Violent Death Reporting System (non-add)	*$24,500,000*	*	*$24,500,000*
Opioid Overdose Prevention and Surveillance (non-add)	*$505,579,000*	*	*$475,579,000*
FTE	**	**	502[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in CDC FTE totals.
1\FY 2026 FTE represents entire Primary Care FTE total.

Allocation Methods:

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

Program Description

Injury Prevention and Control activities are dedicated to reducing the devastating impact of suicide, violence, and drug overdose across the United States. With nearly 50,000 Americans lost to suicide each year, the Comprehensive Suicide Prevention Program (CSP) focuses on high-risk populations such as youth, veterans, and rural residents. CSP strengthens epidemiologic capacity to understand suicide risk factors and supports award recipients, including state health departments and universities, in implementing effective prevention measures. Half of individuals who die by suicide lack a known mental health diagnosis, emphasizing the importance of community-level supports alongside mental health services. Another key component of injury prevention and control work is the National Violent Death Reporting System (NVDRS), which collects data from all 50 states, Washington, D.C., and Puerto Rico to inform targeted prevention efforts and enhance community safety.

Rape and intimate partner and sexual violence (IPV and SV) will be addressed through a new consolidated grant program that replaces the Rape Prevention and Education (RPE) and Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) programs. This grant empowers state health departments to work with coalitions to implement evidence-based strategies that mitigate risks, potentially saving up to $3.9 trillion in societal costs.[16]

The nation's drug overdose crisis will be combatted by supporting state and local health departments through initiatives such as Overdose Data to Action (OD2A) and the Overdose Response Strategy (ORS). Recent data show a promising 26.5% decline in overdose deaths, reflecting the program's impact.[17]

Comprehensive Suicide Prevention Program

CSP focuses on preventing suicides among high-risk groups, including youth, veterans and military personnel, middle-aged men, and rural populations, using data-driven prevention strategies to save lives. Suicide claims nearly 50,000 American lives each year, imposing a $515 billion financial burden, but each prevented suicide can save $10.4 million in medical and societal costs.

The Comprehensive Suicide Prevention Program (CSP), established in 2020, employs a data-driven public health approach to identify vulnerable populations, leverage existing prevention programs, implement evidence-based strategies, and support rigorous program evaluation. The program aligns with the 2024 National Strategy for Suicide Prevention's focus on Community-Based Suicide Prevention. Award recipients are encouraged to build on proven community-based strategies, such as equipping employers, coaches, faith leaders, and veterans with tools to strengthen connections, identify those at risk, and provide support before crises occur. This proactive, community-based approach complements crisis response efforts.

Preventing Intimate Partner and Sexual Violence Program Grant

The Preventing Intimate Partner and Sexual Violence (IPV and SV) Grant replaces the Rape Prevention Education and Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) programs, empowering state, territorial, and tribal health departments to work with domestic violence and sexual assault coalitions to implement proven prevention strategies. Data from the National Intimate Partner and Sexual Violence Survey (NISVS) show that 41% of women and 26% of men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner, leading to significant negative impacts on physical, mental, and social well-being.[18]

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[16] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]) [2025 Feb 21]. Available from URL: https://wisqars.cdc.gov/cost/?y=2022&o=MORT&i=2&m=20810&g=00&s=0&u=TOTAL&u=AVG&t=COMBO&t=MED&t=VPSL&a=5Yr&g1=0&g2=199&a1=0&a2=199&r1=NONE&r2=NONE&r3=NONE&r4=NONE

[17] Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2025. DOI: https://dx.doi.org/10.15620/cdc/20250305008

[18] *About intimate partner violence*. (2024b, May 16). Intimate Partner Violence Prevention. https://www.cdc.gov/intimate-partner-violence/about/index.html

Preventing intimate partner violence can save over $104,000 in lifetime costs per female victim, while rape prevention can save $3.9 trillion in medical and societal costs.[16] Drawing on 30 years of RPE programming, the grant supports the use of evidence-based strategies—such as teaching healthy relationship skills, empowering at-risk populations, and creating safe environments in schools, workplaces, and communities—to reduce violence.

National Violent Death Reporting System (NVDRS)

This program funds recipients to implement and maintain the NVDRS system, monitor and report data, and use these data to inform prevention efforts. Violence strains local economies, burdens law enforcement, and overwhelms social services, with 22,830 homicides and nearly 50,000 suicides recorded in 2023—one suicide every 11 minutes. Every $1 invested in violence prevention saves at least $5 in costs, including criminal justice and healthcare expenses, while NVDRS, covering all 50 states, Washington, D.C., and Puerto Rico, collects critical data to guide prevention efforts.[19,20] NVDRS is the only system that consolidates data from multiple sources, helping communities understand the causes of violent deaths and develop targeted, effective prevention strategies.

NVDRS supports data collection on all forms of violent deaths and suicides. Information on suicide help determine the effectiveness of strategies to prevent suicidal behavior and expand the number of proven prevention activities. NVDRS data will also enhance understanding of homicides, including the circumstances surrounding these incidents—including mass and multiple homicides— to help create safer and healthier communities. Recent advancements in rapid data analysis give public health professionals and policymakers greater visibility into public health threats, allowing them to make decisions faster. NVDRS continues to use data science—such as machine learning, natural language processing, and software automation—to enhance efficiencies and will continue to pursue linking NVDRS to other data sources.

Opioid Overdose Prevention and Surveillance

Overdose is the leading cause of death for Americans ages 18-44 and a major cause for those 45 and older, with the epidemic driven by an evolving array of substances, including illicit fentanyl, stimulants, and emerging drugs like xylazine.[21] Overdose deaths cost the U.S. economy $5.6 trillion, but community-based naloxone education and distribution can generate a $2,742 return for every $1 spent by saving lives.[22,23] Recent CDC data show a 26.5% decline in overdose deaths in 2024, suggesting progress.[24] This program supports state and local health departments

[19] Provisional Mortality Statistics, 2018 through Last Week Request
[20] https://publichealth.jhu.edu/sites/default/files/2023-10/estimating-the-effects-of-safe-streets-baltimore-on-gun-violence-july-2023.pdf
[21] https://www.cdc.gov/media/releases/2025/2025-statement-from-cdcs-national-center-for-injury-prevention-and-control-on-provisional-2024.htm
[22] Florence C, Luo F, Rice K. The economic burden of opioid use disorder and fatal opioid overdose in the United States, 2017. Drug Alcohol Depend. 2021 Jan 1;218:108350. doi: 10.1016/j.drugalcdep.2020.108350. Epub 2020 Oct 27. PMID: 33121867; PMCID: PMC8091480.
[23] Naumann R, Durrance C, Ranapurwala S, Austin A, Proescholdbell S, Childs R, Marshall S, Kansagra S, Shanahan M. Impact of community-based naloxone distribution program on opioid overdose death rates. Drug Alcohol Depend. 2019 Aug 30;204:107536. Doi: https://doi.org/10.1016/j.drugalcdep.2019.06.038
[24] https://www.cdc.gov/media/releases/2025/2025-statement-from-cdcs-national-center-for-injury-prevention-and-control-on-provisional-2024.html

through initiatives like Overdose Data to Action (OD2A), the Overdose Response Strategy (ORS), and the Opioid Rapid Response Program (ORRP), helping communities use data to target prevention efforts, track emerging drug threats, and provide timely support to those at risk.

All overdose prevention activities align with the Office of National Drug Control Policy's (ONDCP) priorities, focusing on reducing overdose fatalities, especially from fentanyl, by collaborating with public health departments, drug intelligence officers, public safety officials, laboratories, hospitals, and community organizations to share real-time threat data, disrupt the illicit drug supply, and support local prevention efforts. The program also works to secure the global supply chain against drug trafficking, partnering with the High Intensity Drug Trafficking Areas (HIDTA) Program through the ORS to enhance information sharing and protect communities. Prevention is a key priority, with initiatives like the Drug-Free Communities Support Program targeting youth substance use and the CDC Clinical Practice Guideline for Prescribing Opioids for Pain helping clinicians provide safe pain care. The program further supports innovative research, data systems, and surveillance to inform prevention strategies, with funding supporting grant management, performance reviews, and essential program operations.

Budget Request

The FY 2026 request for Injury Prevention and Control is $550,079,000. The FY 2026 request supports the planned HHS realignment of these activities from CDC to AHA.

At the FY 2026 funding level, AHA will collect data and leverage research to identify pressing health problems and monitor success as well as to d promote evidence-based strategies to inform real-world solutions. The budget request consolidates the Domestic Violence and Sexual Violence, Domestic Violence Community Projects, and Rape Education and Prevention programs into a single Preventing Intimate Partner and Sexual Violence grant program funded at $38 million.

This budget request also includes $12 million in funding for the Comprehensive Suicide Prevention program to support data-driven public health approach to prevent suicide. The request also includes $24.5 million for the National Violent Death Reporting System to continue to support NVDRS data collection on all forms of violent deaths and suicides. The Opioid Overdose Prevention and Surveillance program request for $475.6 million will continue to support overdose prevention and support, including funding for states, the District of Columbia, and 40 localities to participate in overdose prevention and surveillance activities under Overdose Data to Action in States (OD2A-S) and Overdose Data to Action: LOCAL (OD2A: LOCAL).

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

Funding History

FY	Amount
FY 2022 Final	$714,879,000
FY 2023 Final	$761,379,000

FY 2024 Final	$761,379,000
FY 2025 Enacted	$761,379,000
FY 2026 President's Budget	$550,079,000

Program Accomplishments

- From 2019-2022, CSP strategies implemented in Tennessee contributed to an 8.8% reduction in suicide rates in rural populations, while Massachusetts saw a 13.4% reduction among veterans and servicemembers.
- Louisiana's CSP program developed the Suicide Community Alert Network, sending 248 alerts in 2023 to school-based mental health professionals when youth suicidal behaviors spiked.
- North Carolina's CSP program trained 43 faith leaders as mental health providers, reaching 24,000 congregants in rural areas, addressing mental health provider shortages.
- West Virginia's "It's On Us WV To Be The One To Take A Stand" initiative empowered college communities to reduce sexual and dating violence through proactive bystander training.
- South Dakota's Youth Voices in Prevention (Youth VIP), an x award recipient, reduced the odds of sexual harassment perpetration by 86% among middle and high school students.
- Colorado's NVDRS data informed the Man Therapy campaign, a groundbreaking initiative providing mental health resources to working-aged men at high risk of suicide.
- Louisiana's Domestic Fatality Review Panel, informed by NVDRS data, uses a multidisciplinary approach to review and prevent domestic abuse fatalities.
- Over 872,000 doses of naloxone were distributed by OD2A-S recipients, with 74,629 individuals linked to life-saving care.
- Houston's Overdose Prevention Outreach Project trained 1,865 school staff and 4,100 students on fentanyl awareness and naloxone administration.
- In FY 2023, for the first time in years, the age-adjusted annual rate of opioid deaths involving prescription opioids decreased to 3.8 per 100,000 among states funded by the Overdose Data to States.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
7.1.6 Reduction in suicide rates among vulnerable populations selected by Comprehensive Suicide Prevention Program	FY 2024: 3.2% increase Target: 6.0% decrease *(Target Not Met)*	*	10% decrease	*

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
Recipients. *(Outcome)*				
7.1.8 Increase the percentage of Rape Prevention Education (RPE) states that are assessing community-level risk and protective factors related to sexual violence perpetration & victimization. *(Outcome)*	FY 2024: 84% Target: 84% (Target Met)	*	90%	*
7.2.7b Reduce age-adjusted annual rate of overdose deaths involving synthetic opioids other than methadone (e.g., fentanyl) among funded states (per 100,00 residents) (Outcome)	FY 2023: 22.2 per 100,000 residents Target: 7.7 (Target not met but improved)	*	7.7 per 100,000 residents	*
7.2.7c Reduce the age-adjusted rate of overdose deaths involving natural and semisynthetic opioids (T40.2) or methadone (T40.3) as a contributing cause of death among funded states (per 100,000 residents) (Outcome)	FY2023: 3.8 per 100,000 residents Target: 3.6 (Target met)	*	3.6	*

* Performance targets under development.

Grant Awards Tables

Comprehensive Suicide Prevention Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	24	*	*
Average Award	$889,683	*	*
Range of Awards	$700,000 – 1,033,000	*	*

*Grant award estimates under development

Preventing Intimate Partner and Sexual Violence Program Grant

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	91	*	*
Average Award	$510,471	*	*
Range of Awards	$40,000 – 4,155,379	*	*

*Grant award estimates under development

National Violent Death Reporting System (NVDRS) Grants

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	52	*	*
Average Award	$323,713	*	*
Range of Awards	$178,505-962,085	*	*

*Grant award estimates under development

Overdose Data to Action: State and OD2A: Local Grants

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	90	*	*
Average Award OD2A: State OD2A: Local	 $3,623,369 $2,188,370	*	*
Range of Awards OD2A: State	$1,865,943-5,473,539	*	*

OD2A: Local	$823,799-3,742,500		

*Grant award estimates under development

ENVIRONMENTAL HEALTH

TAB

ENVIRONMENTAL HEALTH

Safe Water

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$8,600,000	*	$8,600,000
FTE	**	**	929[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in CDC FTE totals.
1\FY 2026 FTE represents entire Environmental Health FTE total.

Allocation Methods:

- Competitive Grant/cooperative agreement

Program Description

For over two decades, the Safe Water Program has helped protect Americans from environmental contamination and waterborne illness stemming from the water they rely on for drinking, recreation, sanitation, and hygiene. The Safe Water Program provides critical subject matter expertise to state, local, tribal, and territorial health departments to address and eliminate water-related environmental exposures from natural and industrial processes, including flooding, harmful algal blooms, industrial accidents, and water system failures. In FY 2024, the program provided funding through cooperative agreements for 29 health departments to strengthen state and local programs and services for drinking and recreational water.

Funding History

FY	Amount
FY 2022 Final	$8,600,000
FY 2023 Final	$8,600,000
FY 2024 Final	$8,600,000
FY 2025 Enacted	*
FY 2026 President's Budget	$8,600,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Budget Request

The FY 2026 Budget Request for the Safe Water Program is $8,600,000. The FY 2026 request supports the planned HHS realignment of these activities from CDC to AHA.

This request strengthens and supports services in health departments for drinking and recreational water within their jurisdiction. The safe water programs in health departments will

provide support to address the cause of water-related environmental exposures; including preventing exposure to legionellosis and other contaminants found in building plumbing systems, and prioritizing efforts to keep small drinking water systems free from contamination.

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 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	29	*	*
Average Award	$85,000	*	*
Range of Awards	$49,000-$249,000	*	*

*Grant award estimates under development.

Program Accomplishments

- The cooperative agreement enabled funded states to develop well-water initiatives, including identifying at-risk wells and other private water systems with elevated levels of chemical, radiological, and biological contaminants such as arsenic, uranium, nitrates, and E. coli. Funded states collected and tested over 26,000 well water samples, finding that one out of six (over 4,300), had high levels of contaminants. This well testing allowed the states to take action to protect the health of the approximately 11,000 people served by those wells.
- With support from the Safe Water Program, the Madison County Department of Health in New York sampled over 400 private wells, finding 39% contaminated with coliform bacteria. The sampling results and subsequent outreach by the county led to 40% of households disinfecting their well and 61% replacing well caps to prevent future contamination.
- Fourteen states used the cooperative agreement to improve the prevention and control of Legionella, leading to systems that prevent the growth and exposure to the bacteria in 70,000 buildings.
- The Safe Water Program provided expertise that allowed one state to analyze the risks of harmful algal blooms at 41 locations and supported actions to post needed signage and notices in areas depending on risks.
- A local health department in Wisconsin used the Safe Water cooperative agreement to support the certification of laboratory staff to test for arsenic, reducing well water testing prices for western Wisconsin.

Childhood Lead Poisoning Prevention

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	---	---	$51,000,000[1]
PPHF[2]	$51,000,000	$51,000,000	--
FTE	**	**	929[3]

**FY 2024 and FY 2025 FTE included in CDC FTE totals.
1\Funding is planned to be transferred from the Policy, Research and Oversight account
2\The FY 2026 Budget eliminations the Prevention and Public Health Fund.
3\FY 2026 FTE represents entire Environmental Health FTE total.

Allocation Methods:

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

Program Description

Lead exposure can cause adverse effects in nearly every system in the body and seriously harm a child's health or cause death. Even at low levels, lead exposure has the potential to affect growth and development, hearing and speech, IQ, academic achievement, and behavior. Nearly 29 million U.S. homes contain at least one lead hazard, and over 10 million U.S. homes rely on lead-containing service lines to carry water from municipal sources into family dwellings, putting large numbers of children at risk for lead exposure. An analysis from the Health Impact Project estimates that eliminating lead hazards from the places where children live, learn, and play could generate approximately $84 billion in long-term benefits per birth cohort, including $18.5 billion in savings for the federal government and $9.6 billion for states from increased revenue and savings to the health care, education, and criminal justice systems.[25] Permanently removing lead hazards from the environment would also benefit future birth cohorts, compounding savings over time.

The Childhood Lead Poisoning Prevention Program (CLPPP) reduces the number of children exposed to lead by funding state and local health departments to improve blood lead testing and reporting systems, analyze and track trends to identify risk hot spots, link lead-exposed children to services, and implement community-specific interventions to prevent lead exposure. Currently, this program funds 62 states and localities to address critical gaps in services.

CLPPP also conducts research to identify and evaluate best practices in lead poisoning prevention; develops case management guidelines to assist health departments and healthcare providers; assists states with the development, implementation, and evaluation local lead poisoning prevention activities; provides training and education materials for public health professionals, healthcare providers, and others; and maintains the Childhood Blood Lead

[25] Health Impact Project. (2017). 10 policies to prevent and respond to childhood lead exposure.

Surveillance System voluntarily used by state and local health departments to efficiently manage blood lead surveillance, case management, and reporting activities. These activities are essential for a coordinated approach for eliminating childhood lead poisoning within the United States and have led to increased lead testing in pediatric healthcare practice.

This program also supports communities across the United States eliminate lead exposures and its associated negative health effects. Communities have access to a national network of resources and subject matter experts that can help them engage the multiple areas of the public and private sector that can provide education on the risks of lead exposure and steps to prevent exposure. In FY 2024, this program funded 11 community-based organizations to help families avoid the dangers of lead in their homes through community engagement, prevention education, and family support.

Budget Request

The FY 2026 Budget Request is $51.0 million for the Childhood Lead Poisoning Prevention Program. The FY 2026 request supports the planned HHS realignment of these activities from CDC to AHA.

Funding History

FY	Amount
FY 2022 Final	$41,000,000
FY 2023 Final	$51,000,000
FY 2024 Final	$51,000,000
FY 2025 Enacted	$51,000,000
FY 2026 President's Budget	$51,000,000

Program Accomplishments

- In FY 2024, the CLPPP-funded North Carolina Childhood Lead Poisoning Surveillance Program discovered the cause of a nationwide lead poisoning outbreak linked to cinnamon applesauce pouches. Their work began the chain of events that has led to the removal of the product from retailers around the world and the identification of more than 550 cases from 44 states.
- The Indiana state health department used CLPPP support to launch universal blood lead testing for children under age 7, prioritizing testing during 1 to 2 years of age. Nearly 94,000 children received blood lead testing in 2023, an increase of more than 57 percent compared to 2022.
- To increase the number of children tested for lead poisoning, the Salt Lake County Health Department used CLPPP funding to provide participating clinics with a point of care analyzer, education, and help with creating and implementing policies and workflows to test blood lead levels. As a result, three participating clinics had a 260 percent increase in capillary blood tests and a 405 percent increase in venous testing.

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	73	*	73
Average Award	$500,000	*	$500,000
Range of Awards	$200,000-$750,000	*	$200,000-$750,000

*Grant award estimates under development.

Lead Exposure Registry

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$5,000,000	*	$5,000,000
FTE	**	**	929[3]

**FY 2024 and FY 2025 FTE included in CDC FTE totals.
1\Funding is planned to be transferred from the Policy, Research and Oversight account
2\The FY 2026 Budget eliminates the Prevention and Public Health Fund.
3\FY 2026 FTE represents entire Environmental Health FTE total.

Allocation Methods:

- Single source grant

Program Description

This program supports the Flint Lead Exposure Registry, a model for the nation's first lead-free city and support for the Flint community. In FY 2024, Michigan State University continued its work under the five-year grant awarded in 2022 to continue community, tribal, and stakeholder outreach and training; registrant enrollment via targeted outreach; data collection; referral of registrants to services to reduce or control lead exposure effects; measurement of registrants' exposure, health, and developmental milestones with their interventions, services, and enrichment activities; cohort maintenance of enrolled participants; and evaluation and dissemination of findings to share best practices. As of May 2025, over 22,200 people have been fully enrolled in the Flint Registry and over 35,100 referrals to services have taken place.

Budget Request

The FY 2026 Budget Request is $5.0 million for the Lead Exposure Registry. The FY 2026 request supports the planned HHS realignment of these activities from CDC to AHA.

Funding History

FY	Amount
FY 2022 Final	$5,000,000
FY 2023 Final	$5,000,000
FY 2024 Final	$5,000,000
FY 2025 Enacted	*
FY 2026 President's Budget	$5,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	1	*	*
Average Award	$5.000	*	*
Range of Awards	$5.000	*	*

*Grant award estimates under development.

Mining Research

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$66,500,000	*	$66,500,000
FTEs	**	**	929[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in CDC FTE totals.
1\FY 2026 FTE represents entire Environmental Health FTE total.

Allocation Methods:

- Direct federal/intramural
- Contracts
- Competitive grants/cooperative agreements

Program Description

The Mining Health and Safety Program directly enhances miner safety and health practices associated with the extraction and processing of critical minerals essential to U.S. economic and national security. Its work reduces operational risks in critical mineral supply chains, helping ensure a reliable and safe domestic mining workforce and infrastructure. Addressing these issues is essential to achieving the program's goal of preventing mining-related illness, injury, and death and supports the America First priorities.

This program funds several high-impact initiatives: (1) emergency disaster response and rescue training, (2) automation and autonomous operations, (3) exposure assessment and interventions of hazards related to the mining and processing of critical minerals, (4) mine ventilation and explosion prevention, (5) battery safety, (6) behavioral science and mental health among miners and (7) medical surveillance and interventions to mitigate black lung in coal miners. These priorities are informed by industry and partner input, recent mining accidents and fatalities, and shifts in mining operations, including the increased use of battery-powered equipment and demand for critical minerals.

Budget Request

The FY 2026 Budget Request for the Mining Health and Safety Program is $66.5 million. The FY 2026 request supports the planned HHS realignment of these activities from CDC to AHA. This funding will continue to support high-impact initiatives to ensure miner safety and health practices.

Funding History

FY	BA
FY 2022 Final	$62,500,000
FY 2023 Final	$66,500,000
FY 2024 Final	$66,500,000
FY 2025 Enacted	*
FY 2026 President's Budget	$66,500,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

- Enabled rapid on-site measurement of respirable crystalline silica exposure with the Field Analysis of Silica Tool (FAST), allowing immediate action to protect miners from lung disease.
- Enhanced emergency response capabilities for over 950 mine workers using advanced Virtual-Reality Mine Rescue Training (VR-MRT), directly improving workplace safety.
- Addressed a wide range of health risks in mining, including opioid use, mental health challenges, and unique risks for women mine workers through the National Miner Health Program.
- Reduced the risk of uncontrollable fires in mines by developing improved battery enclosures, directly enhancing safety for underground workers.
- Improved operational safety and efficiency in mining with real-time data access through wireless integration and advanced automation.
- Strengthened the workforce in critical safety and technical areas by supporting over 70 faculty members and training more than 280 MS and PhD candidates in mining safety and related fields.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result /(Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
9.2.2e: Achieve and sustain percentage of active underground and surface coal mines in the U.S. that possess NIOSH-approved plans to perform surveillance for respiratory disease *(Outcome)*	FY 2024: 99% Target: 93% (Target Exceeded)	*	93%	*

* Performance targets under development.

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	5	*	*
Average Award	$750,000	*	*
Range of Awards	$250,000 - $2 million	*	*

***** Grant award estimates under development.

National Mesothelioma Registry and Tissue Bank

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$1,200,000	*	$1,200,000
FTE	**	**	929[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in CDC FTE totals.
1\FY 2026 FTE represents entire Environmental Health FTE total.

Allocation Methods:

- Direct federal/intramural
- Contracts
- Competitive grants/cooperative agreements

Program Description

This program supports National Mesothelioma Registry and Tissue Bank (NMBV). Mesothelioma is a rare and aggressive cancer affecting the lining of the chest or abdomen and is almost exclusively linked to previous asbestos exposure up to 50 years in the past. Progress in translational and clinical research depends on the ability of researchers to access high-quality tissue samples and robust clinical and demographic data. Low-incidence rates have limited the number of mesothelioma cases available for banking or tissue collection and storage. Funded in 2006 in response to this need, the NMVB provides biospecimens (blood, plasma, white blood cells, and normal and mesothelioma tissues) together with demographic and clinical data to the research community. These resources assist in the development of early markers of disease, biomarkers of stage and prognosis, as well as improved clinical treatments.

Budget Request

The FY 2026 Budget Request for the National Mesothelioma Virtual Bank (NMVB) is $1.2 million. The FY 2026 request supports the planned HHS realignment of these activities from CDC to AHA. This funding will enable the NMBF to continue to expand its collection of high-quality biospecimens, accelerating research on diagnostics and treatments for this deadly cancer.

Funding History

FY	BA
FY 2022 Final	$1,200,000
FY 2023 Final	$1,200,000
FY 2024 Final	$1,200,000
FY 2025 Enacted	*
FY 2026 President's Budget	$1,200,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

- Contributed to advances in diagnosing and treating mesothelioma by expanding biomaterial collections and providing valuable research data for malignant mesothelioma studies.

National Firefighter Registry for Cancer

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$5,500,000	*	$5,500,000
FTE	**	**	929[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in CDC FTE totals.
1\FY 2026 FTE represents entire Environmental Health FTE total.

Allocation Methods:

- Direct federal/intramural
- Contracts
- Competitive grants/cooperative agreements

Program Description

The National Firefighter Registry (NFR) for Cancer advances firefighter health research and first responder safety. Firefighters are exposed to toxic substances on the job and are at increased risk for certain cancers. The U.S. has lacked a national system to comprehensively study cancer incidence in this population. The NFR for Cancer addresses this gap by collecting data from active and retired U.S. firefighters to support high-quality epidemiologic research. The funding supports continued development of formal partnerships to conduct further outreach with fire services, enhanced and more in-depth data analysis, identification of new data sources, essential data linkages (e.g., with state cancer registries), and new follow-up questionnaires and resources for firefighters and fire service leaders.

Budget Request

The FY 2026 Budget Request for the National Firefighter Registry (NFR) for Cancer is $5.5 million. The FY 2026 request supports the planned HHS realignment of these activities from CDC to AHA. This funding will continue support for enhancements to data collection, adding new data sources and partnerships to improve our understanding of cancer risks among U.S. firefighters.

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

Funding History

FY	BA
FY 2022 Final	$3,000,000
FY 2023 Final	$5,500,000

FY	BA
FY 2024 Final	$5,500,000
FY 2025 Enacted	*
FY 2026 President's Budget	$5,500,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

- Enrolled 24,000 firefighters nationwide in the NFR for Cancer initiative, addressing cancer risks among firefighters across all 50 states and demonstrating significant national reach and impact.
- Reduced occupational cancer risks for firefighters through collaboration with the Fire Fighter Cancer Cohort Study and targeted initiatives for exposure reduction.

National Institute of Environmental Health Sciences (NIEHS)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA[1]	$913,979,000	$913,979,000	$594,086,000
FTE	**	**	929[2]

1\Amounts do not include the HIV/AIDS permissive transfer under the authority of NIH's Office of AIDS Research.
******FY 2024 and FY 2025 FTE included in NIH-NIEHS FTE totals.
2\FY 2026 FTE represents entire Environmental Health FTE total.

Allocation Methods:

- Competitive Grant
- Cooperative Agreement
- Contract
- Direct Federal/Intramural
- Other

Program Description

The mission of the National Institute of Environmental Health Sciences (NIEHS) is to research how the environment affects biological systems across the lifespan and to translate this knowledge to reduce disease and promote human health.

Understanding environmental impacts on health helps us understand their myriad effects on organ systems and consequent contributions to major illnesses and chronic disease; it also informs prevention and treatment, uncovering pathways to protection from harm and the means of enabling a healthy life. New technologies are yielding insights daily that affect how we view and engage with the world around us. We are focusing our research efforts in areas where we see the greatest potential for discovery and translation, and providing the support needed to help us identify, prepare for, and seize the best opportunities to apply the findings and knowledge that result from these efforts to ensuring the Nation's health.

NIEHS supports research through its extramural program, including research project and center grants, and research training. NIEHS' intramural scientists are engaged in Investigator-Initiated laboratory and clinical research, such as studies to explore genetic and mechanistic causes of disease, investigate the exposome, and develop new scientific approaches to elucidating as-yet undiscovered connections between the environment that can inform the development of disease screenings, treatments and cures. In addition, research supported by the NIEHS Division of Translational Toxicology (DTT) conducts predictive toxicology in support of the National Toxicology Program (NTP).

NIEHS research spans many areas, including:

Fundamental Research: Fundamental research is a primary scientific emphasis of NIEHS. Investments in this area are aimed at tackling the undiscovered by identifying and understanding basic shared mechanisms or common biological pathways that underlie diseases and disorders, such as inflammation, changes outside DNA (epigenetic) that affect its expression, and DNA mutations. Knowledge of these fundamental processes will enable the development of precision environmental health interventions—targeted prevention and treatment strategies at the individual level.

Exposure Research: Exposure research seeks to identify and quantify the exposome—an individual's environmental exposures over their life course. Studies investigate exposures in combination with genetics, diet, and stressors such as extreme weather events and disasters and social determinants of health to determine impacts on biological systems that lead to both health and disease. Exposure research improves methods of detecting and measuring exposures in humans and other model organisms and systems using innovative data collection technologies like personal exposure sensors and geoscience tools, and applying advanced statistical, informatics, and analytical approaches to mining such data for insights and discoveries.

Translational Research and Special Populations: NIEHS prioritizes the translation of clinical, population, and community-based science into public health and biomedical interventions that reduce health disparities across society. Translational research investments focus on understanding environmental exposures in combination with social determinants of health of especially disproportionately affected populations across life stages. Epidemiological studies are conducted over long periods of time and among large cohorts of participants to gather robust health that can yield findings that will be the most translatable to public health.

Predictive Toxicology: NIEHS works to develop more efficient, effective, and actionable ways to predict a person's risk of harmful health outcomes from environmental exposures. Predictive toxicology includes assessing the hazards of real-world chemical mixtures and determining how to evaluate broad classes of chemicals efficiently, identifying early biomarkers of health effects, and modeling non-chemical stressors that contribute to health disparities. This research is supported by literature-based and integrative informatics, high throughput and computational modeling, and translation to build scientific and regulatory confidence in new approach methodologies.

Training and Education: NIEHS seeks to attract and inspire the next generation of scientists and provide them with the training needed to solve complex, real-world environmental health problems. Programs include undergraduate laboratory-based training, institutional training grants and fellowships for graduates, and postgraduate support for early career investigators across fields that support NIEHS research priorities. NIEHS supports training in state-of-the-science tools and approaches to generate discoveries of the interactions among the environment, genetics, and social determinants of health that result in human disease. Recognizing the critical benefits of bringing a range of expertise and perspectives to its mission, NIEHS works to enhance its workforce and implements educational activities to foster a workplace culture of excellence. NIEHS extends the reach of efforts in this area to include educational programs to

increase the knowledge and ability of those affected by environmental hazards to protect the health of their communities.

Budget Request

The FY 2026 Budget Request for the National Institute of Environmental Health Sciences (NIEHS) of $594.1 million is $319.9 million below the FY 2025 Enacted level.

This request will support focused research investments across scientific divisions and research areas, in alignment with administration priorities, to continue essential research into how the environment impacts human biology and human health, to support the prevention and treatment of illnesses and chronic diseases as well as living a healthy life. In addition, this request will support competitive Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) awards in FY 2026.

Funding History

FY[1]	Amount
FY 2022 Final	$842,169,000
FY 2023 Final	$913,979,000
FY 2024 Final	$913,979,000
FY 2025 Enacted	$913,979,000
FY 2026 President's Budget	$594,086,000

1\Amounts do not include the HIV/AIDS permissive transfer under the authority of NIH's Office of AIDS Research.

Program Accomplishments

Below we highlight research conducted and supported by NIEHS across research areas that advance knowledge about how the environment impacts human health and disease. This research informs efforts to improve the health of people and communities.

Fundamental Biology:

NIEHS provided support for a study in model organisms that uncovered a potential mechanism for neurodegenerative diseases. Short segments of RNA that repeat too many times in a row within a gene are called nucleotide repeat expansions. Scientists found that the specific repeat of cytosine, adenine, and guanine (CAG) nucleotides alters how a gene expresses proteins in ways that can act as markers of the development of neurological diseases.[26]

Mitochondrial dysfunction and cell death are mechanisms involved in many human diseases, such as Parkinson's Disease (PD). NIEHS-supported research uncovered a mechanism that may show how one metabolite, called PhIP, causes mitochondrial dysfunction, and resulted in

[26] pubmed.ncbi.nlm.nih.gov/37938769/

significant cell death.[27] This research exposed nerve cells widely used in PD studies to chemicals called heterocyclic aromatic amines (HAAs) that are formed in well-done cooked meats, as well as to metabolites they form in the body.

A chemical's point of departure (POD) is the experimental dose level at which health outcomes begin to occur that may be extrapolated to determine exposure levels in the general population to predict health risks. Common risk assessments and frameworks used to determine safe exposure levels rely on PODs, however toxicity data is not available for most chemicals in commerce to determine PODs. NIEHS-supported researchers developed a machine-learning system trained on structural and health effects data for chemicals with known PODs and used it to predict PODs for 34,046 environmental chemicals. The study found several thousand chemicals of *moderate* concern and several hundred chemicals of *high* concern for health effects at estimated median population exposure levels, greatly expanding the ability to characterize chemical risks and impacts.[28]

Exposure Research:

With increased ocean and lake temperatures, people are increasingly at risk of exposure to toxins released from harmful algal blooms (HABs) through food, water, and recreation. Researchers combined data from mouse and human model's exposure to microcystin-LR, a toxin created by cyanobacteria, the most prevalent blue-green HAB, and found it interferes with follicle maturation and ovulation, posing a potential reproductive risk to women.[29]

Precision environmental health applies advances in data science to the knowledge gained through exposomics, genetics, mechanistic biology and toxicology, and other approaches to move discovery from the population level toward promotion of individual health. NIEHS scientists lead and support the Personalized Environment and Genes Study (PEGS), a long-term project to collect health, exposure, medical, and genetic data from a group of people in North Carolina.[30] Outside researchers leverage PEGS to investigate new research topics, ask research questions in need of additional data, and through add-on studies to collect additional data for research on environmental exposures. An analysis of multi-ancestry data in PEGS found that polyexposure scores—in this case a sum of 13 environmental exposure variables derived from health questionnaire data—were more predictive for type 2 diabetes than scores based solely on genetics.[31] These findings highlight the need for both genetic and exposome-wide studies in different populations and show potential for application to prioritized disease screening.

[27] pubmed.ncbi.nlm.nih.gov/37421305/
[28] pubmed.ncbi.nlm.nih.gov/38693844/
[29] pmc.ncbi.nlm.nih.gov/articles/PMC10284350/
[30] niehs.nih.gov/research/atniehs/labs/crb/studies/pegs
[31] pubmed.ncbi.nlm.nih.gov/36383734/

Oxidative stress is a mechanistic pathway for developing diseases like psoriasis and eczema, which are worsened by chemicals that disrupt the skin barrier, as well as a primary mechanism for effects of air pollution. PEGS findings identified that exposure to mixtures of common air pollutants significantly increased the odds of psoriasis or eczema at a magnitude comparable to the risk associated with smoking.[32]

Pregnancy is a time of physiological stress under normal circumstances; exposure to extreme heat has been associated with outcomes including preterm birth, low birth weight, and stillbirth. Research supported by NIEHS shows that risks of severe maternal morbidity—severe and unexpected conditions during labor and delivery—is significantly associated with short-term heatwave exposure under all heatwave definitions, as well as long-term heat exposure during pregnancy and the third trimester.[33] Associations for long-term heat were significantly higher for pregnancies that began in colder months. Another study that looked at extreme heat during pregnancy found an increased risk for emergency department admissions for any psychiatric disorder and for anxiety, bipolar disorder, and suicidal thoughts for each 5°C (9°F) increase in same-day exposure to heat.[34] This evidence of adverse pregnancy impacts from extreme outdoor heat is fueling a call for more research on potential effects from higher indoor temperatures. Energy insecurity, or the ability to afford sufficient air conditioning, may result in even greater health disparities for low-income maternal populations. Prenatal exposure to heat is a hazard for babies as well. Recent research showed an increased risk for acute lymphoblastic leukemia (ALL), the most common childhood cancer, for every 5°C (9°F) increase in maternal heat exposure during week 8 of pregnancy.[35] Increasing temperatures may help to explain increasing incidence of ALL.

Exposure research teams devised and are testing tools to measure other extreme weather-related health impacts such as heat and air quality. A soft, nanomembrane-based, wearable biopatch will monitor real-time skin temperature, skin hydration, heart rate, respiratory rate, blood oxygen saturation, motion, and cardiac function to inform predictive models for biomarkers heat illness and dehydration.[36] Another research project supported by Small Business Innovative Research (SBIR) funding, is using a combination of personal sensors and stationary monitors to empower mapping of multiple air pollutants inside homes, schools, workplaces and vehicles, and across communities.[37] The program has been deployed in several places, including Ft. Collins, Colorado; Anchorage, Alaska; and Atlanta, Georgia, and in the Navajo Nation, to assess performance across climates and cultures.

Translational Research and Special Populations:

Chronic arsenic exposure has been associated with an increased risk of cardiovascular disease, diabetes, and lung, pancreas, and prostate cancers in American Indian communities. NIEHS research and funding supported an intervention developed by the Strong Heart Water Study and

[32] ncbi.nlm.nih.gov/pmc/articles/PMC10234803/
[33] pmc.ncbi.nlm.nih.gov/articles/PMC10485728/
[34] pubmed.ncbi.nlm.nih.gov/38829735/
[35] pmc.ncbi.nlm.nih.gov/articles/PMC11260908/
[36] reporter.nih.gov/project-details/10887489
[37] reporter.nih.gov/project-details/10679006

led by Northern Great Plains American Indian Nations, which showed that the use of water filters and mobile health programs that use phone call reminders of arsenic threats can significantly reduce exposure and risk of disease in these communities.[38]

Research at NIEHS suggests that factors in our environment and lifestyles may contribute to autoimmune diseases, likely through interactions with genetic risk factors.
Juvenile-onset myositis is an inflammatory disorder in which immune system proteins called myositis-associated autoantibodies (MAAs) attack a person's own proteins, resulting in muscle weakness, skin disorders, and possible effects on other organs. NIEHS scientists characterized the prevalence, clinical features, and outcomes associated with MAAs in a large North American cohort of patients.[39] MAA positivity was associated with Raynaud phenomenon and interstitial lung disease, as well as a chronic disease course and mortality. Research is needed to know if early detection of MAAs might improve outcomes.

NIEHS researchers examined data from The Sister Study,[40] an ongoing research program focused on a large cohort of women with breast cancer and their sisters and found links between exposure to pesticides in childhood and adolescence from residential and farm spraying and application and incidence of inflammatory bowel disease (IBD). Preventing early pesticide exposures may help to prevent development of this disease.

In a study of pregnancies in African American women supported through NIEHS funding, researchers sought to understand why certain populations experience disproportionate rates of preterm birth and early term birth, the leading causes of infant death in the United States. Mothers with indicators of higher exposure to per- and polyfluorinated alkyl substances (PFAS) were more likely to give birth early. Investigators compared molecular signatures of prenatal exposure to gestational age at birth in the children of these women and identified eight pathways and 52 metabolites through which PFAS acts to disrupt pregnancies, providing new targets for interventions to protect babies.[41]

The human tragedy that unfolded in many rural communities in the aftermath of Hurricane Helene in September 2024 has brought into stark relief how close these populations often live to severe environmental health risks and consequences related to both their geographic location, which is often near agriculture, mining, or manufacturing. Researchers at several NIEHS-funded institutions around the United States that are focusing on issues of rural populations posited that the health benefits of access to high levels of greenness in Central Appalachia are overwhelmed by factors such as chronic poverty, limited access to healthcare, and behavioral factors such as drug and alcohol use, leading to worse health outcomes than the rest of the country. Researchers are developing innovative ways to understand and address the unique needs of rural communities. One such group created a tool to explore the causes of rural asthma rates in Kentucky by mapping the incidence of the disease against roadway density.[42] Findings showed that exposure to traffic-related particulates tracks to high asthma risk for those living in public,

[38] pubmed.ncbi.nlm.nih.gov/38534131/
[39] factor.niehs.nih.gov/2024/4/papers/dir#a3
[40] sisterstudy.niehs.nih.gov/English/articles.htm
[41] factor.niehs.nih.gov/2023/8/papers/dert#a2
[42] pubmed.ncbi.nlm.nih.gov/36967398/

multi-unit housing. Another group devised a more accurate model of air pollution emitted from unpaved rural roads. Researchers successfully screen-printed an electrochemical sensor that uses just a few drops of blood to measure lead levels in 1 hour,[43] making it easier to test children in rural, low-resource areas. Although radon is the second leading cause of lung cancer, few residents in rural communities test their homes for the gas, often due to costs. A library-based radon detector loan program provided a feasible and acceptable way for patrons to test their homes, understand results, and learn how to protect their health.[44]

In 2024, nearly 65,000 wildfires burned nearly 9 million acres in the United States, more than three times as many as the prior year, according to the National Interagency Fire Center. Wildfire smoke travels well beyond the acres burned and research suggests it may result in new and far-reaching health impacts. A study that analyzed data from nearly 1.9 million emergency department (ED) visits and satellite data on wildfire smoke events found an association between wildfire smoke events in the prior 48 hours and an elevated risk of ED visits for anxiety disorders among women and girls, but not in men and boys.[45] Another study looked at exposure to wildland fire smoke and more than 5 million pregnancies in California and found that higher exposure to small particulate matter (PM2.5) during wildfire events was associated with increased risk of preterm birth, with highest risks related to exposure in weeks of the second and third trimesters. Researchers investigated the impacts of vegetation and metals carried by smoke on Vibrio vulnificus, a marine pathogen responsible for 95 percent of seafood-related deaths in the United States. The hitchhiking materials altered both growth and gene expression in the pathogen in ways that might lead to increased virulence, with increased risks for public health.[46] Individuals most at risk from wildfire smoke effects are the firefighters working for prolonged periods in close contact with these exposures. A $3.8 million NIEHS grant to the Center for Firefighter Health Collaborative Research will collect personal exposure data to get a better picture of the risks firefighters face and to inform protective measures like improved respiratory equipment and post-exposure skin decontamination.

Another translational research impact is part of the federal response to the train derailment and hazardous materials release in East Palestine, Ohio. NIEHS funded six researcher groups to collect health data, characterize exposures, and report back to the affected communities in the region.[47]

Predictive Toxicology:

Organophosphorous flame retardants (OPFRs) have been used extensively to replace brominated flame retardants (BFRs) phased out due to concerns about neurodevelopmental effects. OPFRs are now widely present in the environment and can be absorbed by skin, inhaled, or ingested in food, water, and dust. Some evidence on OPFRs suggests similar concerns to BFRs. To benchmark the toxicity of OPFRs, the NTP[48], including staff of DTT, devised an assessment

[43] pubmed.ncbi.nlm.nih.gov/38357555/
[44] pubmed.ncbi.nlm.nih.gov/38463029/
[45] pubmed.ncbi.nlm.nih.gov/39568497/
[46] factor.niehs.nih.gov/2024/7/papers/dert#a1
[47] niehs.nih.gov/research/programs/east_palestine
[48] ntp.niehs.nih.gov/

approach that combined data on exposure effects in cells and small model organisms with a review of scientific literature and existing evidence on how similarly structured chemicals affect neurodevelopment. The assessment found that certain OPFRs disrupted the endocrine system and suggested further evaluation to protect children's developmental health.

DTT scientists are working as members of the federal interagency Toxic Exposure Research Working Group[49] to conduct research activities to better understand exposures of U.S. military service members to hazards including herbicides, burn pits, radiation, chemical weapons, and more to inform the development of treatments and cures for associated health outcomes like cancers and Parkinson's Disease, and to inform measures to protect the health of those who serve in the future.

Training and Education:

NIEHS supported recent trainee projects including a participatory intervention that educated farmworkers on heat health; a survey of pediatric providers of asthma care that assessed knowledge gaps on wildfire smoke; and the development of a machine learning model to compare predicted versus observed lead levels in cells of children that showed that prior models underestimated the actual amount of lead in cells with high exposures. NIEHS-supported trainees at academic institutions are often at the leading edge of technology development and adoption. One recent such project is called ExEmPLAR (Extracting, Exploring, and Embedding Pathways Leading to Actionable Research).[50] This user-friendly online interface is designed to help biomedical researchers design queries and explore knowledge graphs, which allow users to visualize multiple study factors at once by combining large amounts of different types of data using features like nodes, edges, and colors to represent relationships among them.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	1,194	1,251	877
Average Award	$378,628	$364,893	$440,708
Range of Awards	$2,000-$4,107,072	$5,000-$3,303,869	$5,000 - $7,728,747

[49] niehs.nih.gov/research/programs/jeep/toxic-exposure
[50] pmc.ncbi.nlm.nih.gov/articles/PMC10812875/

NIEHS Superfund-Related Activities

The Superfund Research Program and the Worker Training Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$79,714,000	$79,714,000	$51,814,000
FTE	**	**	929[1]

****FY 2024 and FY 2025 FTE included in NIH-NIEHS FTE totals.
1\FY 2026 FTE represents entire Environmental Health FTE total.

Allocation Method:

- Competitive Grant
- Cooperative Agreements
- Other

Program Description

The National Institute of Environmental Health Sciences (NIEHS) Hazardous Substance Basic Research and Training Program, or Superfund Research Program (SRP) and the Worker Training Program (WTP), were created to meet the need for innovative strategies and technologies to provide solutions to the magnitude and complexity of Superfund assessment and remediation. The two programs, SRP and WTP, complement each other, bridging laboratory research and community interaction that improves health for all by solving a wide array of environmental health and cleanup issues and providing economic benefits. SRP and WTP are collectively referred to as the "NIEHS Superfund-Related Activities."

NIEHS Superfund Research Program

The NIEHS Superfund Research Program (SRP) supports research into practical, scientific solutions to protect health, the environment, and communities. In concert with the new NIEHS Strategic Plan, SRP grants fund teams of professionals to research, develop, test, and implement unique, solution-oriented approaches that positively impact public health and address complex environmental health problems. As part of NIEHS, SRP works to learn more about ways to protect the public from exposure to hazardous substances, such as industrial solvents, arsenic, lead, and mercury. These and other toxic substances are found in contaminated water, soil, and air at hazardous waste sites throughout the United States. SRP grants also help train the next generation of environmental health researchers by funding grants on basic biological, environmental, and engineering processes.

NIEHS Worker Training Program

The NIEHS Worker Training Program (WTP) provides the nation with a workforce trained in the safe handling of hazardous materials and waste. This includes thousands of workers employed at Superfund sites. WTP provides grants to nonprofit organizations, including academic institutions

and labor-based health and safety organizations, so they can deliver training to workers who may face a hazardous work environment. This in turn makes communities safer from dangerous environmental exposures and disasters. WTP funds training conducted in all regions of the country through a network of nonprofit organizations. These organizations are committed to protecting workers and their communities by creating and delivering high quality safety and health curricula. The program has built a national workforce that can protect themselves, co-workers, and communities from environmental hazards as well as respond to all types of disasters.

Budget Request

The FY 2026 Budget Request for Superfund-Related Activities of $51.8 million is $27.9 million below the FY 2025 Enacted level.

At this funding level, NIEHS will align investments with administration priorities to continue to fund critical, high-impact research and training support through existing grants under the SRP and WTP.

Funding History

FY	Amount
FY 2022 Final	$82,540,000
FY 2023 Final	$83,035,000
FY 2024 Final	$79,714,000
FY 2025 Enacted	$79,714,000
FY 2026 President's Budget	$51,814,000

Program Accomplishments

Together the SRP and WTP programs work together to support research from a variety of disciplines to address complex environmental health problems and leverage this work to provide resources and train workers to protect themselves, their colleagues, and communities from harmful exposures.

Through their activities, both SRP and WTP economically benefit or save hundreds of millions of dollars. A case study analysis of five research projects supported by SRP,[51] over a period of 20 years, with the most complete information available on cost savings, estimated that more than $100 million was saved when compared to traditional approaches. The analysis identified numerous added societal benefits such as development of small businesses, land and water reuse, sustainable technologies, exposure reduction, and university–industry partnerships.

Similarly, a 2024 study of the WTP's Environmental Career Worker Training Program (ECWTP) showed that from 2014 to 2022, the program added a cumulative value of $893.8 million, or about an average of $99.3 million annually to the U.S. economy.[52] This is an

[51] ehp.niehs.nih.gov/doi/10.1289/ehp3534
[52] factor.niehs.nih.gov/2024/7/community-impact/ecwtp-impact

estimated return of approximately 28 times the amount invested by the federal government back into the economy.

Examples of SRP and WTP program accomplishments include:

Superfund Research Program (SRP): Highlights of Past Advances in Science, Health, Technology, and Training That Improve Health for All

Building upon past successes, the SRP is continuing work to better understand the link between chemical exposure and disease to protect our health and our communities. As an example, SRP-funded researchers and collaborators have developed the Key Characteristics Approach to more quickly and accurately evaluating health risks of thousands of chemicals in our environment. SRP grantees have also expanded the approach making it adaptable to a wider range of health effects caused by harmful toxins. To achieve this success, the grantees engaged communities and formed a multidisciplinary team of experts from 35 academic and research organizations, five U.S. government agencies, two intergovernmental agencies, three SRP Centers, and three pharmaceutical companies. This new methodology will save significant time and money.

SRP has a long tradition of funding research resulting in new technologies, products, and therapies.[53] For example,

- SRP grantees developed a therapeutic sorbent technology that binds to hazardous chemicals in the body after exposure, reducing their uptake and bioavailability. They also developed a skin cream that can successfully block pesticides, PFAS, benzene, toluene, and xylene, which are sometimes found in floodwaters after an adverse weather event, from penetrating the skin.
- A new technology called SediMite, developed with SRP funding, successfully adds soil amendments that immobilize and degrade polychlorinated biphenyls (PCBs), a group of persistent chemicals linked to harmful health effects, in sediment. SediMite has documented cost savings compared to other approaches. In one location, it was estimated that using SediMite saved approximately $22 million compared to traditional methods.
- SRP grantees translated basic research on insects and rodents into promising new therapies and pain treatment options. The team is developing these special therapies to treat pain in humans and animals through a small business partly funded by SRP.

Over the years, wildfires have had disastrous consequences for human health across our nation. In a ground-breaking study, an SRP Center grant recipient analyzed air quality after wildfires in Arizona, California, and Washington and conducted animal studies to examine the health effects of wildfire smoke. The scientists found that exposure to wildfire smoke, as far as 1,000 km away from the source, could cause neurological problems and premature aging.[54]

[53] niehs.nih.gov/research/supported/centers/srp/research-briefs
[54] pubmed.ncbi.nlm.nih.gov/34865172/

SRP: Current Activities That Bridge Laboratory, Clinic, and Communities to Improve Health for All

Community Health Information
Bridging basic and epidemiological research to protect communities researchers at a SRP Center helped improve fish consumption advisories and created awareness campaigns to help ensure people are eating the safest fish, which is especially important for children and pregnant women. Determining the most consumed fish and popular fishing areas, the scientists partnered with community groups to analyze fish toxins. Then, they implemented an online media campaign to share their findings and resources to improve fish consumption advisories and protect health.[55]

PCBs, a large group of persistent chemicals found at approximately 30 percent of Superfund sites, have been linked to cancer and other harmful health effects. SRP-funded researchers working with rural communities addressed concerns about PCB exposures and potential low-cost interventions, such as changes in nutrition to improve health. For example, the team discovered that diets rich in flavonoids from fruits and vegetables can reduce the risk for PCB-associated type 2 diabetes. Using their findings, they created clear and easy-to-understand public health messages and partnered with community organizations to educate on increased fruit and vegetable consumption, particularly among older adults who may be more susceptible to hazardous exposures.

Many people in rural North Carolina (NC) communities rely on private wells for their drinking water, which are not regulated by health departments. Working with local citizens, a SRP Center launched a project to help rural communities in NC test their drinking water for metals. Researchers helped inform a decision to update NC real estate disclosure forms, requiring sellers to report when private well water was tested for contaminants. They also recently launched NC ENVIROSCAN, which is an interactive map of environmental and societal indicators that can impact health, increasing awareness among communities of potential risk.[56]

Protecting Americans Through Scientific Innovation
Preventing harmful exposures from impacting a person's health is one of the best ways to protect communities. An SRP-funded small business, Cyclopure, is doing exactly that. SRP grantees produced a technology that removes PFAS from water.[57] The technology has been applied in a variety of commercial products including a filter for tabletop water pitchers, a device to test water for PFAS, a whole-home water filter, and large-scale filtration technology being used in municipal and industrial water treatment plants across the United States.

Finding ways to optimally remediate contaminated water is a goal of the SRP. Scientists funded by SRP have developed an approach to cleaning polluted groundwater that uses tiny beads containing chemical-eating bacteria. Further research optimized these beads to last longer and remove more contaminants.[58] The grant recipients plan to boost production of these beads and

[55] niehs.nih.gov/research/supported/centers/srp/science_digest/2024/3/features
[56] niehs.nih.gov/research/supported/centers/srp/science_digest/2024/9/features
[57] niehs.nih.gov/research/supported/centers/srp/phi/archives/remediation/cyclopure
[58] tools.niehs.nih.gov/srp/researchbriefs/view.cfm?Brief_ID=353

conduct additional performance tests in contaminated groundwater to better determine ideal methods to protect our health.

SRP funding also helped the communities in the East Palestine, Ohio train derailment in 2023. Examples of activities supported by several SRP-supported research Centers include using a mobile laboratory to monitor air pollutants in East Palestine following the train derailment, and use of wristbands developed by one SRP Center were deployed by another research group for monitoring of polycyclic aromatic hydrocarbons (PAHs), which are type of persistent organic pollutant found in air, soil, and food, to assess health symptoms such as headaches, coughing, or eye irritation, and stress in residents of East Palestine after the derailment.[59,60]

Worker Training Program (WTP): Highlights of Past Advances Improve Health for All

Bridging activities from scientific study and fieldwork, the WTP helps protect our communities from hazardous waste and disasters. WTP empowers workers and communities with the knowledge and skills needed for disaster preparedness and response. WTP courses have trained over 4.2 million workers since 1987. In 2024, trained over 166,200 workers in more than 9,900 courses for nearly 1.7 million contact hours. WTP-funded consortia have a broad reach across work sectors and provide tailored health and safety training to workers facing or responding to a hazardous work environment. WTP grantees engage in partnerships to distribute knowledge and expertise across the United States and its territories.[61]

For example, the WTP annually funds training for about 2,300 workers through more than 600 health and safety courses in Kentucky.[62] Through one WTP grantee, which partners with the Kentucky Division of Fire Prevention and Kentucky Emergency Management (KYEM) to bring HAZMAT training to rural areas across the state. The training involves first responders and law enforcement personnel on handling emergencies and hazardous material incidents. These trainings provided crucial knowledge for responses to major floods and catastrophic tornadoes in the state.

Another example of WTP trainees keeping our communities safe occurred in 2023 after an anhydrous ammonia tanker crash in Illinois. Trainees who completed a 40-hour site worker training were among responders from the Illinois Department of Public Health Toxicology Division who were dispatched to perform sampling and conduct a hazard assessment. They utilized the skills and knowledge attained from WTP training to accomplish their tasks safely.[63]

Another grant recipient addressed an emerging silicosis epidemic in California, using funding to develop educational materials and training resources to raise awareness about harmful risks of exposure to silica in artificial stone fabrication. By partnering with state and local health

[59] pubmed.ncbi.nlm.nih.gov/40285870/
[60] factor.niehs.nih.gov/2023/8/science-highlights/silicone-wristbands-measures-exposures
[61] niehs.nih.gov/careers/hazmat/about_wetp
[62] niehs.nih.gov/sites/default/files/careers/assets/docs/wtp_state_profile_kentucky_508.pdf
[63]

departments and several community-based organizations, they sponsored silica training workshops.[64]

WTP: Current Activities That Protect Our Health

WTP funds health and safety training for American Indian and Alaska Native Tribal workers and communities across the nation to protect workers, improve emergency and disaster response, increase employment opportunities, and build capacity.[65] Examples include CPR and first aid training for Alaskan Native populations, and training for CPR, resiliency, and mold in hurricane-torn Robeson County, North Carolina, which included a high population of Native Americans.

The Environmental Career Worker Training Program (ECWTP) provides opportunities for unemployed and underemployed individuals to obtain careers in environmental cleanup, construction, hazardous waste removal, and emergency response. Over 14,500 people have been trained by the program's partners, which include institutions that historically receive low levels of funding, community colleges, and apprenticeship programs, among others. From 1995 to 2023, the ECWTP has maintained an average job placement rate of 70 percent, and it has provided an economic boon to communities across the country while advancing a stronger workforce.

WTP's Small Business Innovation Research (SBIR) E-Learning for HAZMAT Program funds small business to develop innovative applications that are used for health and safety training.[66] WTP SBIR grantees have revolutionized methods to deliver training to workers through online learning, mobile applications, virtual reality (VR), and immersive learning systems. These advanced technologies help train workers who are involved in cleanup and response to hazardous waste, illicit drugs, infectious diseases, and natural disasters – saving property, communities, and lives.

By leveraging partnerships, SBIR HAZMAT grantees can test, refine, and improve their products. A decades-long partnership, Cell Podium and the Atlantic Center, at Rutgers University, has facilitated numerous training products to protect the health and safety of HAZMAT workers. This partnership created an VR system that simulates hazardous environments, creating training exercises to better use equipment that locates, classifies, and isolates hazards.

Similarly, the SBIR HAZMAT program fosters competition, productivity, and economic growth, partly, by encouraging small businesses to commercialize their products. For example, Q-Track Corporation successfully commercialized Q-Rad, a radiation simulation tool. The technology can be used to train radiation workers in commercial and military applications. Using this Q-Rad technology, the Y-12 National Security Complex in Tennessee, helps keep the DOE's nuclear security enterprise safe.

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[64] https://factor.niehs.nih.gov/2024/12/feature/2-feature-worker-training

[65] niehs.nih.gov/sites/default/files/careers/assets/docs/wtp_success_story_native_americans_building_capacity_report_2023_508.pdf

[66] niehs.nih.gov/careers/hazmat/training_program_areas/att

WTP: Ongoing Activities that Address Critical Environmental Health Issues

The WTP has been working with its grant recipients and federal partners to better understand the risks that workers and communities face due to extreme heat. Tackling this problem head on, WTP created the Heat Stress Prevention Training Program which is designed to reduce the risk of heat stress for workers.[67] It is the first of a series of tools that will be featured in the WTP Heat Stress Prevention Toolkit. The toolkit's primary target audience is health and safety trainers and representatives. Using the toolkit, a WTP grant recipient created a series of video clips to inform workers about heat illness.

The WTP has a long history of partnership with the Department of Energy (DOE). For instance, the Energy Facility Contractors Group (EFCOG), which supports DOE, continues to enhance worker safety. WTP interacts specifically with the Training Working Group within EFCOG, certifying efficient and effective trainings across DOE sites, as both organizations seek to ensure hazardous materials workers receive the best training. The 2024 EFCOG Training Working Group meeting involved sharing best practices in worker training and implementation strategies.[68] Regularly networking with EFCOG at the annual meeting ensures that WTP sustains close working relationships with DOE, which better prepares employees with essential safety and health trainings.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	71	61	46
Average Award	$1,030,774	$1,236,285	$1,050,239
Range of Awards	$16,000 - $3,460,810	$20,000 - $4,912,227	$27,000 - $1,751,059

[67] tools.niehs.nih.gov/wetp/index.cfm?id=2558
[68] factor.niehs.nih.gov/2024/6/community-impact/worker-training

Energy Employees Occupational Illness Compensation Program Act (EEOICPA)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Mandatory[1]	$ 50,763,000	$50,763,000	$50,763,000
FTE	**	**	929[2]

[1]*EEOICPA funds are subject to Defense sequestration amount of 8.6 percent. Levels reflect post-sequester amount.*

******FY 2024 and FY 2025 FTE included in CDC FTE totals.

2\FY 2026 FTE represents entire Environmental Health FTE total.

Allocation Methods:

- Direct federal/intramural
- Contracts
- Competitive grants/cooperative agreements

Program Description

The Energy Employees Occupational Illness Compensation Program Act provides compensation and medical benefits for workers who became ill due to their employment at certain Department of Energy (DOE) facilities, their contractors, or subcontractors. The program supports efforts toward determining eligibility for compensation for DOE employees, or survivors of employees, that were diagnosed with an ionizing radiation-related cancer, beryllium-related disease, or chronic silicosis resulting from a DOE employee's duties involving production or testing of nuclear weapons. The program conducts scientific estimates of a DOE worker's past radiation exposure and provides that estimate to DOL which makes the final compensation determination. The program also evaluates petitions for adding classes of workers to the Act's Special Exposure Cohort (SEC) and provides administrative support to the Advisory Board on Radiation and Worker Health (Advisory Board) which makes recommendations to the HHS Secretary concerning whether a class of employees should be added. The EEOICPA program will complete radiation dose reconstructions for all claims requiring such information to permit final adjudication. Radiation monitoring information provided by the DOE and any relevant information provided by claimants will be used to develop a dose reconstruction report.

Budget Request

The FY 2026 Budget Request for the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) is $50.8 million in mandatory funding post-sequester. The FY 2026 request supports the planned HHS realignment of these activities from CDC to AHA. EEOICPA under AHA will ensure accurate exposure assessments for former Department of Energy (DOE) workers, supporting fair compensation.

Funding History

FY	Mandatory Amount*
FY 2022 Final	$50,763,000
FY 2023 Final	$50,763,000
FY 2024 Final	$50,763,000
FY 2025 Enacted	$50,763,000
FY 2026 President's Budget	$50,763,000

*****Post-sequester amount.

Program Accomplishments

In 2024 EEOIPCA:

- Completed 2,400 dose reconstructions.
- Received one Special Exposure Cohort (SEC) petition.
- Supported 12 meetings of the Advisory Board, its Subcommittees, and Work Groups.
- Informed recommendations of the Advisory Board to the HHS Secretary concerning the addition of classes of employees to the SEC. The total number of classes added as of 2024 remains at 129.

World Trade Center Health Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Mandatory funding [1]	$768,392,835	$847,682,873	$913,024,523
FTEs	**	**	929[2]

[1]*Reflects the federal share of WTCHP only. These amounts are based on trend analysis and are the best estimates at the time but are subject to change. The FY 2024 amounts exclude supplemental funding of $676 million in the FY 2024 National Defense Authorization Act (P.L.118-31).*

**FY 2024 and FY 2025 FTE included in CDC FTE totals.

2\FY 2026 FTE represents entire Environmental Health FTE total.

Allocation Methods:

- Direct federal/intramural
- Contracts
- Competitive grants/cooperative agreements

Program Description

Resources will support the program's ongoing operations, which provide annual monitoring, diagnosis, cancer screening, and treatment, including prescriptions, for the list of WTC-related health conditions at no-cost to enrolled members. Program members receive these healthcare benefits through contracted Clinical Centers for Excellence in New York City and New Jersey and a Nationwide Provider Network for members who reside outside the New York metropolitan area. In addition, the program awards grants for research into physical and mental health conditions related to 9/11 exposures. This funding will support monitoring and treatment services, including services for certain types of cancer; necessary implementation infrastructure; extramural research projects; outreach and education projects; and scientific support.

Budget Request

The FY 2026 Budget Request for the World Trade Center Health Program is $913.0 million in mandatory federal share funding. The FY 2026 request supports the planned HHS realignment of these activities from CDC to AHA. With this funding, the program will continue to provide critical care, including cancer screening and treatment, to thousands of 9/11 responders and survivors.

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

Funding History

FY	Mandatory Amount
FY 2022 Final	$641,485,000
FY 2023 Final	$709,848,000
FY 2024 Final	$768,392,000
FY 2025 Enacted	$847,682,873
FY 2026 President's Budget	$913,025,000

Program Accomplishments

- Delivered critical cancer care to 46,200 members of the WTC Health Program, supporting thousands of 9/11 responders and survivors through comprehensive health services.

Grant Award Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget*
Number of Awards	38	*	*
Average Award	$637,583	*	*
Range of Awards	$160,804 - $7,895,000	*	*

* Grant award estimates are under development

WTC Health Program Enrollment

	March 31, 2024	June 30, 2024	Sept. 30, 2024	Dec. 31, 2024	March 31, 2025
New Members since July 2011[1]	71,711	74,119	76,783	79,204	81,775
Total Members[2]	125,492	127,425	137,595	140,016	142,563

[1]New members enrolled under the Zadroga Act requirements (adjustments are made each quarter to account for member records changes), including Pentagon and Shanksville, PA.

[2]New members and members enrolled prior to 7/1/2011 (adjustments are made each quarter to account for member records changes).

WTC Health Program Paid Claims

Healthcare Services as of Date[1]	**March 31, 2024**	**June 30, 2024**	**Sept. 30, 2024**	**Dec. 31, 2024**	**March 31, 2025**
Members who had monitoring or screening exams	50,218	53,962	56,416	50,908	54,737
Members who had diagnostic evaluations[2]	24,015	26,061	26,827	27,557	29,097
Members who had out-patient treatment	37,306	38,205	39,043	39,262	39,516
Members who had in-patient treatment	1,280	1,285	1,319	1,327	1,322
Members who received medications	35,733	36,694	37,490	37,876	38,515

[1] Based on claims for services that were paid during the previous 12-month period.

[2] For determining if a member has a WTC-related health condition and for certifying that health condition.

HIV/AIDS

TAB

HIV/AIDS

Ryan White HIV/AIDS Program

Program Description

The Ryan White HIV/AIDS Program (RWHAP) funds and coordinates with states, cities, counties, local clinics, and community-based organizations to deliver efficient and effective HIV care, treatment, and support to low-income people with HIV. Since 1990, the RWHAP has developed a comprehensive system of safety net providers who deliver high-quality direct HIV health care and support services to more than half a million people with HIV – more than half of all people with diagnosed HIV in the United States.[1] In 2023, 90.6 percent of patients receiving RWHAP medical care were virally suppressed[2], far exceeding the 65.1 percent rate of viral suppression for the general population of people with diagnosed HIV.[3]
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[4] or state programs, or private insurance. Another key component of the RWHAP statute is that funding priorities are guided by stakeholders at state and local levels, resulting in uniquely structured programs that address their jurisdictions' critical gaps and needs.

The RWHAP provides grants to states, cities, counties, local clinics, and community-based organizations. The grants fund medical and support services, and medication to meet the needs of people with HIV and family members affected by HIV. Together these grants provide the health care infrastructure to ensure low-income people with HIV have access to services aimed at early diagnosis of HIV, linkage to care, medically appropriate treatment, retention in care, and sustained viral suppression (a very low or undetectable amount of HIV in the blood).

HIV medicine can make the viral load so low that it doesn't show up in a standard lab test. An overwhelming body of clinical evidence has firmly established that a person with HIV who has an undetectable viral load cannot sexually transmit HIV to others.[5,6] Reaching and maintaining an undetectable viral load (viral suppression) is the end goal of the HIV care continuum. The HIV care continuum is the successive steps that people with HIV experience from diagnosis to achieving and maintaining viral suppression.

Not only do improved viral suppression rates reduce the transmission of HIV, but they also result in significant cost-savings to the health care system.[7] As noted earlier, patients served by the RWHAP have viral suppression rates that far exceed those for the general population, demonstrating the effectiveness of the program.[8] These results align with a study published in *Clinical Infectious Diseases*, which found that patients 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.[9] The low rate of viral suppression in the general population is primarily due to poor adherence to clinic appointments and antiretroviral therapy (ART).[10,11] The success of the RWHAP in achieving optimal clinical outcomes that far exceed those seen in non-RWHAP providers, making it a key component in public health programs and strategies for addressing HIV.[12]

With advances in care and treatment, HIV has evolved from a terminal illness to a chronic manageable disease. Even with these positive outcomes, ending the HIV epidemic domestically continues to be a challenge as many remain out of care. The Centers for Disease Control and Prevention (CDC) estimates that over 1 million people in the United States have HIV, and 1 in 8 are unaware of their HIV status.[13] In addition, over 38,000 new HIV diagnoses occur every year.[14]

Ending the HIV Epidemic in the U.S.

In February 2019, the Ending the HIV Epidemic in the U.S (EHE) initiative was launched to further expand federal efforts to reduce HIV infections. The EHE initiative focuses on 48 counties, Washington, D.C., and San Juan (Puerto Rico), which account for more than half of new HIV diagnoses, and seven states that have a substantial rural HIV burden. The initiative brings expedient access to HIV care and treatment services, through streamlined enrollment, improved technology, and resources needed to address the challenges noted to end the HIV epidemic in the United States.

EHE recipients have made significant progress to date, including developing service delivery infrastructure, engaging with community members and new partners, and delivering services to patients. In 2023, RWHAP EHE-funded service providers served approximately 26,830 clients new to care and 20,940 clients re-engaged in care. Many of the EHE initiative projects focus on addressing needs of people who are not in care or who have fallen out of care. This work involves a strategic approach that addresses HIV and other chronic conditions such as substance abuse disorder, mental health, and environmental challenges like housing and stigma – all issues that affect one's ability to engage in HIV care.

Ryan White Program 2030

The RWHAP has demonstrated tremendous strides in increasing viral suppression among people receiving HIV medical care from 69.5% in 2010 to 90.6% in 2023. Building on 35 years of success and innovation, the Ryan White Program 2030 (RWP 2030) vision integrates lessons learned from the RWHAP and the EHE initiative. This framework is designed to sustain high-quality care and treatment for people currently receiving services through the RWHAP while expanding efforts beyond the areas funded by EHE to identify and engage individuals with HIV who are undiagnosed or out-of-care. CDC estimated in 2016 that 80% of new HIV infections in the U.S. were transmitted from the nearly 40 percent of people with HIV who either did not know they had HIV or who had been diagnosed but were not receiving HIV care. RWP 2030 efforts to engage people with HIV who are not in care, get them into care, and help them reach viral suppression will interrupt new HIV transmissions which supports ending the HIV epidemic.

Additional Collaborative Efforts

In FY 2026, the RWHAP will continue to ensure effective use of resources and a coordinated and focused public health response to HIV. The RWHAP will continue to coordinate and collaborate with other federal, state, and local entities as well as external HIV organizations to further leverage and promote efforts to address the unmet care and treatment needs of people with HIV who are uninsured and disproportionately impacted by this chronic disease. These

efforts help to align priorities and activities in sustaining a multi-faceted and comprehensive federal response to the HIV epidemic.

The RWHAP also coordinates with federal partners, grant recipients, and other partners to address the co-occurring and chronic conditions of HIV, viral hepatitis, STIs, and substance use disorder through the following HHS efforts:

- *Sexually Transmitted Infections (STI) National Strategic Plan for the United States: 2021-2025:* This plan develops, enhances, and expands STI prevention and care programs with the aim of reversing the dramatic rise in STIs in the United States, particularly syphilis.

- *Viral Hepatitis National Strategic Plan for the United States: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.

- *HHS Roadmap for Behavioral Health Integration:* In alignment with HHS's strategy to advance behavioral health care in the most rural communities, AHA will continue to work collaboratively with other federal partners to address opioid use disorder screening, treatment, and support for people with HIV.

- *Strategies to Address Unstable Housing:* AHA will continue to work with partners to support access to housing for people with HIV and impacted communities.

- *Leveraging Collaboration between the RWHAP and Aging Agencies: Enhancing Support Services for Older Adults with HIV:* Aging with HIV is an important topic for the RWHAP; approximately half of people served by the program are 50 years and older. AHA will continue to collaborate and share information to improve the assessment of psychosocial needs and delivery of health care for older adults with HIV so that they may age with dignity and independence and have access to a broad array of services.

RWHAP Part A - Emergency Relief Grants

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$680,752,000	*	$680,752,000
FTE	**	**	212[1]

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire HIV/AIDS FTE total.

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

Established in 1990, the 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 extent of the epidemic in their jurisdiction. Seventy percent of all people with diagnosed HIV reside in a RWHAP Part A EMA or TGA.[15,16] RWHAP Part A funding prioritizes primary medical care, access to antiretroviral treatment, and other core medical and supportive services to engage and retain people with HIV in care. These grants fund systems of care to provide services for people with HIV in 24 EMAs and 28 TGAs.

The RWHAP requires EMAs and TGAs to utilize local needs assessments and planning processes to develop coordinated systems of HIV care to improve health outcomes for low-income people with HIV, thereby reducing costs in the health care system and reducing transmission of HIV. These grants assist EMAs/TGAs in developing and enhancing access to a comprehensive continuum of high quality, community-based care for low-income people with HIV.

Ending the HIV Epidemic in the U.S. - RWHAP Part A Jurisdictions
Thirty-nine of the RWHAP Part A jurisdictions are implementing EHE initiative activities related to strategy two (Treat) and strategy four (Respond). 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.

Budget Request

The FY 2026 Budget Request for the RWHAP Part A of $680.7 million will support the provision of core medical and support services for people with HIV in the 24 EMAs and 28 TGAs. EMAs are jurisdictions with 2,000 or more reported AIDS cases over the last five years as reported, while TGAs are jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases reported over the last five years.

Two-thirds of the funds available for EMAs and TGAs are awarded according to a formula, based on the number of people diagnosed with HIV in the EMAs and TGAs.[17] The remaining funds are awarded as discretionary supplemental grants based on the demonstration of additional need by the eligible EMAs and TGAs, and as Minority AIDS Initiative (MAI) grants. The MAI funds are a statutory set-aside "to evaluate and address the disproportionate impact of HIV on, and the disparities in access, treatment, care, and outcomes for racial and ethnic minorities". MAI funds are also awarded based on a formula utilizing the number of minorities with diagnosed HIV and AIDS in a jurisdiction and support HIV care, treatment, and support services.

RWHAP Part A jurisdictions are experienced in developing data-driven, community-based needs assessments and responsive procurement of a variety of direct HIV medical and supportive services, working across service providers to develop and maintain a system of services for people with HIV. Approximately 64 percent of all RWHAP clients are served by one of the 52 cities funded under RWHAP Part A and 70 percent of all people with diagnosed HIV reside within these metropolitan areas.

Part A funding contributes to achieving the FY 2026 targets for performance goals that relate to cross-cutting activities, such as the total clients served and percentage of clients who reached viral suppression.

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

Funding History[18]

FY	Amount
FY 2022 Final	$670,458,000
FY 2023 Final	$680,752,000
FY 2024 Final	$680,752,000
FY 2025 Enacted	*
FY 2026 President's Budget	$680,752,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments[19]

The RWHAP Part A has contributed to the tremendous progress the RWHAP has made toward ending the HIV epidemic in the United States, supporting over 3 million visits for medical services. From 2010 to 2023, HIV viral suppression among RWHAP patients has increased from 69.5 percent to 90.6 percent. However, even with these positive outcomes, fully addressing the HIV epidemic domestically continues to be a challenge as many remain out of care. The CDC estimates that more than 1 million people in the United States have HIV, and 1 in 8 are unaware of their HIV status. In addition, over 38,000 new HIV diagnoses occur every year.

An overwhelming body of clinical evidence has firmly established that a person with HIV who is in treatment and has an undetectable viral load cannot sexually transmit HIV. Not only do

improved viral suppression rates reduce the transmission of HIV, but they also result in significant cost-savings to the health care system.[20]

The high level of viral suppression among RWHAP patients aligns with a study published in *Clinical Infectious Diseases*, which found that clients receiving care and support at RWHAP-funded facilities are associated with improved outcomes (such as viral suppression), compared to those not served by the RWHAP. Furthermore, RWHAP patients are more likely to achieve viral suppression regardless of other health care coverage (e.g., Medicaid, Medicare, private insurance).

Outputs and Outcomes Table

RWHAP Part A, Part B, Part C, and Part D (includes Ending the HIV Epidemic initiative) contribute to over-arching performance measures. The Outputs and Outcomes Table containing these measures is located at the end of this document.

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	52	*	52
Average Award	$12,570,729	*	$12,570,729
Range of Awards	$2,845,413 – $92,080,526	*	$2,845,413 – $92,080,526

*Grant award estimates under development.

RWHAP Part A – FY 2024 Formula, Supplemental & MAI Grants[21]

Table 1. Eligible Metropolitan Areas

EMAs	Formula	Supplemental	MAI	Total
Atlanta, GA	$19,510,354	$9,912,233	$2,851,028	$32,273,615
Baltimore, MD	$9,176,065	$5,422,828	$1,399,349	$15,998,242
Boston, MA	$9,533,433	$4,518,557	$1,004,189	$15,056,179
Chicago, IL	$17,156,261	$8,333,714	$2,327,910	$27,817,885
Dallas, TX	$12,849,791	$6,457,895	$1,642,706	$20,950,392
Detroit, MI	$6,192,323	$3,180,915	$825,721	$10,198,959
Ft. Lauderdale, FL	$9,928,447	$4,975,344	$1,256,101	$16,159,892
Houston, TX	$16,615,825	$8,097,092	$2,417,008	$27,129,925
Los Angeles, CA	$28,355,350	$14,420,596	$3,672,927	$46,448,873
Miami, FL	$16,391,503	$8,419,251	$2,600,572	$27,411,326
Nassau-Suffolk, NY	$3,307,591	$1,978,651	$424,919	$5,711,161

New Haven, CT	$3,160,106	$1,878,003	$412,269	$5,450,378
New Orleans, LA	$4,747,379	$2,839,465	$618,586	$8,205,430
New York, NY	$52,911,147	$31,312,967	$7,856,412	$92,080,526
Newark, NJ	$7,214,922	$4,239,961	$1,143,888	$12,598,771
Orlando, FL	$7,056,607	$3,600,071	$885,241	$11,541,919
Philadelphia, PA	$13,327,314	$7,716,214	$1,854,483	$22,898,011
Phoenix, AZ	$6,804,438	$3,409,840	$674,101	$10,888,379
San Diego, CA	$7,511,956	$3,801,686	$784,859	$12,098,501
San Francisco, CA	$9,020,844	$5,192,075	$745,088	$14,958,007
San Juan, PR	$6,023,178	$3,561,419	$1,060,615	$10,645,212
Tampa-St. Petersburg, FL	$6,733,790	$3,361,204	$705,408	$10,800,402
Washington, DC-MD-VA-WV	$19,121,013	$10,644,064	$2,794,421	$32,559,498
West Palm Beach, FL	$4,465,300	$2,604,474	$620,497	$7,690,271
Subtotal EMAs	$297,114,937	$159,878,519	$40,578,298	$497,571,754

Table 2. Transitional Grant Areas

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$3,402,135	$1,797,425	$397,981	$5,597,541
Baton Rouge, LA	$2,711,321	$1,462,265	$430,562	$4,604,148
Bergen-Passaic, NJ	$2,298,303	$1,366,574	$332,000	$3,996,877
Charlotte-Gastonia, NC-SC	$4,098,827	$2,063,766	$607,938	$6,770,531
Cleveland, OH	$2,931,793	$1,574,946	$379,597	$4,886,336
Columbus, OH	$3,047,419	$1,576,514	$307,245	$4,931,178
Denver, CO	$4,774,943	$2,503,738	$395,615	$7,674,296
Fort Worth, TX	$3,304,637	$1,760,306	$437,024	$5,501,967
Hartford, CT	$1,726,544	$1,015,516	$231,344	$2,973,404
Indianapolis, IN	$2,978,338	$1,578,712	$336,277	$4,893,327
Jacksonville, FL	$3,742,152	$1,952,621	$512,197	$6,206,970
Jersey City, NJ	$2,817,638	$1,659,727	$437,934	$4,915,299
Kansas City, MO	$2,767,664	$1,470,657	$284,675	$4,522,996
Las Vegas, NV	$4,489,799	$2,377,684	$530,489	$7,397,972
Memphis, TN	$4,167,419	$2,140,949	$684,840	$6,993,208

Middlesex-Somerset-Hunterdon, NJ	$1,651,583	$958,391	$235,439	$2,845,413
Minneapolis-St. Paul, MN	$3,796,535	$2,010,549	$395,342	$6,202,426
Nashville, TN	$2,864,672	$1,478,231	$315,163	$4,658,066
Norfolk, VA	$3,629,956	$1,854,956	$527,759	$6,012,671
Oakland, CA	$4,460,892	$2,356,791	$585,368	$7,403,051
Orange County, CA	$4,088,049	$2,215,440	$481,527	$6,785,016
Portland, OR	$2,612,843	$1,343,731	$155,807	$4,112,381
Riverside-San Bernardino, CA	$5,527,490	$2,835,151	$647,709	$9,010,350
Sacramento, CA	$2,301,242	$1,209,786	$227,977	$3,739,005
Saint Louis, MO	$3,940,577	$2,042,001	$478,341	$6,460,919
San Antonio, TX	$3,700,507	$1,977,623	$567,985	$6,246,115
San Jose, CA	$2,060,682	$1,095,660	$263,288	$3,419,630
Seattle, WA	$4,550,061	$2,404,644	$390,336	$7,345,041
Subtotal TGAs	$94,444,021	$50,084,354	$11,577,759	$156,106,134
TOTAL EMAs/TGAs	$391,558,958	$209,962,873	$52,156,057	$653,677,888

RWHAP Part B - HIV Care Grants to States

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$1,364,878,000	*	$1,364,878,000
ADAP (non-add)	*$900,313,000*	*$900,313,000*	*$900,313,000*
FTE	**	**	212[1]

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire HIV/AIDS FTE total.

Allocation Method:

- Formula Grants
- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

Established in 1990, the RWHAP Part B is the largest RWHAP Part and provides formula 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 access to high quality and affordable healthcare, including efforts to reduce costs and ensure access to medications. RWHAP Part B funding prioritizes primary medical care, access to antiretroviral treatment, and other core medical and supportive services to engage and retain people with HIV in care.

A portion of the RWHAP Part B appropriation supports ADAPs which are state or jurisdiction operated programs that support the provision of HIV medications and related services, including health care coverage premiums and cost-sharing assistance. ADAPs provide FDA-approved prescription medications for people with HIV who cannot afford HIV medications and are instrumental in efforts to end the HIV epidemic across the nation.[22] An overwhelming body of clinical evidence has firmly established that a person with HIV who is in treatment and has an undetectable viral load cannot sexually transmit HIV. ADAP provides access to medications and health care coverage necessary for people with HIV to achieve optimal health outcomes and viral suppression.

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 or TGA), are implementing EHE initiative activities related to strategy two (Treat) and strategy four (Respond). Jurisdictions will continue to utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States.

AIDS Drug Assistance Program

With the advances in care and treatment, HIV has evolved from a terminal illness to a chronic manageable disease. The RWHAP Part B has been successful in helping to ensure that people with HIV have access to the care and treatment services they need to live longer, healthier lives. According to the RWHAP ADAP Report, which is comprised of data reported by recipients annually to evaluate the national impact of ADAP through client-level data on individuals being served, services being delivered, and costs associated with these services, ADAPs continue to provide robust formularies of antiretroviral medications to treat HIV infection, prevent and treat opportunistic infections, manage side effects, and treat co-morbidities such as hepatitis C, and other chronic conditions.

Across the RWHAP, grant recipients are encouraged to maximize resources and leverage efficiencies. Increased demand for RWHAP ADAP services has led States to implement cost-containment strategies for their ADAPs, such as coordinating benefits with Medicare Part D and improving drug-purchasing models, which result in effective funds management, enabling ADAPs to serve more people. In 2022, ADAPs participating in cost-savings strategies on medications saved $2 billion. Over the last 5 years, ADAPs participating in medication cost-savings strategies saved $11.7 billion.[23]

With no individuals on the ADAP waiting lists since 2015, the RWHAP distributed $75 million in ADAP Emergency Relief Funding (ERF) in FY 2024. ADAP ERF awards are intended for states and territories that demonstrate the need for additional resources to prevent, reduce, or eliminate ADAP waiting lists, including through cost-containment measures (for example, the provision of health care coverage assistance). These funds are required to be used for ADAP services, including the purchase of medications, health care coverage premium assistance, and medication copay assistance.

Budget Request

The FY 2026 Budget Level Request for the RWHAP Part B of $1.36 billion, which includes $900.3 million for RWHAP ADAPs, will support access to life saving HIV related medications and funding to provide direct health care services for people with HIV in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and five Associated Pacific Jurisdictions.

RWHAP Part B funds are distributed through base and supplemental grants, ADAP base and ADAP supplemental grants, Emerging Communities (EC) grants, and 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.[24] 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.

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. ADAP 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.

MAI funds are a statutory set-aside "to evaluate and address the disproportionate impact of HIV on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities". The RWHAP Part B MAI funding is statutorily required to specifically support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to the RWHAP ADAP. MAI funds are also awarded based on a formula utilizing the number of minorities with diagnosed HIV and AIDS in a jurisdiction.

RWHAP Part B funding will also contribute to achieving the FY 2026 targets for performance goals that relate to cross-cutting activities, such as the total number of clients served, and the 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.

Funding History[25]

FY	Amount
FY 2022 Final	$1,344,240,000
FY 2023 Final	$1,364,878,000
FY 2024 Final	$1,364,878,000
FY 2025 Enacted	*
FY 2026 President's Budget	$1,364,878,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments[26]

The RWHAP Part B has contributed to the tremendous progress the RWHAP has made toward ending the HIV epidemic in the United States. From 2010 to 2023, HIV viral suppression among RWHAP patients has increased from 69.5 percent to 90 percent, with decreases in community disparities. However, even with these positive outcomes, fully addressing the HIV epidemic domestically continues to be a challenge as the CDC estimates that more than 1 million people in the United States have HIV, and 1 in 8 are unaware of their HIV. In addition, over 38,000 HIV diagnoses occur every year.

An overwhelming body of clinical evidence has firmly established that a person with HIV who is in treatment and has an undetectable viral load cannot sexually transmit HIV. Not only do improved viral suppression rates reduce the transmission of HIV, but they also result in significant cost-savings to the health care system.[27]

The high level of viral suppression among RWHAP patients aligns with a study published in *Clinical Infectious Diseases*, which found that clients receiving care and support at RWHAP-

funded facilities are associated with improved outcomes (such as viral suppression), compared to those not served by the RWHAP. Furthermore, RWHAP patients are more likely to achieve viral suppression regardless of other health care coverage (e.g., Medicaid, Medicare, private insurance).

AIDS Drug Assistance Program

According to the RWHAP ADAP data, the number of people with HIV receiving ADAP services has grown 39 percent over the last 12 years from 208,809 clients in 2010, to 291,170 clients in 2022. The number of clients receiving ADAP services exceeded the FY 2022 target by nearly 4 percent. In FY 2022, the RWHAP ADAP provided medication and health care coverage assistance for nearly 27 percent of people diagnosed with HIV in the United States. Of all the ADAP clients served nationwide, 68 percent had incomes at or below 200 percent of the federal poverty level, and 70 percent were racial and ethnic minorities.[28,29]

The RWHAP ADAP plays a crucial role in ensuring access to HIV medications for pregnant women. Mother-to-child transmission in the United States has decreased dramatically since its peak in 1992 due to 1) an increased focus on HIV testing for all pregnant women; and 2) the use of antiretroviral therapy (ART), which significantly reduces the risk of HIV transmission from the mother to the baby. In 2023, nearly 100 percent of pregnant women with HIV served by the RWHAP (Part A, Part B, Part C, and Part D) were prescribed ART to prevent maternal-to-child transmission of HIV.

Outputs and Outcomes Table

RWHAP Part A, Part B, Part C, and Part D (includes Ending the HIV Epidemic initiative) contribute to over-arching performance measures. The Outputs and Outcomes Table containing these measures is located at the end of this document.

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	59	*	59
Average Award	$23,923,542	*	$23,923,542
Range of Awards	$32,301 – $155,440,630	*	$32,301 – $155,440,630

*Grant award estimates under development.

RWHAP Part C - Early Intervention Services

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$208,970,000	*	$208,970,000
FTE	**	**	212[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire HIV/AIDS FTE total.

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

Established in 1990, the RWHAP Part C provides grants directly to community-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 people with HIV who are low-income, uninsured, and disproportionately impacted by this chronic disease. 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.

Budget Request

The FY 2026 Budget Request of $208 million will fund 354 RWHAP Part C grant recipients located in 49 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. This level will continue support for comprehensive medical, treatment and support services necessary to achieve improved health outcomes, such as improved viral suppression rates, essential to ending the HIV epidemic.

RWHAP Part C funding is allocated using a data driven methodology that includes a minimum award per service area, the number of clients served by the grantee, populations disproportionately impacted by the HIV epidemic, and funding for service areas partially or wholly outside of RWHAP Part A jurisdictions. This amount also funds the statutory RWHAP Part C capacity development grants to strengthen organizational capacity to respond to the changing health care landscape and increase access to high-quality HIV primary health care services for low-income and underserved people with HIV. RWHAP Part C MAI funds are a statutory set-aside "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.

RWHAP Part C supports direct health care services for low-income people with HIV who are uninsured or disproportionately impacted by this chronic disease. 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 RWHAP Part C funding will contribute to achieving the FY 2026 targets for performance goals that relate to cross-cutting activities, such as the total number of clients served, and the 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.

Funding History

FY	Amount
FY 2022 Final	$205,054,000
FY 2023 Final	$208,970,000
FY 2024 Final	$208,970,000
FY 2025 Enacted	*
FY 2026 President's Budget	$208,970,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments[30]

The RWHAP Part C has a history of implementing effective clinical and support services; Providers funded through RWHAP Part C have the clinical expertise to provide quality care and treatment to people with HIV who are low-income.

The RWHAP Part C has contributed to the tremendous progress the RWHAP has made toward ending the HIV epidemic in the United States. From 2010 to 2023, HIV viral suppression among RWHAP patients has increased from 69.5 percent to 90.6 percent, with decreases in community disparities. However, even with these positive outcomes, fully addressing the HIV epidemic domestically continues to be a challenge as many remain out of care. The CDC estimates that over 1 million people in the United States have HIV, and 1 in 8 are unaware of their HIV status. In addition, over 38,000 new HIV diagnoses occur every year.

An overwhelming body of clinical evidence has firmly established that a person with HIV who is in treatment and has an undetectable viral load cannot sexually transmit HIV. Not only do improved viral suppression rates reduce the transmission of HIV, but they also result in significant cost-savings to the health care system.[31]

The high level of viral suppression among RWHAP patients aligns with a study published in *Clinical Infectious Diseases*, which found that clients receiving care and support at RWHAP-

funded facilities are associated with improved outcomes (such as viral suppression), compared to those not served by the RWHAP. Furthermore, RWHAP patients are more likely to achieve viral suppression regardless of other health care coverage (e.g., Medicaid, Medicare, private insurance).

Outputs and Outcomes Table

RWHAP Part A, Part B, Part C, and Part D (includes Ending the HIV Epidemic initiative) contribute to over-arching performance measures. The Outputs and Outcomes Table containing these measures is located at the end of this document.

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	356	*	354
Average Award	$517,464	*	$515,950
Range of Awards	$99,486 – $1,188,512	*	$96,503 – $1,187,910

* Grant award estimates under development.

RWHAP Part D - Women, Infants, Children and Youth

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$77,935,000	*	$77,935,000
FTE	**	**	212[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire HIV/AIDS FTE total.

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description

Established in 1990, the RWHAP Part D provides grants directly to public or private community-based organizations, hospitals, and State and local governments. The RWHAP Part D focuses on providing access to coordinated, comprehensive, family-centered HIV primary medical care and support services. RWHAP Part D services focus on women, infants, children, and youth (WICY) with HIV and their affected family members who are low-income, uninsured, and disproportionately impacted by this chronic disease.[32] RWHAP Part D also funds essential support services, such as case management and transportation that help clients' access medical care and stay in care.

Budget Request

The FY 2026 Budget Request for the RWHAP Part D of $77.9 million will support the comprehensive array of medical and support services necessary to achieve improved health outcomes, such as improved viral suppression rates, essential to ending the HIV epidemic. This request will fund 111 RWHAP Part D grant recipients located in 39 states and Puerto Rico. RWHAP Part D funding is allocated using a data driven methodology that includes a minimum award per service area, the number of women, infant, children, and youth clients served by the grantee, and funding for service areas partially or wholly outside of RWHAP Part A jurisdictions. RWHAP Part D MAI funds are a statutory set-aside" to evaluate and address the disproportionate impact of HIV on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities". RWHAP Part D MAI funding supports HIV care, treatment, and support services.

The RWHAP Part D supports health care services for women, infants, children, and youth with HIV who are uninsured or disproportionately impacted by this chronic disease. Such critical health care services include intensive case management and care coordination services, linking and retaining people with HIV into care, and starting them on antiretroviral medications as early as possible.

RWHAP Part D funding will contribute to achieving the FY 2026 targets for performance goals that relate to cross-cutting activities, such as the total number of clients served and the 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.

Funding History

FY	Amount
FY 2022 Final	$77,252,000
FY 2023 Final	$77,935,000
FY 2024 Final	$77,935,000
FY 2025 Enacted	*
FY 2026 President's Budget	$77,935,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments[33]

The RWHAP Part D has a history of implementing effective clinical and support services for women, infant, children, and youth – populations that tend to have poor health outcomes due to poverty, lack of access to health care, and other factors. RWHAP Part D providers have the clinical expertise to provide quality care and treatment to low-income, women, infant, children, and youth with HIV.

The RWHAP Part D has contributed to the tremendous progress the RWHAP has made toward ending the HIV epidemic in the United States: from 2010 to 2023, HIV viral suppression among RWHAP patients has increased from 69.5 percent to 90.6 percent, with decreases in community disparities. However, even with these positive outcomes, fully addressing the HIV epidemic domestically continues to be a challenge as many remain out of care. the CDC estimates that over 1 million people in the United States have HIV, and 1 in 8 are unaware of their HIV status. In addition, over 38,000 new HIV diagnoses occur every year.

Not only do improved viral suppression rates reduce the transmission of HIV, but they also result in significant cost-savings to the health care system.[34] The high level of viral suppression among RWHAP patients aligns with a study published in *Clinical Infectious Diseases,* which found that clients receiving care and support at RWHAP-funded facilities are associated with improved outcomes (such as viral suppression), compared to those not served by the RWHAP. Furthermore, RWHAP patients are more likely to achieve viral suppression regardless of other health care coverage (e.g., Medicaid, Medicare, private insurance).

Outputs and Outcomes Table

RWHAP Part A, Part B, Part C, and Part D (includes Ending the HIV Epidemic initiative) contribute to over-arching performance measures. The Outputs and Outcomes Table containing these measures is located at the end of this document.

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	112	*	111
Average Award	$611,308	*	$616,815
Range of Awards	$172,386 – $2,000,640	*	$172,386 – $2,000,640

* Grant award estimates under development.

Ending the HIV Epidemic Initiative (EHE)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	**$385,000,000**	*****	**$385,000,000**
RWHAP EHE (non-add)	*$165,000,000*	*$165,000,000*	*$165,000,000*
EHE (previously part of CDC) (non-add)	*$220,000,000*	*	*$220,000,000*
FTE	**	**	212[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA and CDC FTE totals.
1\FY 2026 FTE represents entire HIV/AIDS FTE total.

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts
- Direct federal/intramural

Program Description

Launched in February 2019, the Ending the HIV Epidemic in the U.S (EHE) initiative aims to reduce new HIV infections by targeting 48 high-burden counties, Washington, D.C., San Juan (Puerto Rico), and seven rural states with substantial HIV rates. It supports rapid access to care through streamlined enrollment, enhanced technology, and resources needed to end the HIV epidemic in the United States. EHE is a multi-agency national effort built on four key strategies: diagnose, treat, prevent, and respond. It supplements existing federal HIV programs to accelerate progress toward ending the epidemic.

By achieving EHE goals by 2030, the U.S. could prevent 255,000 HIV cases and save an estimated $100 billion in lifetime medical costs.[69]

Budget Request

The FY 2026 Budget Level Request of $385 million for the EHE initiative activities, including $165 million for Ryan White HIV/AIDS Program activities and $220 million for activities previously carried out by CDC. Funds will support activities to end the HIV epidemic, including HIV care and treatment in the 48 counties, DC, San Juan (Puerto Rico) that contain more than 50

[69] *Ending the HIV epidemic in the US funding*. (2024, March 19). Ending the HIV Epidemic in the US (EHE). https://www.cdc.gov/ehe/php/about/funding.html

percent of new HIV infections, and seven states with substantial rural HIV burden. Resources to continue EHE activities in Health Centers are included in Primary Care.

In FY 2026, AHA will continue to direct EHE funding to 39 Ryan White HIV/AIDS Program (RWAP) 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 recipient). AHA coordinates with the respective RWHAP ADAPs to ensure necessary resources are available to provide assistance for medications and health care coverage premiums and cost sharing for people newly diagnosed with HIV or re-engaged in care through the initiative. The RWHAP's comprehensive system of HIV care and support services and effective system for medication delivery creates a very efficient and effective service delivery mechanism for this initiative.

The FY 2026 request will allow the RWHAP to continue current efforts to engage new clients and support HIV care and treatment needs for an estimated 43,000 clients who are either reengaged or were newly diagnosed in prior years of the initiative. As more people with HIV receive HIV care and treatment, an increase in EHE funding is critical for engaging those out of care and keeping an increasing number of patients on medications to prevent HIV transmissions and improve HIV health outcomes.

The FY 2026 request will also support the continuation of key activities previously carried out by CDC, such as HIV surveillance and laboratory services, including outbreak response to stop them at their source. Additionally, the program will focus efforts in jurisdictions for testing and other prevention services. Data collected by these activities is also used to inform resource allocation, including for the Ryan White HIV/AIDS Program.

The request supports technical assistance and systems coordination to improve the Reporting Systems (BRS) for timely EHE initiative monitoring and provide additional technical assistance to jurisdictions to implement care models that link and retain key populations.

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.

RWHAP EHE Funding History[70]

FY	Amount
FY 2022 Final	$125,000,000
FY 2023 Final	$165,000,000
FY 2024 Final	$165,000,000
FY 2025 Enacted	$165,000,000
FY 2026 President's Budget	$165,000,000

[70] EHE initiative was launched in FY 2019 and first received appropriations in FY 2020.

EHE (previously part of CDC) Funding History[71]

FY	Amount
FY 2022 Final	$195,000,000
FY 2023 Final	$220,000,000
FY 2024 Final	$220,000,000
FY 2025 Enacted	*
FY 2026 President's Budget	$220,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

EHE funded jurisdictions made significant progress to date toward implementing the EHE workplans, including:

- Linkage, retention, and re-engagement activities (e.g., peer navigators, data to care re-engagement efforts)
- Service delivery approaches (e.g., telehealth and use of technology, expanded access)
- Infrastructure development (e.g., recruitment and hiring, onboarding, and training, data infrastructure)
- Community engagement and information dissemination (e.g., social media efforts, marketing campaigns)

In 2023, EHE-funded service providers served 26,830 clients new to care and an estimated 20,940 clients re-engaged in care. By the end of the year, over 81% of new clients achieved viral suppression, a 2% improvement from 2022. This means they cannot transmit HIV to sexual partners and can live longer, healthier lives—demonstrating the effectiveness of rapid treatment initiation.

From January 2022 to December 2024, 404 HIV clusters were reported and addressed by 49 health departments, helping contain potential outbreaks quickly.
Between 2018 and 2022, 11,000 HIV infections were prevented, saving $5.9 billion in lifetime medical costs.

From 2021–2023, EHE-funded health departments tested over 1 million people for HIV, identified 4,600 new diagnoses and distributed over 570,000 HIV self-test kits, a proven cost-saving approach.

[71] EHE initiative was launched in FY 2019 and first received appropriations in FY 2020.

Outputs and Outcomes Table

RWHAP Part A, Part B, Part C, and Part D (includes Ending the HIV Epidemic initiative) contribute to over-arching performance measures. The Outputs and Outcomes Table containing these measures is located at the end of this document.

Contextual Measures

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)
2.1.1 Reduce the number of new HIV diagnoses by at least 75%	FY 2022: 37,601
2.1.3 Increase the percentage of people with HIV who know their serostatus to 95%	FY 2022: 87.2%
2.1.9 Reduce the number of new HIV infections by 75%	FY 2022: 31,800
2.1.10 Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%	FY 2022: 65.1%

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	49	*	59
Average Award	$3,004,637	*	$5,285,960
Range of Awards	$2,000,000 – $16,773,053	*	$208,979 – $16,773,053

***** Grant award estimates under development.

Outputs and Outcomes Table for Over-Arching Performance Measures – RWHAP Part A, Part B, Part C, and Part D

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
4000.04: Number of people served by the Ryan White HIV/AIDS Program. (Outcome)	FY 2023: 576,040 Target: Not Defined (Historical Actual)	*	565,000	*
4000.03: Percentage of Ryan White HIV/AIDS Program clients who are virally suppressed. (Outcome)	FY 2023: 90.6% Target: 84% (Target Exceeded)	*	85%	*
4000.06: Percentage of Ryan White HIV/AIDS Program female clients who are virally suppressed. (Outcome)	FY 2023: 90.9% Target: Not Defined (Historical Actual)	*	85%	*
4000.05: Percentage of Ryan White HIV/AIDS Program racial and ethnic minority clients who are virally suppressed. (Outcome)	FY 2023: 89.8% Target: Not Defined (Historical Actual)	*	85%	*
4020.01: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. (Output)	FY 2022: 291,170 Target: 280,000 (Target Exceeded)	*	289,000	*
4060.01 Number of new clients served by RWHAP EHE-funded providers (Output)	FY 2023: 26,830 Target: 22,000 (Target Exceeded)	*	20,000	*

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
4060.02 Percentage of new clients who are virally suppressed among those clients in medical care served by RWHAP EHE-funded providers (Outcome)	FY 2023: 81.4% Target: 76.2% (Target Exceeded)	*	76.2%	*

* Performance targets under development.

Considerations for Target Setting

Viral suppression rates are lower among certain population groups than among others. The RWHAP aims to continue to achieve high viral suppression rates for clients in medical care that far exceed the national average and to reduce viral suppression rates among those disproportionately impacted by HIV. The following helped inform the methodology for establishing all four viral suppression targets:

- People with HIV who are not engaged in care tend to have more complex needs than those that remain engaged. Multiple studies indicate that those retained in care are more likely to achieve viral suppression compared to those not engaged in regular care.
- Viral suppression can take up to three months to achieve based on viral dynamics while a person establishes routine engagement in care and maintains adherence to HIV medications. The RWHAP and EHE initiative focus on people with HIV unaware of their diagnosis or not in routine care. The programs have been highly successful in engaging and re-engaging people in care and treatment to date, but additional resources and flexibility are needed to achieve additional gains and reach those who are not currently engaged in care. Due to the significant number of clients who are not in care or routinely retained in care who will be engaged/re-engaged through the EHE efforts, reaching new clients may lead to temporarily lower overall viral suppression rates as people who are not diagnosed or in care have lower viral suppression rates.
- Despite the improved rates of durable viral suppression in the RWHAP overall, populations with multiple needs, including clients who have been out of care and who have co-occurring conditions such as mental health challenges and substance use disorders, or are unhoused, remain at increased risk of not meeting optimal viral suppression.[36]
- The targets for Measure 4000.04 reflect funding levels and rising health care costs[37, 38].

- The FY 2022 target for Measure 4060.01 reflects requested funding amounts as well as the methodology for counting new clients enrolled and is based on the most recent data available.
- The targets for Measure 4060.01 reflect the higher costs associated with identifying and linking key populations into care and treatment. EHE clients face complex barriers to care which require significant resources and staffing. This requires significant resources and staffing. Low-barrier HIV clinics and rapid initiation of antiretroviral therapy (ART) are two successful investments made by EHE-funded providers to engage people in HIV care and treatment by delivering suites of multiple services, such as behavioral health and case management, to address complex and intersecting barriers to care. The reduced target also reflects fewer numbers of new HIV diagnoses and the increasing costs of maintaining EHE clients in care.
- The FY 2026 target for Measure 4060.02 is to maintain enrollment as each year will represent a new cohort of patients who are new or reengaged in care and who therefore will have lower rates of viral suppression than the overall RWHAP.

Office of Infectious Disease and HIV/AIDS Policy

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$7,582,000	*	$7,582,000
FTE	**	**	212[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA and CDC FTE totals.
1\FY 2026 FTE represents entire HIV/AIDS FTE total.

Allocation Methods:

- Contracts
- Direct federal

Program Description

The Office of Infectious Disease and HIV/AIDS Policy (OIDP), previously within the Assistant Secretary of Health improves outcomes for patients with infectious diseases in America through evidence based policies and programs. OIDP's policies are designed to improve prevention, diagnosis, and treatment for all infectious diseases including HIV/AIDS, sexually transmitted infections, viral hepatitis, nosocomial infections, and antibiotic resistant organisms.

Also, OIDP operationalizes the statute for blood supply and the National Vaccine Program Office.

Budget Request

The FY 2026 Budget Request for OIDP is $7.6 million. At this level, OIDP will lead the Department's priorities to advance Make America Healthy Again. OIDP will implement innovative interventions to improve prevention, diagnosis, and treatment for HIV/AIDS, sexually transmitted infections, viral hepatitis, nosocomial infections, and antibiotic resistant organisms.

OIDP will create measures with up-to-date data to improve health outcomes for patients with infectious disease. These measures will be based on gold standard science and be transparent so that Americans can understand how they can prevent and treat acute and chronic disease.

Funding Table

FY	Amount
FY 2022 Final	$7,582,000
FY 2023 Final	$7,582,000
FY 2024 Final	$7,582,000

FY	Amount
FY 2025 Enacted	*
FY 2026 President's Budget	$7,582,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

- The National Syphilis and Congenital Syphilis Syndemic Federal Task Force published guidelines for point-of-care testing focused on decreasing the burden of congenital syphilis among Native communities.
- Through Ending the HIV Epidemic coordination, 411 community health centers conducted a cumulative total of 7.2 million HIV tests, performed over 20,000 HIV tests in Native communities, and 600,000 free HIV self-tests were distributed. Additionally, more than 183,000 people were provided with PrEP management services and 61,000 people were prescribed PrEP.
- America's HIV Epidemic Analysis Dashboard led to a 13% increase in engagement and a 16% rise in events per user and initiated integration of Indian Health Service data.

Maternal and Child Health

TAB

MATERNAL AND CHILD HEALTH

Maternal and Child Health Block Grant

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$813,700,000	*	$767,250,000
FTE	**	**	188[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

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

Program Description

The Maternal and Child Health (MCH) Block Grant program seeks to improve the health of mothers, children, and their families. The activities authorized as part of the MCH Block Grant program include the State MCH Block Grant program, Special Projects of Regional and National Significance (SPRANS), and Community Integrated Service Systems (CISS) grants. The MCH Block Grant program funding, combined with state investments, improves access to quality health care services for mothers, children, and their families in all 50 states, the District of Columbia, and other jurisdictions. The MCH Block Grant program enables each state to ensure access to quality maternal and child health care services for mothers and children, especially those with low incomes or limited availability of care.

State MCH Block Grant Program

The Title V State MCH Block Grant Program, a partnership between the federal government and states, awards formula grants to 59 states and jurisdictions to address the health needs of mothers, infants, and children, as well as children with special health care needs in their state or jurisdiction. Nearly 60 million pregnant women, infants, and children, including children with special health care needs, benefitted from a service supported by the State MCH Block Grant program in FY 2023. Nationwide, the 59 State MCH Block Grant programs reached approximately 95 percent of pregnant women and 61 percent of children. Infants are included within the percent of children reached, and when looked at separately, 98 percent of infants were reached. The MCH Block Grant Program gives states flexibility in meeting their unique health needs, while assuring accountability and impact through performance measurement and technical assistance.

The MCH Block Grant Program distributes funding based on a statutory funding formula tied to a state's level of child poverty compared to the overall level of child poverty in the United States. Federal funds, combined with required state matching investments, support activities that address an individual state's MCH needs.

States use Title V State MCH Block Grant funding to support infant screening and other preventive services, address gaps in health care coverage and services for both insured and uninsured mothers and children, and support quality improvement initiatives, workforce training, outreach, and disease prevention and health promotion. The MCH Block Grant Program provides technical assistance to states in addressing their MCH priority needs and the performance and programmatic requirements of the MCH Block Grant program, and makes state-reported financial, program, performance, and health indicator data available to the public through the Title V Information System.[72]

Special Projects of Regional and National Significance (SPRANS)

SPRANS grants address national or regional needs, priorities, or emerging issues, and demonstrate methods for improving care and outcomes for mothers and children. SPRANS awards drive innovation, help improve systems of care for MCH populations and enable efforts to address emerging issues. For example:

- ***Maternal Mortality*** – SPRANS funding is integral to promoting maternal health and reducing maternal mortality and morbidity. For example, the State Maternal Health Innovation (State MHI) Program supports state-specific actions and innovations that address disparities in maternal health and improve maternal health outcomes. Outcomes from this program demonstrate facilities are able to recommend and implement practice changes to prevent future severe maternal morbidity and adverse maternal outcomes.
- ***Children's Mental Health*** – SPRANS funding supports the mental health of children and youth in communities across the country through the Children's Safety Network (CSN). CSN works with states and jurisdictions to strengthen their capacity to use data to identify and implement effective strategies to reduce fatal and serious injuries among children and youth, including suicide.
- ***Supporting the Maternal and Child Health (MCH) Workforce*** – SPRANS funding plays a vital role in enhancing and expanding the MCH workforce in communities across the country. The National MCH Workforce Development Center, for example, partners with states and jurisdictions to tackle complex challenges through training, collaborative learning, coaching, and consultation. The Center has helped address challenges such as helping states develop connected and coordinated care for children and youth with special health care needs (CYSHCN) and creating models of multi-stakeholder collaboration to support perinatal women with substance use disorder.

Community Integrated Service Systems (CISS)

CISS grants help states and communities build a comprehensive, integrated system of care to improve access and outcomes for all children, including children with special health care needs.

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

For example, CISS funding supports the Early Childhood Comprehensive Systems (ECCS) program, which help states improve access to, and quality of, preventive health and support services for people who are pregnant or have young children.

Budget Request

The FY 2026 Budget Request for the MCH Block Grant program is $767 million. The request includes $593 million for formula awards to states to promote and improve the health and well-being of the nation's mothers, children (including CYSHCN), and their families. Additionally, the request includes $163.7 million in SPRANS to continue to address critical and emerging issues in maternal and child health, and $10.3 million for CISS programs

Eligible entities for the Title V State MCH Block Grant Program include all 59 states and jurisdictions, while organizations eligible for most SPRANS and CISS programs include any domestic public or private entity, including an Indian tribe or tribal organization.

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

Table 1. MCH Block Grant Activities

MCH Activities	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
State MCH Block Grant Awards	$593,308,000	*	$593,308,000
SPRANS	$210,116,000	*	$163,666,000
CISS	$10,276,000	$10,276,000	$10,276,000
Total	**$813,700,000**	*****	**$767,250,000**

* Grant award estimates under development.

Funding History

FY	Amount
FY 2022 Final	$733,003,000[73]
FY 2023 Final	$816,200,000[74]
FY 2024 Final	$813,700,000
FY 2025 Enacted	*

[73] Retroactively adjusted to reflect shift in funding from SPRANS for Innovation for Maternal Health, Integrated Services for Pregnant and Postpartum Women, and the Maternal Mental Health Hotline to their own budget lines due to newly passed stand-alone authorities in FY 2022

[74] Reflects a shift in funding from SPRANS for the Maternal Mental Health Hotline to its own budget line due to a stand-alone authority for the Hotline in FY 2023.

FY	Amount
FY 2026 President's Budget	$767,250,000

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

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

- Access to health services for mothers has improved with the support of the State MCH Block Grant program. Seventy-six percent of women received early prenatal care in the first trimester of pregnancy in 2023. Recognizing the importance of continuity of care in the postpartum period, all 59 states and jurisdictions are now working to improve access to and quality of postpartum care for all mothers.
- The infant mortality rate is a widely used indicator of the nation's health. The State MCH Block Grant program has played a lead role in the 22 percent decline in U.S. infant mortality from 7.2 infant deaths per 1,000 live births in 1997 to 5.6 infant deaths per 1,000 live births in 2023.
- States are also working to reduce maternal mortality, which has risen over the past two decades. All states use MCH Block Grant funds for women and maternal health activities such as promoting well-woman visits, increasing access to prenatal and postpartum care, supporting Maternal Mortality Review Committees (MMRCs), and enhancing systems of care for maternal mental health.
- States are addressing behavioral health needs of the MCH population. For example, Connecticut's Title V program supported a *1 Word 1 Voice 1 Life* campaign to educate Connecticut residents on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources. In addition, Kansas's Title V program added behavioral health screening tools to their data collection system to increase the availability of evidence-based screenings to local MCH agencies in the state and provided supporting resources to assist local providers with conducting these screenings.
- Title V funding is a key resource to support newborn screening throughout the nation. The State Title V programs work with partners to ensure every newborn receives a screening as well as the appropriate follow-up services, care, and intervention. Title V assures that referrals to providers take place for infants who are screened and confirmed positive for a metabolic or genetic condition. In 2023, 98 percent of all infants received at least one newborn screening.

Select National Outcome and National Performance Measures in effect from 1997 to 2023 illustrate the program's successes:

National Outcome or Performance Measures	Percent Change (1997 – 2023[75] unless otherwise noted)	Data Source
Infant mortality rate per 1,000 live births	22% decrease	National Vital Statistics System (NVSS)
Neonatal mortality rate per 1,000 live births	25% decrease	NVSS
Postneonatal mortality rate per 1,000 live births	20% decrease	NVSS
Perinatal mortality rate per 1,000 live births plus fetal deaths	25% decrease	NVSS
Child mortality rate, ages 1 through 9 per 100,000 children	27% 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[76]	No change (2011-2020)	National Immunization Survey (NIS)
Percentage of children without health insurance	73% decrease	National Health Interview Survey (NHIS)
Percent of infants breastfed exclusively through 6 months of age	97% increase (2007-2021)	NIS
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	7% increase (2007-2023)	NVSS

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3010.01**:** The percentage of children served by the Maternal and Child Health Block Grant *(Outcome)*	FY 2023: 61% Target: 63% (Target Not Met)	*	64%	*

[75] All measures that use data from the NVSS include 2023 data.
[76] Childhood vaccination measure definition has been updated to align with CDC reporting of vaccination rates by birth year cohort.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3010.02**:** The percentage of pregnant women served by the Maternal and Child Health Block Grant *(Outcome)*	FY 2023: 95% Target: 93% (Target Exceeded)	*	93%*	*
3010.04: Reduce the infant mortality rate *(Outcome)*	FY 2023: 5.6 per 1,000 Target: 5.4 per 1,000 (Target Not Met)	*	5.3 per 1,000	*
3010.05: Reduce the incidence of low birth weight births *(Outcome)*	FY 2023: 8.6% Target: 8% (Target Not Met)	*	8%	*
3010.10: Percentage of women who attended a postpartum checkup up to 12 weeks after giving birth	FY 2023: 90.3% Target: N/A (Historical Actual)	*	92.6%	*

* Performance targets under development.

Grant Awards Table – Maternal and Child Health Block Grant

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	59	*	59
Average Award	$9,734,896	*	$9,734,896
Range of Awards	$155,078-$41,139,508	*	$155,078-$40,475,059

* Grant award estimates under development.

Grant Awards Table – SPRANS

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	325	*	285
Average Award	$580,088	*	$503,609
Range of Awards	$12,910-$11,282,998	*	$31,181-$6,700,000

* Grant award estimates under development.

Grant Awards Table – CISS

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	26	26	26
Average Award	$330,200	$329,968	$326,189
Range of Awards	$296,959-$700,000	$295,959-$700,000	$293,000-$700,000

Innovation for Maternal Health

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$15,300,000	*	$15,300,000
FTE	**	**	188[1]

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
******FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

- Contract
- Competitive grant/co-operative agreement

Program Description

The Alliance for Innovation on Maternal Health (AIM) program improves maternal health and safety in the United States by increasing access to safe, reliable, and quality care, particularly through the implementation of patient safety bundles. These bundles are sets of evidence-based practices designed to address specific maternal health conditions and improve outcomes; they can be adapted to a variety of birth settings. The program works to eliminate preventable maternal mortality and severe maternal morbidity.

AIM currently offers eight patient safety bundles. AIM state enrollees can choose which bundle(s) to implement, according to their needs and priorities:

- Obstetric Hemorrhage
- Severe Hypertension in Pregnancy
- Safe Reduction of Primary Cesarean Birth
- Cardiac Conditions in Obstetric Care
- Care for Pregnant and Postpartum Women with Substance Use Disorder
- Postpartum Discharge Transition
- Sepsis in Obstetrical Care
- Perinatal Mental Health Conditions

The program supports AIM Capacity grants to strengthen state-level capacity to implement and sustain the AIM program. These grants help states expand the reach and quality of AIM efforts, ultimately aiming to increase the number of participating birthing facilities and number of patient safety bundles implemented and sustained. In addition, these grants build data capacity for participating entities to track quality improvement cycles for bundle implementation and support data collection improvement. The AIM Technical Assistance Center supports technical assistance for implementation of AIM patient safety bundles within birthing facilities in states, the District of Columbia, territories, and tribal entities, and dissemination of these bundles to a broader array of providers, health care settings, and organizations within communities across the United States.

Budget Request

The FY 2026 Budget Request for the AIM program is $15.3 million. This request supports AIM Capacity grants and Technical Assistance Center activities.

Eligible entities include any domestic public or private entity, domestic faith-based and community-based organizations, tribes, and tribal organizations.

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

Funding History

FY	Amount
FY 2022 Final	$11,775,000
FY 2023 Final	$15,300,000
FY 2024 Final	$15,300,000
FY 2025 Enacted	*
FY 2026 President's Budget	$15,300,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

As of June 2024, 49 states, the District of Columbia, and Puerto Rico are enrolled in AIM, with participation from 2,069 birthing facilities or 75 percent of birthing facilities located in participating states. As of June of 2024, 84 percent of participating states had at least half of their birthing facilities engaged in AIM. States and birthing facilities implementing the patient safety bundles report improvements in readiness to provide care, recognition and prevention of adverse events, timely treatment, patient and provider education, and policies to facilitate high-quality care. Sample accomplishments from states include:

- **Arizona:** In December 2020, the severe maternal morbidity (SMM) rate in Arizona among women with hypertensive disorders of pregnancy was reported to be three times as high as the rate among women without hypertensive disorders of pregnancy. In April 2021, Arizona began implementing the AIM Severe Hypertension in Pregnancy Patient Safety Bundle with 32 of the state's 42 birthing facilities. After bundle implementation, in participating facilities the percentage of pregnant and postpartum women with persistent severe hypertension who were treated within one hour increased by 38% between 2021 and 2023.
- **West Virginia:** In 2020, the West Virginia Perinatal Partnership began implementation of the AIM Severe Hypertension in Pregnancy Patient Safety Bundle. Between October 2022 and September 2023, the percentage of patients who experienced persistent severe hypertension during their birth admission and had a postpartum blood pressure and symptoms check scheduled before their hospital discharge increased from 17.5% to

36.7%. Additionally, the proportion of nurses who received education on respectful and supportive care increased from 67.2% in October 2022 to 79.2% in September 2023.

- **Montana:** Obstetric hemorrhage is a leading cause of severe maternal morbidity in Montana. To strengthen the capacity of birthing facility teams to appropriately respond to obstetric hemorrhages, the Montana Perinatal Quality Collaborative (MPQC) began implementing the AIM Obstetric Hemorrhage Patient Safety Bundle in October 2021 with 17 of the state's 26 birthing facilities. Between July 2021 and September 2022, the percentage of birthing facilities conducting hemorrhage risk assessments increased from 59.0% to 87.2%. During the same period, the percentage of participating birthing facilities who had policies and procedures in place to measure blood loss during birth admission increased from 23.5% to 68.9%.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3020.01: Number of birthing facilities that are participating in the Alliance for Innovation on Maternal Health (AIM) *(Output)*	FY 2024: 2,069 Target: N/A (Historical Actual)	*	2,028	*

* Performance targets under development.

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	38	*	37
Average Award	$344,172	*	$300,796
Range of Awards	$199,978-$3,000,000	*	$199,999-$3,000,000

Grant award estimates under development.

Integrated Services for Pregnant and Postpartum Women

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$10,000,000	*	$10,000,000
FTE	**	**	188[1]

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

- Competitive grant/co-operative agreement

Program Description

The Integrated Services for Pregnant and Postpartum Women program funds demonstration projects that coordinate services across providers to improve maternal health outcomes. This includes:

- Coordinating prenatal and perinatal services among health care providers, social services organizations/providers, state Medicaid programs, and state and local health departments;
- Developing and enhancing maternal health data infrastructure; and
- Analyzing integrated health service models for pregnant and postpartum women to ensure they improve maternal health, especially models that can be replicated.

This work is modeled on the Pregnancy Medical Home (PMH) model, which organizes and coordinates the often-fragmented network of social, behavioral, and health care services.

Over three million births occur in the United States each year.[77] Despite advances in medical care and investments in improving access to care, rates of maternal mortality and severe maternal morbidity (SMM) have not improved.[78] Over 800 women die each year in the United States from maternal causes[79] and approximately 30,000 women experience unexpected outcomes of labor or delivery that have serious short- or long-term effects on their health and well-being (i.e., severe maternal morbidity).[80] Maternal health outcomes vary significantly by factors such as geography, as maternal mortality rates are higher in rural areas.[81,82]

[77] https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-01.pdf
[78] https://datatools.ahrq.gov/hcup-fast-stats/?tab=special-emphasis&dash=92
[79] https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/E-stat-Maternal-Mortality-Rates-2022.pdf
[80] https://mchb.tvisdata.hrsa.gov/Admin/FileUpload/DownloadContent?fileName=FadResourceDocument.pdf&isForDownload=False
[81] https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm
[82] https://mchb.tvisdata.hrsa.gov/Admin/FileUpload/DownloadContent?fileName=FadResourceDocument.pdf&isForDownload=False

Budget Request

The FY 2026 Budget Request for the Integrated Services for Pregnant and Postpartum Women program is $10 million. This request will support projects to foster the development and demonstration of innovative models that integrate care and services, to reduce adverse maternal health outcomes and pregnancy-related deaths, and to promote optimal health for all women.

Eligible entities for the Integrated Services for Pregnant and Postpartum Women program include any domestic public or private entity, including an Indian tribe or tribal organization, and domestic faith-based and community-based organizations.

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

Funding History

FY	Amount
FY 2022 Final	---
FY 2023 Final	$10,000,000
FY 2024 Final	$10,000,000
FY 2025 Enacted	*
FY 2026 President's Budget	$10,000,000

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

Award recipients are in their second year of program implementation. Thus far, awardees have:

- Hired and onboarded program staff to conduct pregnancy risk assessments and provide case management of enrolled clients.
- Created the IMHS Annual Data Report to collect measures across all award recipients.
- Implemented their Pregnancy Medical Home models and enrolled clients within the target communities.
- Identified Pregnancy Medical Home models for replication and implementation within their target communities.
- Finalized program performance and evaluation measures, which will be used throughout the five-year funding cycle.

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	5	*	5
Average Award	$1,845,692	*	$1,813,640
Range of Awards	$1,715,550-$1,851,976	*	$1,715,550-$1,851,976

*Grant award estimates under development.

Maternal Mental Health Hotline

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$7,000,000	*	$7,000,000
FTE	**	**	188[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

- Contract
- Grant

Program Description

The National Maternal Mental Health Hotline program supports a national hotline (1-833-TLC-MAMA) that provides 24/7 free, confidential emotional support, resources, and referrals to pregnant and postpartum women facing mental health challenges and their loved ones. Professional counselors – including licensed mental health clinicians and health care providers such as nurses or doctors, certified doulas or childbirth educators, and certified peer support specialists – staff the hotline. They provide support via telephone and text, so people can get the help they need, when they need it. Interpreter services are also available in 60 languages, and a relay service is available for people who are deaf or hard-of-hearing. A portion of funds are also used to promote widespread national awareness and use of the hotline through public service announcements, a paid social media campaign, presentations, conference exhibitions for maternal and child health care providers, and free printed promotional materials.

Budget Request

The FY 2026 Budget Request for the National Maternal Mental Health Hotline program is $7 million. The hotline will continue to address maternal mental health needs and enhance awareness. Requested funding will support hotline operation and staffing, including public awareness, and training and support for counselors. Funding supports hotline availability 24/7 in English and Spanish, with interpreter services for 60 other languages.

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

Funding History

FY	Amount
FY 2022 Final	$4,000,000
FY 2023 Final	$7,000,000

FY	Amount
FY 2024 Final	$7,000,000
FY 2025 Enacted	*
FY 2026 President's Budget	$7,000,000

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

The Maternal Mental Health Hotline was launched in a phased manner during its first year of implementation, which included partner outreach to more than 100 provider associations, national organizations, community groups, and federal partners to promote the hotline to their constituents.

Since its launch,[83] the hotline's professional counselors had over 62,000 conversations, of which about 68 percent were by phone and 32 percent were by text. The top reasons individuals contacted the hotline included: feeling overwhelmed, anxiety, depression, issues related to pregnancy, and relationship conflict. Most individuals contacting the hotline were seeking help for themselves (75 percent), while 5 percent of individuals were calling on behalf of someone else, like a family member or friend. (Other callers did not identify this information.) The hotline has received contacts from every state in the country.

[83] May 2022-March 2025

Autism and Other Developmental Disabilities

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$56,344,000	*	$38,245,000
FTE	**	**	188[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

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

Program Description

The Autism and Other Developmental Disabilities program improves care and outcomes for children, adolescents, and young adults with autism and other developmental disabilities through the Leadership Education in Neurodevelopmental and Other Related Disabilities (LEND) training program. LEND trains health care professionals to screen, diagnose, refer, and provide services for children with autism and other developmental disabilities so that children and youth with autism and other developmental disabilities have increased access to these services.

LEND focuses on training professionals to provide care tailored to the unique needs of the population and recruiting students and professionals from a variety of disciplines (e.g., medicine, social work, nursing, psychology, physical therapy, audiology, nutrition) into the program. LEND also includes individuals with autism and other developmental disabilities and family members as trainees and faculty. These participants enhance trainee understanding of individual's and families' experiences while also increasing their leadership skills.

Budget Request

The FY 2026 Budget Request for the Autism and Other Developmental Disabilities program is $38.2 million. This request continues support for the Autism and Other Developmental Disabilities training, through the LEND program.
Eligible applicants include domestic public or non-profit agencies, including institutions of higher education.

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

Funding History

FY	Amount
FY 2022 Final	$54,344,000
FY 2023 Final	$56,344,000
FY 2024 Final	$56,344,000
FY 2025 Enacted	*
FY 2026 President's Budget	$38,245,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

Data from FY 2023 showed that the 60 LEND programs provided:

- Diagnostic services to confirm or rule out autism and other developmental disabilities to over 153,000 children;
- Training to over 24,000 trainees in pediatrics, developmental-behavioral pediatrics, other health professions, and people with lived experience; and
- Over 3,900 continuing education events on early screening, diagnosis, and services that reached over 432,000 pediatricians and other health professionals.

FY 2026 targets for LEND reflect the potential changes in grantees that may occur following the FY 2026 recompetition, which could lead to a change in the cohort of awardees and we anticipate new awardees would need time to ramp-up their activities.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3020.02**:** Percentage of Leadership Education Neurodevelopmental and Other Related Disabilities (LEND) Training Program long-term trainees who at 5 years post-training have worked in an interdisciplinary manner to serve the MCH population *(Outcome)*	FY 2023 Result: 94% Target: 90% (Target Exceeded)	*	94%	*

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3020.06: Percentage of Leadership Education in Neurodevelopmental and Other Related Disabilities (LEND) Training Program long-term trainees working with underserved populations 5 years post-training *(Outcome)*	FY 2023 Result: 82% Target: 82% (Target Met)	*	84%	*

* Performance targets under development.

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 Budget Request
LEND	$37,224,675	*	$36,000,000
DBP	$3,678,482	*	---
Research	$7,602,877	*	---
State Best Practices	$1,799,518	*	---
Resource Centers	$975,000	*	---
Number of Awards	88	*	60
Average Award	$582,734	*	$546,481

*Grant award estimates under development.

Sickle Cell Disease Treatment Demonstration Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$8,205,000	*	$8,205,000
FTE	**	**	188[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

- Competitive grant/co-operative agreement
- Contract

Program Description

The Sickle Cell Disease Treatment Demonstration Program (SCDTDP) helps individuals with sickle cell disease (SCD) access quality, coordinated, comprehensive care by building sickle cell disease care teams that extend specialty care from centrally based SCD experts in hospitals, clinics, or university health centers to the communities where people live. This program:

- Increases the number of individuals living with sickle cell disease that are served by comprehensive sickle cell care teams;
- Increases the number of clinicians or health professionals knowledgeable in evidence-based treatment of SCD and improving quality of care; and
- Improves care coordination with other providers.

SCD affects over 100,000 individuals in the United States. While advances in science and medicine mean individuals with SCD have an increased life expectancy, not everyone who needs therapy and treatment has been able to benefit. Individuals with SCD have unequal access to comprehensive, quality health care and treatment for many reasons. The program uses a hub-and-spoke regional model to address barriers to access and help prevent and treat SCD complications.

Since 2014, the program has supported five regional SCDTDPs that work collectively to increase access to evidence-based care in the communities in which SCD patients live and leverage telehealth support to link individuals with specialty services within their regions. The program supports partnerships between clinicians and community organizations to improve patients' quality of care with SCD, and educates providers, families, and patients to improve knowledge and capacities, particularly as patients transition to adult health care settings.

The Hemoglobinopathies National Coordinating Center (HNCC) leads quality improvement activities to support SCDTDP grantees, and provides strategies to improve sickle cell disease care. The HNCC also collects SCDTDP activity data that informs a report to Congress.

Budget Request

The FY 2026 Budget Request for the Sickle Cell Disease Treatment Demonstration program is $8.2 million. This request will support the regional SCD infrastructure so that individuals with SCD can lead full and productive lives wherever they live. AHA will partner with states to develop and support knowledgeable SCD care teams to improve and increase access to appropriate care; implement telehealth technologies for health care delivery, education, and health information services; increase access to evidence-based care and the latest treatment options; and increase collaboration and care coordination within each region.

Eligibility for the program includes a Federally-qualified health center, a nonprofit hospital or clinic, or a university health center that provides primary health care, that has a collaborative agreement with a community-based sickle cell disease organization or a nonprofit entity with experience in working with individuals who have sickle cell disease; and demonstrates to the AHA Administrator that either the federally-qualified health center, the nonprofit hospital or clinic, the university health center, the organization or entity described in clause (i) 42 USC § 300b-5, or experts as described in paragraph (2)(C) of 42 USC § 300b-5, has at least five (5) years of experience in working with individuals who have sickle cell 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.

Funding History

FY	Amount
FY 2022 Final	$7,010,000
FY 2023 Final	$8,205,000
FY 2024 Final	$8,205,000
FY 2025 Enacted	*
FY 2026 President's Budget	$8,205,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

According to data from September 1, 2023 through August 31, 2024, the program successfully reached individuals with SCD, health care providers, and the community. The program:

- Served over 25,000 individuals in 51 sites, representing about a quarter of the SCD population in the United States.
- 80% of individuals with SCD received the disease modifying therapies for which they were eligible through the sickle cell treatment demonstration program. In FY 2024, AHA implemented a new data collection methodology so that all grantees report to AHA's Discretionary Grants Information System (DGIS) using a uniform data collection and reporting methodology, which uses percentages that are estimates based on sample data.

FY 2026 targets take into account the program's FY 2026 recompetition, which could lead to a change in the cohort of awardees. We anticipate new awardees will need time to ramp up prog their activities

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3030.01: Number of sickle cell patients served by Sickle Cell Disease Treatment Demonstration Program network providers in the past year *(Output)*	FY 2024: 25,446 Target: 22,000 (Target Exceeded)	*	25,000	*
3030.02: Percentage of individuals with sickle cell disease receiving disease modifying therapies within a Sickle Cell Disease Treatment Demonstration Program *(Outcome)*	FY 2024: 80% Target: 80% (Target Met)	*	70%	*

* Performance targets under development.

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	5	*	5
Average Award	$1,124,000	*	$1,240,000
Range of Awards	$1,024,000-$1,274,000	*	$1,240,000

*Grant award estimates under development.

Pediatric Mental Health Care Access

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$13,000,000	*	$13,000,000
FTE	**	**	188[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Method

- Competitive grant/co-operative agreement

Program Description

The Pediatric Mental Health Care Access (PMHCA) program promotes behavioral health integration in pediatric primary care by developing new, or expanding statewide, or regional pediatric mental health care access programs. Pediatric primary care providers are often the first responders in behavioral disorder identification and service provision. However, they may not have adequate knowledge, training, or resources to screen, diagnose, and treat behavioral disorders. Tele-consultation strategies, like the ones the PMHCA program supports, connect primary care providers with specialty behavioral health care providers. Participating providers also gain knowledge and increase their capacity/capability to address some behavioral concerns on their own, which over time will decrease the need for consultation. PMHCA increases access to behavioral health care by addressing the shortage of psychiatrists, developmental-behavioral pediatricians, psychologists, and other behavioral health clinicians who provide care to children and adolescents with behavioral concerns.[84]

The need for PMHCA programs is great. The most recent data from the National Survey of Children's Health shows that approximately 1 in 6 children ages 3-17 were currently diagnosed with depression, anxiety, or behavior problems, with significant increases observed for both depression and anxiety since 2016.[85] Data further show that the availability of treatment and support has not kept pace with need for many American children with mental health conditions. For example, of the over 5 million adolescents in the United States who are currently diagnosed with depression, anxiety, or behavior/conduct problems, about 1 in 6 did not receive the treatment they needed from a mental health professional, and over 60% reported difficulty in getting needed treatment.[86]

[84] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf
[85] Health Resources and Services Administration. National Survey of Children's Health, 2022-23. Unpublished estimates.
[86] Health Resources and Services Administration. National Survey of Children's Health: Adolescent Mental and Behavioral Health, 2023. Accessed April 25, 2025. https://mchb.hrsa.gov/sites/default/files/mchb/data-research/nsch-data-brief-adolescent-mental-behavioral-health-2023.pdf

Budget Request

The FY 2026 Budget Request for the PMHCA program is $13 million. The program has been funded through a combination of annual appropriations and supplemental funding through FY 2025 from the Bipartisan Safer Communities Act (BSCA) ($80 million) and American Rescue Plan Act (ARPA) ($80 million).

In 2026, PMHCA programs will focus on continuing to provide tele-consultation for pediatric primary care providers to diagnose, treat, and refer children with behavioral health conditions. The program is expected to recompete in FY 2026 and will support up to 22 statewide or regional pediatric mental health care telehealth access programs. The PMHCA program may serve an estimated 7,100 children and adolescents.

Entities eligible for PMHCA program funding include states, political subdivisions of states, territories, and Indian Tribes and Tribal organizations.

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

Funding History

FY	Amount
FY 2022 Final	$11,000,000
FY 2023 Final	$13,000,000
FY 2024 Final	$13,000,000
FY 2025 Enacted	*
FY 2026 President's Budget	$13,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

PMHCA program award recipients addressed behavioral health issues among children and adolescents, including anxiety, depression, and suicidal ideation and attempts. Award recipients also supported resilience strategies among families and clinicians. Across 50 states, Tribes, and territories in FY 2023 the program achieved the following:

- Over 21,500 providers enrolled in a statewide or regional PMHCA program;
- Over 10,300 providers used consultation and care coordination support services and nearly 11,800 providers were trained; and
- Pediatric providers who contacted the pediatric mental health team served approximately 28,800 children and adolescents.

Approximately 21 awardees of the Program's 50 recipients funded in FY 2023 for reporting period 9/30/22 – 9/20/23 were funded through annual appropriations. Funding through the American Rescue Plan Act and Bipartisan Safer Communities Act allowed the program to more than double its reach and expand activities into emergency departments and schools.

Outputs and Outcomes Table[87]

(Note: Results and targets in the table below reflect annual discretionary funding. These data do not include results/targets from PMHCA programs supported through supplemental appropriations.)

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3080.01: Number of providers using the Pediatric Mental Health Care Access Program consultation (teleconsultation and in-person) and care coordination services for treatment and referral of children with behavioral health conditions (Output)	FY 2023: 3,574 Target: 4,500 (Target Not Met)	*	5,500	*
3080.04: Number of providers trained through the Pediatric Mental Health Care Access Program to better screen, diagnose, treat, or refer children with behavioral health conditions (Output)	FY 2023: 7,172 Target: 7,500 Target Not Met	*	8,250	*
3080.05: Number of children and adolescents for whom a provider contacted the Pediatric Mental Health Care Access Program for consultation or referral (Output)	FY 2023: 13,136 Target: 10,000 Target Exceeded	*	13,000	*

* Performance targets under development.

[87] Data presented in the Outputs and Outcomes Table reflect 20 of the 21 awardees funded by annual appropriations. FY 2026 targets reflect the reporting period of 9/30/25 – 9/30/26.

Grant Awards Table[88]

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	25	*	22
Average Award	$438,602	*	$450,000
Range of Awards	$289,683-$456,960	*	$450,000

*Grant award estimates under development.

[88] Program currently funds 54 grant awards. Table does not include BSCA and ARPA funding.

Screening and Treatment for Maternal Mental Health and Substance Use Disorders

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$11,000,000	*	$11,000,000
FTE	**	**	188[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

- Competitive co-operative agreement
- Contract

Program Description

The Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD) program helps expand health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for maternal mental health and substance use disorders. The program supports statewide, tribal, or regional[89] networks that provide:

- Real-time psychiatric consultation;
- Care coordination support services; and
- Culturally and linguistically appropriate training to maternity care providers and clinical practices.

The program aims to improve the mental health and well-being of women who are pregnant, postpartum, or have given birth within the preceding 12 months. Maternal mental health conditions, such as depression, anxiety, and substance use disorder are common complications during pregnancy and the postpartum period. Given the significant shortage of psychiatrists and mental health providers across the country[90], it is important to build the capacity of front-line providers to identify and treat behavioral health conditions as part of routine primary care for pregnant and postpartum women.

Funding for MMHSUD supports 13 awardees. The program:

- Requires grant recipients to provide a 10 percent match to support program activities.
- Expands eligible entities to include Indian Tribes and Tribal Organizations.
- Gives priority, as appropriate, to entities that: 1) focus on enhancing screening, prevention, and treatment; 2) partner with community-based organizations that address maternal mental health and substance use disorders; 3) are in, or provide services to,

[89] Regional MMHSUD teams are defined as MMHSUD care teams within regions of a state, jurisdiction, or Tribal area.
[90] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf

areas with disproportionately high rates of maternal mental health or substance use disorders, or other related disparities; and 4) operate in a health professional shortage area.

Budget Request

The FY 2026 Budget Request for the Screening and Treatment for Maternal Mental Health and Substance Use Disorders program is $11 million. With requested funding, the program plans to support state awards to fill critical gaps in behavioral health support for pregnant and postpartum women.

Eligible entities for MMHSUD program funding include states, Indian Tribes, and Tribal Organizations.

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

Funding History

FY	Amount
FY 2022 Final	$6,500,000
FY 2023 Final	$10,000,000
FY 2024 Final	$11,000,000
FY 2025 Enacted	*
FY 2026 President's Budget	$11,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

Awardees trained approximately 880 providers in FY 2023, and, by extension, the program reaches the many women served by each of these providers. Trainings covered a variety of evidence-based practices such as: Screening, Brief Intervention, and Referral to Treatment (SBIRT); Medication Assisted Treatment; how to use standardized validated screening tools for perinatal depression and anxiety; ways to integrate behavioral health in primary care settings; and training on perinatal mood and anxiety disorders. Providers trained include obstetricians/ gynecologists, psychiatrists, licensed clinical social workers, licensed professional counselors, nurses/nurse practitioners, certified nurse midwives, physician assistants, care coordinators/patient navigators, family medicine physicians, and other health professionals.

In FY 2023, the programs received 1,828 calls from providers for behavioral health consultation[91] and/or care coordination programs. As training health care providers through the MMHSUD program enhances providers' ability to identify and treat the mental health and

[91] "Consultation" refers to psychiatric consultation and/or care coordination support provided either via telehealth or in-person by the program.

substance use disorders of their patients, this capability may allow them, over time, to address some patient needs without calling into tele-consultation/care coordination service lines for all patients. Therefore, the positive impact of the MMHSUD program may be greater than the additional training and consultation/care coordination estimates noted.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3090.01: Number of pregnant or postpartum women about whom a provider contacted the Screening and Treatment for Maternal Mental Health and Substance Use Disorders Program for consultation or referral *(Output)*	FY 2023: 1,511 Target: Not Defined (Historical Actual)	*	1,511	*
3090.03: Number of providers using the Screening and Treatment for Maternal Mental Health and Substance Use Disorders Program for consultation (teleconsultation or in-person) and care coordination support services for treatment and referral of pregnant and postpartum women with behavioral health conditions (Output)	FY 2023: 781 Target: Not Defined (Historical Actual)	*	781	*

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3090.04: Number of providers trained through the Screening and Treatment for Maternal Mental Health and Substance Use Disorders program to better screen, diagnose, treat, and refer pregnant and postpartum women with behavioral health conditions *(Output)*	FY 2023: 880 Target: Not Defined (Historical Actual)	*	880	*

* Performance targets under development.

Grant Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	13	*	13
Average Award	$731,637	*	$727,088
Range of Awards	$597,766 - $750,000	*	$597,666 - $750,000

*Grant award estimates under development.

Poison Control Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$26,846,000	*	$26,846,000
FTE	**	**	188[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

- Contracts
- Competitive grants/co-operative agreements

Program Description

The Poison Control Program (PCP) ensures that individuals can call a national toll-free Poison Help line (1-800-222-1222) to connect to a local poison control center (PCC) in an emergency. The PCP:

- Supports the national toll-free number to ensure access to poison control services;
- Implements a national media campaign to educate and support outreach to the public and health care providers; and
- Supports PCCs to help prevent and manage poisonings and toxic exposures, and comply with accreditation requirements.

The program ensures that individuals can call from anywhere in the United States and the U.S.-affiliated jurisdictions and connect to the PCC that serves their respective area. The program maintains the toll-free Poison Help line, provides interpretation services in over 161 languages, and offers services for the hearing impaired. Through the PCCs, individuals and families have access to health care providers and other specially trained toxicology experts twenty-four hours a day, seven days a week who provide assessments, triage, and treatment recommendations at no cost to callers across the United States. PCCs are consulted for a range of exposures including, for example, when a child swallows a household product; when an adolescent intentionally ingests an over-the-counter medication; when a worker is exposed to harmful substances; or when a senior takes an additional dose of a prescribed medication. Emergency professionals regularly consult PCCs in managing poisonings. PCCs also follow-up to monitor case progress and document medical outcomes.

PCCs can provide critical real-time surveillance data to identify public health emergencies. Access to around-the-clock professional guidance from PCCs decreases unnecessary visits to emergency departments and underscores the PCCs' role as trusted sources of information to prevent and manage poisonings and related health concerns. For example, PCCs provide education about the safe use of generators during loss of electrical power to reduce risk of carbon

monoxide poisoning and death; and when new poisons such as the synthetic opioid fentanyl enter a community, PCCs help community providers address these types of life threatening poisonings and provide education to the public.

Additionally, the PCP supports a national Poison Help media campaign, which educates the public and health care providers about poison and toxic exposure prevention, poison resources in local communities, and advertises the national toll-free Poison Help line.

Budget Request

The FY 2026 Budget Request for the Poison Control program is $26.8 million. This requested funding level will support the 54 PCCs[92] in the United States. These grants provide a small base of support for each PCC, contributing on average 13 percent to each PCC's overall budget that is needed to maintain infrastructure and core triage and treatment services. The FY 2026 request will continue to support interpretation services for non-English speaking callers and maintenance of the national toll-free Poison Help line. The nationwide media campaign will continue to provide education about poisoning and toxic exposure prevention, the availability of the national toll-free number, and local PCC services.

Eligible entities for funding through the Poison Control program are accredited Poison Control Centers that include domestic organizations within the United States, territories, or compacts of free association.

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

Funding History

FY	Amount
FY 2022 Final	$25,846,000
FY 2023 Final	$26,846,000
FY 2024 Final	$26,846,000
FY 2025 Enacted	*
FY 2026 President's Budget	$26,846,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

[92] The Puerto Rico Poison Center and the National Capital Poison Center have closed operations. Other accredited poison centers are currently providing services to Puerto Rico and the Washington DC area

Program Accomplishments

In 2023, PCCs managed 2.42 million encounters.[93] Calls from health care facilities have returned to pre-pandemic levels, while still accounting for 24 percent of all human exposure cases in 2023. Sixty-six percent of calls originated from residences and were managed by the PCC without requiring emergency medical attention.

In FY 2024, the Poison Help campaign distributed paid public service announcements (PSAs) through traditional platforms, including broadcast television networks, national and regional cable networks, and radio stations. The campaign also distributed PSAs on several social media platforms.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
5030.02: Number of calls received each fiscal year via the national, toll-free, Poison Help line *(Output)*	FY 2023: 2,956,285 Target: 2,900,000 (Target Exceeded)	*	2,900,000	*
5030.03: Number of human cases of poison exposure managed by the Nation's Poison Control Centers *(Output)*	FY 2023: 2,428,257 Target: 2,150,000 (Target Exceeded)	*	2,130,000	*

* Performance targets under development.

[93] Gummin DD, Mowry JB, Beuhler MC, Spyker DA, Rivers LJ, Feldman R, Brown K, , Nathaniel PTP, Bronstein AC, & DesLauriers, C . (2024). 2023 Annual Report of the National Poison Data System (NPDS) from America's Poison Centers: 41st Annual Report. Clinical Toxicology, 62;12:793-1027.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards[94]	51	*	51
Average Awards	$459,357	*	$459,357
Range of Award	$91,632-$2,782,395	*	$91,632-$2,782,395

*Grant award estimates under development.

Contracts Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Contracts	2	*	2
Average Contract	$584,214	*	$611,880
Range of Contracts	$581,796-$586,632	*	$605,181-$618,578

*Contract award estimates under development.

[94] There are 54 Poison Control Centers across the U.S. and 51 awards were made in FY 2024. For grant purposes, AHA counts the California Poison Control System as a single entity, while it encompasses multiple California poison centers.

Family-To-Family Health Information Centers

	FY 2024 Final[95]	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Current Law Mandatory	$5,658,000	$6,000,000	---	-$6,000,000
Proposed Mandatory	---	---	$6,000,000	+$6,000,000
Total	$5,658,000	$6,000,000	$6,000,000	---
FTE	**	**	188[1]	

****FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Method:

- Competitive grant/co-operative agreement

Program Description

The Family-to-Family Health Information Centers (F2F HICs) program offers families of children and youth with special health care needs (CYSHCN) peer support and information on accessing care and coverage for their children's complex needs. Staffed by family members of CYSHCN with first-hand experience navigating health care and other needed services and supports for their children, F2F HICs also advise health care professionals on developing more effective partnerships with families. The program aims to empower families of CYSHCN to be active partners in health care decision making. F2F HIC supports include:

- Guidance on building productive relationships between families and health professionals
- Training and guidance for health professionals on caring for CYSHCN
- Promoting F2F HIC services and resources to families, health professionals, schools, etc.
- Engaging families of CYSHCN and health professionals as staff and leaders for these programs

When families are empowered to make informed choices about their care and partner with health professionals, evidence shows CYSHCN experience improved health outcomes and cost-savings.[96] 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

[95] Amount reflects post-sequestration
[96] Smalley et al. (2014). Family perceptions of shared decision-making with health care providers: Results of the National Survey of CYSHCN, 2009-2010. Doi 10.1007/s10995-013-1365-z

- Increased access to preventive health care in a medical home.

Budget Request

The FY 2026 Budget Request extends mandatory funding for Family-to-Family Health Information Centers at $6 million, which is equal to the current authorized amount. Funding will continue to support the 59 F2F HICs nationwide that provide patient-centered information, education, technical assistance, and peer support to families of CYSHCN. The F2F HICs will continue to support targeted outreach and leadership development to specific underrepresented populations, such as populations living in rural or urban areas. F2F HICs also continue to develop partnerships with organizations serving families.

Eligible applicants include any domestic public or private entity. Domestic faith-based and community-based organizations, tribes, and tribal organizations are eligible to apply. Eligibility is limited to applicants within the 50 states, the District of Columbia, the 5 U.S. Territories and entities that will serve American Indian and/or Alaska Native Tribes.

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

Funding History

FY	Amount[97]
FY 2022 Final	$5,658,000
FY 2023 Final	$5,658,000
FY 2024 Final	$5,658,000
FY 2025 Enacted	$6,000,000
FY 2026 President's Budget	$6,000,000

Program Accomplishments

F2F HICs provided services to 171,204 families according to FY 2024 grantee data reported to AHA. FY 2024 survey data reveal that ninety percent of families reported that the information they received from an F2F HIC met their needs and ninety-four percent reported they would recommend F2F HIC services to another family. Eighty-six percent of families reported that the information or services received from F2F HICs helped prepare them to work with those who serve their children.

Additionally, F2F HICs trained and provided information, resources, and referrals to 81,144 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 according to FY 2024 grantee data reported to AHA. FY 2024 survey data show ninety-one percent of professionals

[97] FY 2021-FY 2024 funding amounts reflect the post-sequestration amount.

served by an F2F HIC reported they were satisfied with the information received and ninety-three percent would recommend F2F HIC services to families or other professionals. Eighty-nine percent of professionals reported the information or services received from F2F HICs helped prepare them to work better with families and/or others who serve CYSHCN.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3100.01**:** Number of families with children with special health care needs who have been provided information, education, and/or training from Family-to-Family Health Information Centers *(Outcome)*	FY 2024: 171,204 Target: 210,000 (Target Not Met)	171,204	171,204	Maintain
3100.02**:** Number of professionals who serve children with special health care needs who have been provided information, education, and/or training from Family-to-Family Health Information Centers *(Output)*	FY 2024: 81,144 Target: 100,000 (Target Not Met)	81,144	81,144	Maintain

Grant Awards Table[98]

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	59	59	59
Average Award	$87,044	$94,794	$94,794
Range of Awards	$38,219-$96,750	$38,219-$96,750	$38,219-$96,750

[98] Does not include carryover funding. FY 2024 reflects post-sequestration funding.

Maternal, Infant, and Early Childhood Home Visiting Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA[99]	$518,650,000	$565,800,000	$612,950,000
FTE	**	**	188[1]

****FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

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

Program Description

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program supports pregnant women and parents with young children who live in communities that face greater risk and barriers to achieving positive maternal and child health outcomes. The MIECHV Program builds upon decades of gold-standard scientific research showing that voluntary home visits by a nurse, social worker, or other trained professional during pregnancy, and in the first years of life can improve the lives of children and families by:

- Helping to prevent childhood and adult chronic disease and behavioral health conditions;
- Supporting families to prevent child abuse and neglect;
- Promoting child development and school readiness; and
- Boosting families' economic self-sufficiency.

The MIECHV Program is administered by the Administration for a Healthy America (AHA) in partnership with the Administration for Children and Families (ACF). State and jurisdiction grantees conduct statewide needs assessments to identify eligible at-risk communities, reach statutorily-defined priority populations, and choose one or more of the 24 approved evidence-based home visiting models or identify promising approaches that will best meet the specific needs of their states and communities. As part of all MIECHV programs, trained home visiting professionals meet regularly in the home with expectant parents or families with young children who want and ask for help. Home visitors provide services tailored to families' needs, such as:

- Educating on topics such as breastfeeding, safe sleep, injury prevention and nutrition, and promoting healthy lifestyles.
- Screening and providing referrals to address caregiver mental health needs and family violence.
- Screening children for developmental delays and facilitating early diagnosis and intervention for autism and other developmental disabilities.

[99] FY 2024, FY 2025, and FY 2026 reflect the post-sequestration funding amount.

- Creating a language-rich environment that stimulates early language development and prepares children to succeed in school.
- Supporting parents to reach economic goals, like going back to school or obtaining employment.
- Connecting families to health care and other community resources that meet their needs.

Consistent with the program's authorizing statute, AHA distributes MIECHV funds through base and matching grants to states, jurisdictions, and nonprofit organizations and ACF distributes MIECHV funds through competitive cooperative agreements to Indian tribes, tribal organizations, and urban Indian organizations. Statute sets aside funds for other purposes, such as technical assistance, workforce supports, including the Jackie Walorski Center for Evidence-Based Case Management, and research, evaluation, and federal administration.

- **Base Grants:** In FY 2024, MIECHV awarded $406 million in base grants to 56 states, jurisdictions, and nonprofit organizations. Grants are generally administered by the lead state agency for home visiting designated by the Governor, or they can be competitively awarded to a nonprofit organization in those states or jurisdictions that opted not to participate in the grant program. By law, state and jurisdictional grantees must spend the majority of their MIECHV funds to implement evidence-based home visiting models, with up to 25 percent of funding available to implement promising approaches that undergo rigorous evaluation.
- **Matching Grants:** In FY 2024, MIECHV awarded $37 million in matching grants to 53 states, jurisdictions, and nonprofit organizations. The same entities that administer the base grants administer matching grants. This funding approach ensures efficient oversight of MIECHV funds and the development of comprehensive statewide early childhood home visiting systems.
- **Tribal Awards:** Six percent of MIECHV funding is reserved for grants to Indian tribes, tribal organizations, and urban Indian organizations. In FY 2024, funding supported 47 awards to tribal entities through the Tribal MIECHV Program. The program:
    - Improves tribal capacity to support and promote the health and well-being of American Indian and Alaska Native families through home visiting programs;
    - Expands the evidence base around home visiting in tribal communities; and
    - Supports and strengthens cooperation and linkages between programs that serve Native children and their families.

Budget Request

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is funded at $612.9 million in FY 2026, with sequestration, and at $754.4 million in FY 2027, with sequestration. 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 improve maternal and child health, help prevent child abuse and neglect, and promote child development and school readiness. Statute requires the allocation of funding for certain activities. In FY 2026, this level of funding will provide:

- Awards to 54 state and territory grantees and two non-profit organizations.
- Awards to approximately 53 tribal entities.
- Technical assistance for state, jurisdictional, and tribal MIECHV grantees.

- Support for the home visiting workforce, workforce retention, and case management, including the operation of the Jackie Walorski Center for Evidence-Based Case Management.
- Support for research, evaluation, and federal administration.

Table 1. Mandatory Funding (FY 2023 – FY 2027)[100]

MIECHV Program	**FY 2023**	**FY 2024[101]**	**FY 2025[102]**	**FY 2026[103]**	**FY 2027[104]**	**Five-Year Total**
Mandatory Funding	$500,000,000	$550,000,000	$600,000,000	$650,000,000	$800,000,000	$3,100,000,000
Base Funding[105]	*$500,000,000*	*$500,000,000*	*$500,000,000*	*$500,000,000*	*$500,000,000*	*$2,500,000,000*
Matching Funding[106]	---	*$50,000,0000*	*$100,000,000*	*$150,000,000*	*$300,000,000*	*$600,000,000*

The increase in funds will expand the capacity of MIECHV grantees to reach more communities and families. Currently, MIECHV-funded programs serve over 75,000 families, reaching approximately 19 percent of the more than 397,000 families who are likely currently eligible and in need of MIECHV services.[107] Through FY 2027, funding increases will allow MIECHV-funded programs to provide comprehensive, coordinated home visiting services to additional communities and families through targeted evidence-based home visiting. Funds will continue to support a portfolio of research and evaluation on home visiting, technical assistance to ensure families have access to quality evidence-based and promising home visiting service delivery models, and workforce supports to ensure a well-trained and stable home visiting workforce.

Eligible entities for the state/jurisdiction MIECHV Program include all 50 states and 6 territories and jurisdictions: the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands, and American Samoa. Nonprofit organizations that provide services in states that do not apply for and receive award funding are also eligible to apply so long as the state, territory, or jurisdiction continues not to apply. Eligible entities for the Tribal MIECHV Program include federally recognized Indian tribes (or consortium of tribes), tribal organizations, and urban Indian organizations.

[100] FY 2024 – FY 2027 subject to sequestration
[101] Appropriation as provided through the Consolidated Appropriations Act, 2023 (Public Law 117-328, Section 6101). However, FY24 post-sequestration amount is $518.65 million.
[102] Appropriation as provided through the Consolidated Appropriations Act, 2023 (Public Law 117-328, Section 6101). However, FY25 post-sequestration amount is $565.80 million.
[103] Appropriation as provided through the Consolidated Appropriations Act, 2023 (Public Law 117-328, Section 6101). However, FY26 post-sequestration amount is $612.95 million.
[104] Appropriation as provided through the Consolidated Appropriations Act, 2023 (Public Law 117-328, Section 6101). However, FY27 post-sequestration amount is $754.40 million.
[105] Base Funding amounts do not exclude reservation amounts to support Tribal entities; technical assistance; workforce support, retention, and case management; and research and evaluation.
[106] Matching Funding amounts do not exclude reservation amounts to support Tribal entities; technical assistance; workforce support, retention, and case management; and research and evaluation.
[107] AHA internal analysis using 2024 CPS Annual Social and Economic Supplement 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.

Funding History

FY	Amount[108]
FY 2022 Final	$377,200,000
FY 2023 Final	$500,000,000
FY 2024 Final	$518,650,000
FY 2025 Enacted	$565,800,000
FY 2026 President's Budget	$612,950,000

Program Accomplishments

MIECHV state and jurisdictional grantees provided over 10.8 million visits from FY 2012 through FY 2024. In FY 2024, states reported serving more than 150,000 parents and children in over 1,100 counties across all 50 states, the District of Columbia, and 5 territories. This is more than a 300 percent increase in the number of participants served since FY 2012 (see Table 1 below). Tribal grantees provided approximately 199,500 home visits from FY 2012 to FY 2024 and served more than 3,700 parents and children in FY 2024.

Table 1: Number of State/Jurisdictional Participants and Home Visits (FY 2012 – FY 2023)[109]

Fiscal Year	Number of Participants	Number of Home Visits
2012	34,180	174,257
2013	75,970	489,363
2014	115,545	746,303
2015	145,561	894,347
2016	160,374	979,521
2017[110,111]	156,297	942,676
2018[112]	150,291	930,595
2019	154,496	1,015,217
2020[113]	140,606	928,130

[108] Reflects post-sequestration amounts in FY 2021, FY 2022, FY 2024, FY 2025, and FY 2026.
[109] Data in Table 1 represent the number of participants and home visits provided by state and jurisdictional grantees (does not include tribal data).
[110] Reflects changes AHA 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.
[111] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.
[112] Does not include data from the Commonwealth of the Northern Mariana Islands due to reporting delays caused by Super Typhoon Yutu.
[113] 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.

Fiscal Year	Number of Participants	Number of Home Visits
2021[114]	140,674	921,706
2022[115]	137,802	841,694
2023[116]	139,695	919,456
2024	150,332	989,651

The MIECHV Program is effective at reaching families with significant needs living in at-risk communities. In FY 2024:

- 92 percent of participating families had household incomes at or below 200 percent of the federal poverty guidelines[117] ($62,400 for a family of four), 68 percent were at or below 100 percent, and 42 percent were at or below 50 percent of those guidelines.
- 22 percent of adult program participants had less than a high school education, and 39 percent had only a high school degree or equivalent.
- 7 percent of households included pregnant teens; 17 percent reported a history of child abuse and maltreatment; and 14 percent reported substance abuse.

The MIECHV Program achieves positive outcomes for families. In the most recent assessment required by law (FY 2023), all state and jurisdictional grantees showed performance improvement in at least four of the six MIECHV benchmark outcome areas:[118]

- Improving maternal and newborn health.
- Preventing child injuries, maltreatment, and emergency department visits.
- Improving school readiness and achievement.
- Reducing crime or domestic violence.
- Improving family economic self-sufficiency.
- Improving service coordination and referrals for other community resources.

[114] FY 2021 results were impacted by funding cuts due to sequestration and the impacts of COVID-19 on enrollment and service delivery.
[115] FY 2022 results were impacted by funding cuts due to sequestration, the impacts of COVID-19 on enrollment and service delivery, and significant issues with workforce recruitment and retention across the early childhood care and education field.
[116] FY 2023 results were impacted by funding cuts due to sequestration and significant issues with workforce recruitment and retention across the early childhood care and education field.
[117] The HHS Poverty Guidelines are updated annually in February and published in the Federal Register. See https://aspe.hhs.gov/poverty-guidelines
[118] Section 511 of the Social Security Act [42 U.S.C. 711] includes statutory requirements for demonstration of improvements. https://www.ssa.gov/OP_Home/ssact/title05/0511.htm.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3110.04: Percentage of children enrolled in the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program who received daily early language and literacy support from a family member (Outcome)	FY 2024: 82.3% Target: 72.3% (Target Exceeded)	75.9%	77.3%	+1.4 percentage points
3110.05: Percentage of parents enrolled in the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program who were screened for depression after enrollment or after giving birth (Outcome)	FY 2024: 80.4% Target: 78.8% (Target Exceeded)	79.5%	79.6%	+0.1 percentage points
3110.06: Number of home visits to families receiving services under the State/Jurisdiction Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program (Output)	FY 2024: 989,651 Target: 1,201,701 (Target Not Met)	1,310,957	1,349,620	+38,663

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3110:07: Number of home visits to families receiving services under the Tribal Maternal, Infant, and Early Childhood Home Visiting Program. (Output)	FY 2024: 18,677 Target: 22,036 (Target Not Met)	36,000	37,600	+1,600
3110.08: Number of participants served by the State/Jurisdiction Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program (Outcome)	FY 2024: 150,332 Target: 167,096 (Target Not Met)	189,498	192,478	+2,980
3110.09: Number of participants served by the Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program (Outcome)	FY 2024: 3,718 Target: 4,427 (Target Not Met)	6,500	6,950	+450

Grant Awards Tables[119,120]

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	104	110	116
Average Award	$4,639,140	$4,791,593	$4,896,983
Range of Awards	$275,000-$26,402,603	$250,000-$27,892,590	$250,000-$31,773,392

[119] The table does not include carryover funding.
[120] Award projections are based on a funding formula codified in statute (Social Security Act, Title V, as amended by Public Law 117-328, Section 6101).

Birth Defects, Developmental Disabilities, Disability and Health

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$206,060,000	$206,060,000	$157,810,000
Child Health and Development	**$75,550,000**	*****	**$68,050,000**
Birth Defects (non-add)	*$19,000,000*	*	*$19,000,000*
Fetal Death (non-add)	*$900,000*	*	*$900,000*
Fetal Alcohol Syndrome (non-add)	*$11,500,000*	*	*$11,000,000*
Folic Acid (non-add)	*$3,150,000*	*	*$3,150,000*
Infant Health (non-add)	*$8,650,000*	*	*$8,650,000*
Autism (non-add)	*$28,100,000*	*	*$23,100,000*
Neonatal Abstinence Syndrome (non-add)	*$4,250,000*	*	*$2,250,000*
Health and Development for People with Disabilities	**$86,410,000**	*****	**$72,660,000**
Disability and Health (non-add)	*$45,500,000*	*	*$36,000,000*
Tourette Syndrome (non-add)	*$2,500,000*	*	*$2,000,000*
Early Hearing Detection and Intervention (non-add)	*$10,760,000*	*	*$10,760,000*
Muscular Dystrophy (non-add)	*$8,000,000*	*	*$6,000,000*
Attention Deficit Hyperactivity Disorder (non-add)	*$1,900,000*	*	*$1,900,000*
Fragile X (non-add)	*$2,000,000*	*	*$2,000,000*
Spina Bifida (non-add)	*$7,500,000*	*	*$7,000,000*
Congenital Heart Failure (non-add)	*$8,250,000*	*	*$7,000,000*

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Blood Disorders and Other Programs	**$21,100,000**	*****	**$17,100,000**
Public Health Approach to Blood Disorders (non-add)	*$10,400,000*	*	*$6,400,000*
Hemophilia CDC Activities (non-add)	*$3,500,000*	*	*$8,600,000*
Hemophilia Treatment Centers (non-add)	*$5,100,000*	*	---
Thalassemia (non-add)	*$2,100,000*	*	*$2,100,000*
FTE	**	**	188[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
******FY 2024 and FY 2025 FTE included in CDC FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

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

Program Description

The birth defects, developmental disabilities, blood disorders, and disability and health programs, formerly at CDC, promote optimal health across the lifespan by advancing science, leadership, research, tools, and surveillance. This funding will support programs to measure the impact of birth defects, disabilities, and blood disorders and put research findings and recommendations into public health action to foster a safer, healthier population. Programs span across three focus areas, infant health and child development, health and development for people with disabilities, and blood disorders and other programs.

Infant and Child Health and Development

Infant health and child development programs focus on studying and addressing the causes of birth defects and stillbirth to save babies and helping children reach their potential by understanding developmental disabilities. Supported activities help track, analyze, understand, and support prevention and public health actions to promote optimal outcomes. This includes investments in:

- **Birth defects surveillance** to identify prevalence and detect trends in birth defects and funds states to conduct birth defects surveillance through existing cooperative agreements. Every year, 3.6 million babies are conceived in the United States. For 1 in

every 33 of these pregnancies, parents will receive news that their baby has a birth defect. Babies born with a birth defect are more likely to die before their first birthday, while those who survive may face lifelong challenges, such as mobility issues, urinary and bowel problems, and learning disabilities. In the U.S., more than $22 billion per year is spent on medical costs associated with birth defects.

- **Fetal alcohol spectrum disorders (FASDs)** data gathering and analysis to better understand diagnosed **FASDs** among children and alcohol and other substance use during pregnancy. FASDs include a range of lifelong behavioral, intellectual, and physical disabilities caused by Alcohol use during pregnancy. Despite the known adverse effects of FASD, alcohol use during pregnancy remains a critical public health issue. Collected data helps inform collaborations with national partners to implement evidence-based strategies to address substance use during pregnancy and support children with FASDs and their families.

- **Folic Acid** and prevention risk factors for Neural Tube Defects (NTDs) and other birth defects. While most NTDs can be prevented if a woman consumes 400 micrograms (mcg) of folic acid daily before and during early pregnancy, about 23 percent of women remain at elevated risk for NTDs. Identifying who is a risk allows women to make informed decisions about nutrition before and during pregnancy. This program supports a study to identify risk factors focusing on chronic health conditions that might impact a woman's folate levels and increase the risk for birth defects. The program also assesses the safety and effectiveness of folic acid to inform educational materials and support decision making.

- **Stillbirth** activities, including implementing as many of the March 2023 Stillbirth Task Force report recommendations, and continuing support for three centers in Arkansas, Massachusetts, and New York for the Birth Defects Study to Evaluate Pregnancy exposureS (BD-STEPS) to better understand stillbirth risk factors. Stillbirth is the loss of a baby at or after 20 weeks of pregnancy, one of the most common and devastating adverse pregnancy outcomes.

- **Infant health** programs to promote and improve the health of people living with birth defects, infant disorders, and related conditions, and to identify and address preventable causes of such conditions. In FY 2025, the program focused on identifying risk factors for birth defects and stillbirth and supported seven centers including the Georgia center that supports the decade-long BD-STEPS. BD-STEPS uses a population-based public health approach to look at babies who have birth defects and families who have experienced stillbirth to identify possible causes and protective factors of birth defects and stillbirths. In FY 2026, priority topics will include the role of chronic disease and nutrition.

- **Autism spectrum disorder (ASD)** programs to monitor the number of children affected and support early identification. ASD is a developmental disability caused by differences in the brain, affecting social communication, interaction, and leading to restricted or

repetitive behaviors. An estimated 1 in 31 children (3.2%) are identified with ASD, though prevalence varies widely across communities, from 1 in 103 in Texas (Laredo) to 1 in 19 in California. ASD investments track the prevalence and characteristics of ASD among children in 16 communities through the Autism and Developmental Disability Monitoring (ADDM) Network, which also monitors co-occurring conditions and transition planning for teens, along with cerebral palsy (CP) at select sites. Further, the Study to Explore Early Development (SEED), launched in 2007, investigates ASD's causes, characteristics, and co-occurring health conditions, with recent expansions focusing on adolescents and adults. SEED has gathered data on over 6,000 children, including more than 1,800 with ASD, providing insights into how individuals with ASD transition to adulthood. Additionally, the "Learn the Signs. Act Early." (LTSAE) program supports early identification of developmental disabilities, helping families and providers recognize developmental milestones and take timely action, supported by 64 Act Early Ambassadors across the country and a widely used Milestone Tracker app, downloaded over 2.4 million times.

- **Neonatal Abstinence Syndrome** which supports surveillance and communication with providers to increase reporting to better understand the effects of multiple substances and their links to Neonatal Abstinence Syndrome (NAS). NAS is a withdrawal syndrome that can occur in newborns after exposure to opioids during pregnancy.

Health and Development for People with Disabilities

Programs focused on the health and development for people with disabilities seek to protect people with disabilities by reducing complications and improving their health. This includes investments in the following activities:

- **Disability and Health** to support state disability and health programs to address health differences among adults with disabilities and the development of an implementation science model to improve health and well-being among people with disabilities. This program maintains critical partnerships with the National Center on Health, Physical Activity and Disability (NCHPAD) and Special Olympics to reduce health differences and support healthy athletes.

  This program is also working to ensure that people with disabilities are included in public health monitoring and disease prevention and health promotion efforts. This includes addressing multiple areas where people with disabilities are not included or are underrepresented in public health data. These data are essential for identifying targeted support and interventions in the community to address significant differences and enhance quality of life for people with disabilities across the lifespan.

- **Tourette Syndrome** support partners to conduct research on the nearly one in 50 children aged 5 to 14 years with persistent tic disorders, including Tourette Syndrome **(TS)**, to better understand prevalence, risk and protective factors, and health risk behaviors. TS data are used to improve identification of tic disorders in community and clinical settings, treatment of TS, and to address racial and ethnic differences in identification and diagnosis. This program has funded a study to develop and evaluate diagnostic and screening tools for tic disorders. In addition, this program is examining

healthcare expenditures related to tic disorders using claims data. This program also supported the Tourette Association of America's Centers of Excellence to expand the reach of healthcare provider and educator trainings.

- **Early Hearing Detection and Intervention (EHDI)** which supports 38 states and Puerto Rico in FY 2024 to optimize their Early Hearing Detection and Intervention Information Systems to collect, manage, and analyze data related to EHDI programs. Nearly one out of every 500 infants in the United States are born deaf or hard of hearing. Undiagnosed hearing loss can result in serious and long-term consequences by affecting a child's ability to develop speech, language, and social skills. Early identification and intervention in infants can significantly improve developmental outcomes for children.

- **Muscular Dystrophy** to support public health research and collaboration with partners to improve the health and quality of life for people with Muscular Dystrophies by understanding the impact of living with these complex conditions, promoting early diagnosis, and improving care and services. Muscular dystrophies (MDs) are a group of genetic muscle diseases that, over time, cause muscle weakness and wasting, leading to decreased mobility, making the tasks of daily living difficult. There are many muscular dystrophies that vary in age of onset, severity, and patterns of inheritance. This program funds the only population-based surveillance system for muscular dystrophy in the United States, the Muscular Dystrophy Surveillance Tracking and Research Network (MD STARnet). In FY 2024, the program awarded 6 states to conduct longitudinal, population-based surveillance of select muscular dystrophies. This information will help determine prevalence, survival, healthcare needs, disease progression, and other factors that lead to better outcomes.

- **Attention Deficit Hyperactivity Disorder** to support public health efforts for people with ADHD across the lifespan through data, evidence-informed strategies, and partnerships. ADHD is a neurodevelopmental disorder that starts in childhood and often lasts into adulthood. An estimated 7 million children aged 3-17 years (11%) and an estimated 15.5 million adults (6%) have ADHD in the United States. Children with ADHD are at significantly greater risk for other co-occurring mental, developmental, and behavioral disorders. Excess expenses related to childhood ADHD cost Americans up to $124.5 billion per year. This program supports the Children and Adults with ADHD's National Resource Center for evidence-based web resources, virtual trainings, and a live helpline on ADHD for individuals and families, educators, and providers across the United States. In FY 2026, the program will continue to work with partners to promote optimal health and development among children and adolescents with ADHD and describe the public health impact of ADHD.

- **Fragile X** to support FORWARD-MARCH, the latest research study designed to learn more about Fragile X (FXS), the most common inherited cause of intellectual disability**.** FORWARD-MARCH builds on an earlier study, the National Fragile X Foundation's Fragile X Online Registry with Accessible Research Database (FORWARD) which helps researchers and health care providers learn more about co-occurring conditions among individuals with FXS, the impact of FXS on daily living, short-term and long-term

outcomes, and effective interventions and support. More than 600 children and adolescents with FXS and their families from across 22 FXS clinics throughout the United States are participating in the study.

- **Spina Bifida** to support the National Spina Bifida Patient Registry (NSBPR), the Spina Bifida Surveillance across Time and Regions (SB STAR) project, and treatment innovations to help inform clinicians, patients and parents about effective treatment strategies for people of all ages with spina bifida. Approximately 1,400 babies born in the United States each year are affected by spina bifida (SB), a complex, disabling condition that affects the spine and is usually apparent at birth. SB, a neural tube defect, has a tremendous impact on individuals and families, including high healthcare costs associated with frequent surgeries and hospitalizations. The lifetime direct costs to treat just one child with SB are estimated at $790,000.

  The NSBPR is the largest SB patient registry in the United States to understand patient care and longer-term health. Data analysis from NSBPR is underway to better understand health differences for infants living with SB. The Spina Bifida Surveillance across Time and Regions (SB STAR) has recently been implemented to collect health data from people with spina bifida regardless of where they receive care, helping improve understanding of long-term health outcomes, mortality, and prevalence. Funding also supports 9 sites developing and testing the gold standard protocol to preserve kidney function in young children.

- **Congenital Heart Failure** to support the Congenital Heart Defects Surveillance across Time And Regions (CHD STAR) project and the Congenital Heart Survey To Recognize Outcomes, Needs, and well-being (CH STRONG). Congenital heart defects (CHDs) affect the structure of the heart and the way it functions. Collectively, CHDs are the most common type of birth defect. Thanks to advancements in medical care and treatment, infants with CHDs are living longer and healthier lives. However, children with CHDs face new challenges as they transition into adulthood, including increased risk of pregnancy complications and longer-term co-morbidities. The CHD STAR project examines the health of children and adults with heart defects over a 10-year period. To modernize CHD surveillance, funding supports a site to examine whether machine learning can improve the quality of CHD surveillance data. Additionally, eight states are working to better understand when and how critical CHDs are detected, racial and ethnic groups most at risk for late detection, and other barriers to timely detection and intervention.

  CH STRONG gathers information to improve the lives of people living with heart defects. The survey found that many of the estimated 1.4 million adults with congenital heart defects in the U.S. may not be receiving specific care for their heart, despite recommendations for ongoing cardiology care. The CH STRONG-KIDS surveys parents and caregivers of children with CHDs about their child's healthcare utilization, barriers to care, quality of life, social and educational outcomes, and transition of care from childhood to adulthood as well as needs and experiences of the caregiver.

Blood Disorders

Blood disorders and other programs focus on protecting people by reducing complications of blood disorders, genetic conditions, and other conditions. Programs focus on surveillance, research, prevention, and education This includes investments in the following activities:

- **Public Health Approach to Blood Disorders** to address the needs of the one in 76 Americans affected by a blood disorder by gathering data on patient outcomes over time, targeting education campaigns to improve understanding of how to be healthy while living with blood disorders, and working with partners to ensure doctors and patients know how to prevent complications from both heritable and acquired blood disorders.

- **Hemophilia** to support monitoring to improve the health of people with hemophilia, an inherited bleeding disorder in which blood does not clot properly. This can lead to spontaneous bleeding (bleeding that occurs for no known reason) as well as bleeding following injuries or surgery, as well as damage to internal organs, chronic joint disease, and pain. This program works closely with Hemophilia Treatment Centers (HTC) across the country to monitor the health of people with hemophilia. Community Counts is a surveillance system that gathers individual and population-level data to help physicians and scientists improve the lives of people with hemophilia. The data visualization tool for Community Counts represents the largest U.S. publicly accessible database with over 88,000 individuals with bleeding disorders receiving care at HTCs. This program makes data available to the patients, providers, and public.

- **Thalassemia** which supports projects to improve care for patients with Thalasseima. Thalassemia is a group of genetic red blood cell disorders that cause anemia beginning at birth and lasting throughout life. People with thalassemia require blood transfusions to live, which places them at higher risk for transfusion-related infections and complications that can result in organ failure and early death. In FY 2024, CDC concluded the Transfusions Complications Monitoring project to learn more about treatment complications associated with blood transfusions for thalassemia and sickle cell disease (SCD). The goal of the project was to improve access to, coordination of, and continuity of healthcare for people with thalassemia or SCD, leading to fewer transfusion-related complications and improved quality, and increased lifespan.

Budget Request

The FY 2026 request for Birth Defects, Developmental Disabilities, Disabilities and Health, is $157.8 million. The FY 2026 request supports the planned HHS realignment of these activities from CDC to AHA.

At this funding level, AHA will continue to support critical child health and development programs, including the birth defects program at $19 million to support surveillance to identify prevalence and detect trends in birth defects and funding states to conduct birth defects surveillance. The budget will also continue funding to address Autism at $23.1 million, infant health at $8.7 million, fetal alcohol syndrome at $11 million, fetal death at $0.9 million, and folic acid at $3.2 million.

The budget request continues support for activities to support the health and development for people with disabilities, including $36 million to support the Disability and Health, $2 million for the Tourette Syndrome, $10.8 million for the Early Hearing Detection and Intervention, $6 million for Muscular Dystrophy, $1.9 million the Attention Deficit Hyperactivity Disorder, $2 million for the Fragile X, $7 million for Spina Bifida, and $7 million for the Congenital Heart Defects.

The budget also continues key investments in blood disorder and other programs, including $6.4 million for the Public Health Approach to Blood Disorders program, $8.6 million for the Hemophilia program, $2.1 million for the Thalassemia program, and $2.3 million for Neonatal Abstinence Syndrome 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. HHS policy requires maximum competition for discretionary grants to the greatest extent possible and restricting eligibility is only done with appropriate justification in rare cases. Awards may be made to domestic public or private, non-profit or for-profit organizations. Applicant eligibility criteria for all NOFOs are based on statute and/or program regulation. Applicants cannot apply for the same project or activities from multiple HHS Public Health Service agencies at the same time.

Funding History

FY	Amount
FY 2022 Final	$177,060,000
FY 2023 Final	$205,560,000
FY 2024 Final	$206,060,000
FY 2025 Enacted	$206,060,000
FY 2026 President's Budget	$157,810,000

Program Accomplishments

- In January 2024, the program updated national estimates for major birth defects. These bi-yearly national estimates are the foundational data that America uses to understand the number and type of birth defects affecting infants. Accurate estimates are critical to supporting clinicians and jurisdictions providing services and care to impacted families. This funding also supports work increasing jurisdiction's ability to efficiently connect families to necessary services such as Early Intervention and physical and educational therapies.
- The program is modernizing and improving birth defect data collection processes, ensuring timely data that meets national surveillance standards. These modernization efforts improve understanding of long-term health outcomes for children with birth defects by linking data to medical record information and death records.
- In September 2024, the program received the first data for population-based surveillance in Georgia, Illinois, Indiana, and southern Nevada to examine regional stillbirth prevalence using fetal death certificates and hospital discharge data. Notably, preliminary

abstractions from 2020 deliveries captured pathology reports, which are not commonly accessible in fetal death certificates. Pathology reports can provide important clues into cause of stillbirth.

- The program funded national partners, which developed a 12-part video series that highlights the living experience of FASDs. The videos have had over 30,000 views in their first five months since their launch in December 2024. Additionally, through program funding, FASD United's Family Navigator program supported over 1,800 inquiries from across the country, connecting people with much-needed resources and support.
- The infant health line is supporting the final year of data collection for a decade-long study of risk factors for birth defects and/or stillbirth. The nearly 8,500 interviews completed to date focus on factors that a woman may be able to change to reduce the chance of birth defects and/or stillbirth. This study is the second phase of one of the largest studies on causes of birth defects in the US.
- The Tourette Syndrome program leads public health efforts for people with TS through data, evidence-informed strategies, and partnerships so that all people with TS have positive health outcomes and access to services and supports. The program and TAA partnership has supported over 1,350 education programs reaching more than 60,000 professionals and community members in all 50 states as well as in Washington, D.C., and the territories.
- The program leads implementation of a new standardized case definition for monitoring the number of infants diagnosed with NAS at birth, which is used by 70% of reporting U.S. jurisdictions. Additionally, funded jurisdictions are able to connect affected families to services that support health and well-being.
- Findings from the National Spina Bifida Patient Registry found specific sociodemographic, medical, and functional factors are associated with the likelihood of employment for young adults living with SB. Some employment-associated factors, such as continence and self-management skills, are modifiable and are important for clinicians to consider as pediatric patients transition into adult care

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
5.2.8 Decrease the proportion of young children with permanent hearing loss whose enrollment status for early intervention services is unknown (Outcome)	FY 2022: 17.3% Target: 14% (Target Not Met)	*	11%	*

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
5.3.2 Decrease the prevalence of hemophilia treatment inhibitors among Community Counts - Health Outcomes Monitoring System for People with Bleeding Disorders at HTCs (Outcome)	FY 2023: 11% Target: 4.4% (Target Not Met)	*	10.4%	*
5.B Increase the proportion of children less than 4 years old with severe hemophilia A or B who are prescribed early prophylaxis (Output)	FY 2023: 87.2% Target: 84.5% (Target Exceeded)	*	88%	*

***** Performance targets under development.

Grant Awards Tables

Fetal Death (Stillbirth)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	3	*	*
Average Award	$142,667	*	*
Range of Awards	$58,000 - $310,000	*	*

* Grant award estimates are under development

Fetal Alcohol Syndrome

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	22	*	*
Average Award	$326,413	*	*
Range of Awards	$7,000 - $719,082	*	*

* Grant award estimates are under development

Folic Acid

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	3	*	*
Average Award	$95,096	*	*
Range of Awards	$44,000 - $123,000	*	*

* Grant award estimates are under development

Infant Health

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	17	*	*
Average Award	$186,391	*	*
Range of Awards	$18,619 - $486,435	*	*

* Grant award estimates are under development

Autism

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	21	*	*
Average Award	$621,459	*	*
Range of Awards	$329,593-$1,376,684	*	*

* Grant award estimates are under development

Neonatal Abstinence Syndrome

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	13	*	*
Average Award	$188,992	*	*
Range of Awards	$5,000 - $522,500	*	*

* Grant award estimates are under development

Disability and Health

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	12	*	*
Average Award	$2,565,613	*	*
Range of Awards	$572,500-$18,032,425	*	*

* Grant award estimates are under development

Tourette Syndrome

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	2	*	*
Average Award	$825,000	*	*
Range of Awards	$200,000 - $1,400,000	*	*

* Grant award estimates are under development

Early Hearing Detection and Intervention

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	39	*	*
Average Award	$160,000	*	*
Range of Awards	$95,000- $160,000	*	*

* Grant award estimates are under development

Muscular Dystrophy

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	11	*	*
Average Award	$344,727	*	*
Range of Awards	$42,000 - $650,000	*	*

* Grant award estimates are under development

Attention Deficit Hyperactivity Disorder

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	1	*	*
Average Award	$850,000	*	*
Range of Awards	$850,000	*	*

* Grant award estimates are under development

Fragile X

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	1	*	*
Average Award	$800,000	*	*
Range of Awards	$800,000	*	*

* Grant award estimates are under development

Spina Bifida

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	33	*	*
Average Award	$104,391	*	*
Range of Awards	$11,000 - $450,000	*	*

* Grant award estimates are under development

Congenital Heart Failure

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	22	*	*
Average Award	$217,219	*	*
Range of Awards	$33,000 - $550,000	*	*

* Grant award estimates are under development

Public Health Approach to Blood Disorders

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	17	*	*
Average Award	$300,206	*	*
Range of Awards	$204,099 - $389,527	*	*

* Grant award estimates are under development

Hemophilia

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	3	*	*
Average Award	$1,562,000	*	*
Range of Awards	$30,000 - $4,171,000	*	*

* Grant award estimates are under development

Thalassemia

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	2	*	*
Average Award	$99,134	*	*
Range of Awards	$52,768 - $145,500	*	*

* Grant award estimates are under development

Office on Women's Health

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$44,140,000	*	$30,000,000
FTE	**	**	188[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in OASH FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

- Contracts
- Competitive grants/cooperative agreements
- Direct federal

Program Description

- Establishes short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research, and public and health care professional education, for issues of particular concern to women throughout their lifespan;
- Provides expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;
- Monitors the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;
- Leads a Department of Health and Human Services Coordinating Committee on Women's Health, chaired by the Deputy Assistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;
- Administers the National Women's Health Information Center to—
    - Facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care;
    - Facilitate access to such information;
    - Assist in the analysis of issues and problems relating to the matters described in this paragraph; and
    - Provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);
- Coordinates efforts to promote women's health programs and policies with the private sector; and

- Provides platform for the exchange of information between the Office and recipients of OWH grants, contracts, and agreements, and between the Office and health professionals and the general public.

Budget Request

The FY 2026 President's Budget request for OWH is $30 million. At this level, OWH will lead the Department's priorities to advance Make America Healthy Again. OWH will focus on the prevention and treatment of chronic disease, infertility, menopause, eating disorders, preventing violence against women, and cancer, as well as other emerging women's health needs.

OWH will create measures with up-to-date data to address the chronic disease epidemic in women and girls. These measures will be based on gold standard science and be transparent so that Americans can understand how they can prevent and reverse chronic disease.

Funding History

FY	Amount
FY 2022 Final	$38,140,000
FY 2023 Final	$44,140,000
FY 2024 Final	$44,140,000
FY 2025 Enacted	*
FY 2026 President's Budget	$30,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

- OWH launched Protecting Women and Children to promulgate sex-based definitions and share resources to advance women's health research.
- The Stronger than Sarcopenia Campaign developed professional training and additional resources that raise awareness of sarcopenia and provide resources for women and health care providers.
- OWH launched the Menopause Hub to highlight menopause programs and policies. Content includes HHS research, programs and initiatives, and grant and other funding opportunities on perimenopause and menopause.

OWH will create measures with up-to-date data to address the chronic disease epidemic in women. These measures will be based on gold standard science and be transparent so that Americans can understand how they can prevent and reverse chronic disease.

Embryo Adoption Awareness Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$1,000,000	$1,000,000	$1,000,000
FTE	**	**	188[1]

****FY 2024 and FY 2025 FTE included in OASH FTE totals.
1\FY 2026 FTE represents entire Maternal and Child Health FTE total.

Allocation Methods:

- Contracts
- Competitive grants/cooperative agreements
- Direct federal

Program Description

The purpose of the Embryo Adoption Awareness (EAA) Program is to increase public awareness of embryo adoption and donation as a method of family building and to provide medical and administrative services to facilitate the use of embryo adoption and donation. The EAA program provides services to individuals who are currently involved, soon may be involved, or are interested in embryo adoption and donation as a method of family building. The program also provides services to medical facilities and providers involved in assisting individuals with embryo adoption and donation.

The EAA program provides funding annually to grantees, who increase knowledge, awareness, and understanding of embryo adoption and donation as a method of family formation; provide medical and administrative services to facilitate the use of embryo adoption and donation; monitor and evaluate the outcomes of their activities; and communicate and disseminate about their activities, successes, and lessons learned. The EAA program was first funded by Congress in 2002.

Budget Request

The FY 2026 Budget Request for the EAA Program is $1 million. The request will enable the EAA Program to continue to support public awareness and medical and administrative services to facilitate the use of embryo adoption and donation as a method of family formation.

The majority of EAA Program funding is distributed through competitively awarded grants. The remaining funding is used for contract support to collect and analyze grantee performance measure data, agency overhead costs, and costs for the competitive grant review.

Grant funding for the EAA Program is scheduled to be recompeted in FY 2026 as the currently funded EAA recipient projects end in September 2026. HHS anticipates awarding FY 2026 funds

to 3-5 new grant recipients for a project period of up-to five years. The last EAA Program grant competition was in FY 2021 and resulted in grant awards to 3 organizations for a five-year project period. Any public or private entity is eligible to apply for EAA grant funding.

Funding History

FY	Amount
FY 2022 Final	$1,000,000
FY 2023 Final	$1,000,000
FY 2024 Final	$1,000,000
FY 2025 Enacted	$1,000,000
FY 2026 President's Budget	$1,000,000

Program Accomplishments

In FY 2024, EAA program grantees used a variety of public awareness strategies to share information about embryo adoption and donation, including the use of informational websites, brochures, newsletters, and paid advertisements.

EAA recipients provided medical services, including general counseling, genetic counseling, and other medical services to a total to a total of 4,911 individuals. Recipients provided administrative services to 9,311 individuals, including matching services, counseling and education on financial issues, and legal services or counseling for prospective donors/adopters.

Recipients provided education to 10,737 medical professionals and disseminated educational materials. Across EAA recipients, 199 unique individuals signed an agreement to become an embryo adopter, and 274 individuals signed an agreement to become an embryo donor.

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	3	3	4
Average Award	$275,000	$275,000	$250,000
Range of Awards	$200,000-$300,000	$200,000-$300,000	$200,000-$300,000

MENTAL AND BEHAVIORAL HEALTH TAB

MENTAL AND BEHAVIORAL HEALTH

Project AWARE (Advancing Wellness and Resiliency in Education)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$140,001,000	*	$120,501,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grants/Contracts

Program Description

Between 2011 and 2021, a troubling surge in mental health challenges among adolescents saw nearly one-third report persistent feelings of sadness or hopelessness, highlighting a widespread escalation of depression and anxiety.[121] By 2023, the situations intensified, with almost 20 percent of high school students experiencing such acute distress that they seriously contemplated suicide, and nearly one in ten attempted it.[122] These troubling mental health issues are compounded by workforce shortages, limited access to resources, economic insecurity, school and community-based violence, behavioral health workforce shortages, and natural (e.g., tornadoes, hurricanes, earthquakes, power-outages) and human-caused (e.g., mass shootings, chemical spills) disasters.

Project AWARE (Advancing Wellness and Resiliency in Education) is a comprehensive school-aged youth program dedicated to enhancing capacity within schools and communities to deliver trauma-informed and developmentally appropriate services to children, youth, families, and communities. Project AWARE helps to build a sustainable framework and foundation across the country for school-based mental health programs and services.

Grant recipients build collaborative partnerships with state and local education and mental health agencies, community-based behavioral health care providers and other community organizations, and families, and school-aged youth. These partnerships are used to implement mental health related promotion, awareness, prevention, intervention, and resilience activities to ensure that school-aged youth have access to and are connected with appropriate and effective behavioral health services.

[121] Centers for Disease Control and Prevention. (2023).Youth Risk Behavior Survey Data Summary and Trends Report, 2022-2021. Available at https://www.cdc.gov/healthyyouth/data/yrbs/yrbs_data_summary_and_trends.htm
[122] Substance Abuse and Mental Health Services Administration. (2024). Highlights for the 2023 National Survey on Drug Use and Health. Available at https://www.samhsa.gov/data/sites/default/files/NSDUH%202023%20Annual%20Release/2023-nsduh-main-highlights.pdf

Project AWARE uses a three-tiered public health model, encompassing universal, targeted, and intensive strategies, with a particular emphasis on the first two tiers. Tier 1 emphasizes universal strategies to promote positive mental health and prevent problems across school settings, Tier 2 targets early intervention and prevention efforts for students at risk, and Tier 3 focuses on more intensive, individualized interventions for students experiencing mental health challenges. The Administration for a Healthy America expects that this program will continue to promote the healthy social and emotional development of school-aged youth and continue to contribute to allowing all students to thrive in the classroom.

Budget Request

The FY 2026 Budget Request is $120.5 million. The Administration for a Healthy America expects Project AWARE to identify and refer approximately 100,000 school-aged youth to mental health and related services. Additionally, these resources will train 300,000 mental health and mental health-related professionals on evidence-based mental health practices.

Five Year Funding History

FY	Amount
FY 2022 Final	$119,984,000
FY 2023 Final	$140,001,000
FY 2024 Final	$140,001,000
FY 2025 Enacted	*
FY 2026 President's Budget	$120,501,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, SAMHSA funded 139 continuation grants including 98 continuation grants with base budget authority and 41 grants with the Bipartisan Safer Communities Act. In FY 2024, 147,060 individuals were trained in mental health-related practices; 216,869 children and youth were screened for mental health-related concerns; and 92,542 children and youth were referred to mental health and related services.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target

3.2.21 Percentage of individuals receiving mental health services after referral	FY 2024: 75.0 Target: 74.5 (Target Exceeded)	*	74.5	*
3.2.39 Number of individuals who have received training in prevention or mental health promotion (Outcome)	FY 2024: 194,603 Target: 300,000 (Target Not Met)	*	250,000	*
3.2.51 Number of individuals referred to mental health or related interventions (Output)	FY 2024: 96,855 Target: 100,000 (Target Not Met but Improved)	*	85,000	*

*Performance targets under development.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	139	*	74
Average Award	$1,311,321	*	$1,522,127
Range of Awards	$900,000 – 1,800,000	*	$900,000 – 1,800,000

* Grant award estimates under development.

National Strategy for Suicide Prevention

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$28,200,000	*	$28,200,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grants

Program Description

The National Strategy for Suicide Prevention (NSSP) supports a broad-based public health approach to suicide prevention through the implementation of suicide prevention and intervention programs for adults. It works to accomplish this by enhancing collaboration with key community stakeholders, raising awareness of the available resources for suicide prevention, and implementing a lethal means safety strategy.

The NSSP promotes collaboration across suicide prevention efforts and focuses on four primary actions: (1) collaboration with community, state, and federal initiatives to build capacity and integrate suicide prevention efforts, (2) provide training on risk and protective factors for high-risk groups and those underserved; (3) increase awareness and promote safety planning to include commonly misused substances (e.g., alcohol and opioids); and, (4) adoption of evidence-based care addressing suicide risk. While the National Strategy addresses all age groups and populations, the goals and objectives of the NSSP focus on preventing suicide and suicide attempts among adults, with an emphasis on older adults, adults in rural areas, and American Indian and Alaska Native adults.

Established in FY 2017, Grants to Implement Zero Suicide in Health Systems (Zero Suicide) aligns with the NSSP to implement the Zero Suicide intervention and prevention model for adults throughout a health system or health systems, including Tribal health systems.

The Zero Suicide model is a comprehensive, multi-setting approach to suicide prevention in health systems. This model was created through the work of the SAMHSA-funded National Action Alliance for Suicide Prevention's Clinical Care Task Force and is based on the foundational principle that suicide deaths for individuals under the care of health and behavioral health systems are preventable.

Grant recipients implement all seven elements of the Zero Suicide framework: Lead, Train, Identify, Engage, Treat, Transition, and Improve. Within the health system(s), grant recipients systematically apply evidence-based approaches to suicide screening and risk assessment,

develop care protocols, collaborate with patients for safety planning, provide evidence-based treatments, maintain continuity of care for patients during high-risk periods, and improve care and outcomes for individuals who are at risk for suicide. With this program, the Administration for a Healthy America aims to reduce suicide ideation, suicide attempts, and suicide deaths among adults.

Budget Request

The FY 2026 Budget Request is $28.2 million. The FY 2026 funding will support the referral of 98,000 individuals for mental health services.

Funding History Table

FY	Amount
FY 2022 Final	$23,183,200
FY 2023 Final	$28,200,000
FY 2024 Final	$28,200,000
FY 2025 Enacted	*
FY 2026 President's Budget	$28,200,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, SAMHSA funded 50 Zero Suicide and five NSSP grant continuations. The Zero Suicide program evaluation, which started in FY 2023, continued in FY 2024. In 2024, the NSSP program trained 5,077 individuals for mental health interventions with a focus on suicide risk. Also in FY 2024, the Zero Suicide grant program screened 2,053,481 people for mental health interventions with a focus on suicide risk and referred 81,354 individuals for mental health services, with 81 percent receiving services after referral in FY 2024.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	55	*	40
Average Award	$437,111	*	$464,021
Range of Awards	$400,000 -700,000	*	$400,000 -700,000

* Grant award estimates under development.

Garrett Lee Smith Youth Suicide Prevention – State/Tribal and Campus

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
GLS State BA	$31,806,000	*	$43,806,000
GLS State PPH	$12,000,000	$12,000,000	---
GLS Campus	$8,488,000	*	$8,488,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grant/Contracts

Program Description

The Garrett Lee Smith grant programs were established in 2005 through the Garrett Lee Smith Memorial Act, to honor the memory of Garrett Lee Smith, the son of former Oregon Senator Gordon Smith, who died by suicide in 2003, just before his 22nd birthday. This groundbreaking legislation was the first to provide federal funds specifically for states, Tribes, and higher education institutions to develop and enhance early intervention and suicide prevention initiatives for youth. The Garrett Lee Smith (GLS) suicide prevention portfolio supports two grant programs: GLS State/Tribal Youth Suicide Prevention and GLS Campus.

GLS Youth Suicide Prevention – States/Tribes

The GLS State/Tribal Youth Suicide Prevention grant program supports the development and implementation of comprehensive youth suicide prevention and early intervention strategies including public-private collaboration among youth-serving institutions. Since its inception in 2005, SAMHSA has awarded 256 grants to 50 states and the District of Columbia, 67 unique Tribes/Tribal organizations, and two territories. Program evaluations published in peer-reviewed journals have found that implementing GLS State/Tribal grant programming within a county is associated with reductions in both suicide attempts and deaths among youth.[27,28,29]

GLS State/Tribal program activities include outreach and awareness initiatives, school and community-based gatekeeper training (which teaches how to recognize the warning signs of suicide and get people the help they need), clinical trainings for mental health professionals and hotline staff, screening programs, policies and protocols related to intervention and postvention, coalitions and partnerships, direct mental health services, case management, and crisis response services.

GLS Youth Suicide Prevention Campus

The GLS Campus program supports the enhancement of behavioral health and suicide prevention services at institutions of higher education. GLS Campus grant recipients engage the entire college community to enhance protective factors, identify risks, and promote an array of behavioral health suicide prevention initiatives. This comprehensive approach identifies students at risk, increases help-seeking behaviors, provides substance use disorder and mental health services, and promotes social connectedness.

Budget Request

The FY 2026 Budget Request is $52.9 million. Funds will support GLS State/Tribal grants and Campus grants and The Administration for a Healthy America will also continue support for evaluation activities. The program remains committed to developing and implementing youth suicide prevention and early intervention strategies involving public-private collaboration among youth serving institutions as well as supporting suicide prevention among institutions of higher learning.

Five Year Funding History

FY	Amount
FY 2022 Final	$45,260,200
FY 2023 Final	$52,294,000
FY 2024 Final	$52,294,000
FY 2025 Enacted	*
FY 2026 President's Budget	$52,294,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, SAMHSA funded 33 GLS State/Tribal grant continuations and 55 GLS Campus grant continuations and funded a new cohort of 21 GLS State/Tribal grants and 22 GLS Campus grants. The GLS State/Tribal program and the GLS Campus program grants in total screened 113,357 youth for suicide risk in FY 2024, referring 30,565 to mental health or related services, with 78 percent receiving services following their referral. SAMHSA also continued to support evaluation activities.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	131	*	99
Average Award	$330,157	*	$367,638
Range of Awards	$102,000 – 735,000	*	$102,000 – 735,000

*Grant award estimates under development.

Suicide Prevention Resource Center

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$11,000,000	*	$11,000,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grants/Contracts

Program Description

The Suicide Prevention Resource Center (SPRC), first funded in 2002, builds national capacity for suicide prevention efforts, with the overall goal of reducing suicides and suicidal behaviors across the nation. The SPRC provides technical assistance, training, and resources to states, tribes, localities, organizations, and SAMHSA grant recipients to assist in the development of suicide prevention strategies, including programs, interventions, and policies that advance the National Strategy on Suicide Prevention (National Strategy). The SPRC serves as a national center of excellence to address suicide across the county.

The SPRC collaborates closely with national and regional technical assistance (TA) centers that focus on issues related to suicide prevention, such as mental health, injury prevention, substance use prevention and treatment, and violence prevention. SPRC's collaborations have included contacts with the Service Member, Veterans, and their Families TA Center; Center for Integrated Health Solutions; and Health Resources and Services Administration (HRSA)'s National Center for Fatality Review and Prevention.

Budget Request

The FY 2026 Budget Request is $11.0 million. The funding will provide states, tribes, government agencies, private organizations, colleges and universities, and suicide survivors and mental health consumer groups with access to information and resources that support program development, intervention implementation, and adoption of policies that prevent suicide. The funding will expand youth suicide prevention and early intervention strategies involving public-private collaboration. The Administration for a Healthy America anticipates that SPRC will provide training to approximately 14,000 people.

Funding History

FY	Amount
FY 2022 Final	$8,983,200
FY 2023 Final	$11,000,000
FY 2024 Final	$11,000,000
FY 2025 Enacted	*
FY 2026 President's Budget	$11,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In April 2024, an updated National Strategy was released, incorporating advancements in treating, preventing, and addressing critical topics associated with suicide.[30] The modernized National Strategy outlines concrete recommendations for addressing gaps and meeting the needs of at-risk for suicide populations, and is accompanied by the first-ever Federal Action Plan, which identifies 200 actions to be initiated and evaluated over the next three years.[31]

The SPRC has played an important role in transforming suicide prevention and treatment across the lifespan, particularly for those at high risk for suicide. Efforts to advance suicide prevention include:

- Developing and promoting the adoption of evidence-based resources, tools, and online trainings to support strategic, comprehensive, best practice suicide prevention programs around the country.

- Building the capacity of suicide prevention programs nationwide by providing consultation, training, and resources to states, American Indian/Alaska Native (AI/AN) communities, colleges and universities, health systems, and organizations serving groups at higher risk for suicide.

- Improving care for those at risk for suicide, including promoting the Zero Suicide model for safer suicide care in health and behavioral health care systems; and

- Providing leadership and operational support, which brings together more than 250 national partners from the public and private sectors to advance implementation of the goals and objectives of the National Strategy.

In FY 2024, 10,547 individuals had received training through the SPRC and an additional 29,691 participated in an education or awareness activity. The SPRC was a key supporter in the development of the 2024 National Strategy for Suicide Prevention and Federal Action Plan and is working to implement the National Strategy and help monitor its impact.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	1	*	1
Average Award	$7,586,000	*	$10,200,000
Range of Awards	$7,586,000	*	$10,200,000

*Grant award estimates under development.

American Indian/Alaska Native Suicide Prevention Initiative

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$3,931,000	*	$3,931,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grants/Contracts

Program Description

Established in FY 2013, the Tribal Training and Technical Assistance Center (Tribal TTA Center) is an innovative training and technical assistance project that helps Tribal communities facilitate the development and implementation of comprehensive and collaborative community-based prevention plans to reduce violence, bullying, substance misuse, and suicide among American Indian/Alaska Native (AI/AN) youth. These plans mobilize Tribal communities' existing social and educational resources to meet their goals.

Budget Request

The FY 2026 Budget Request is $3.9 million. This funding will help support the Tribal TTA Center and to provide comprehensive, broad, focused, and intensive training and technical assistance to federally recognized tribes and other AI/AN communities to address and prevent mental illness and alcohol/other drug addiction, prevent suicide, and promote mental health.

Funding History

FY	Amount
FY 2022 Final	$2,931,000
FY 2023 Final	$3,931,000
FY 2024 Final	$3,931,000
FY 2025 Enacted	*
FY 2026 President's Budget	$3,931,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

From March 2024 to March 2025, SAMHSA's Tribal TTA Center processed 175 TTA requests which included 300 on-site support days and 1,200 virtual support days. The Center provided services to 529 communities with a total of 6,010 participants. The Center conducted two learning communities. The Center provided logistical and subject matter support to the Office of Tribal Affairs and Policy, SAMHSA's Tribal Technical Advisory Committee members, and their meetings. Finally, the Center continued their partnerships with the Service Members, Veterans, and their Families (SMVF) Technical Assistance Center, the Disaster Technical Assistance Center, and Strategic Prevention Technical Assistance Center.

Output and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
2.3.59 Number of individuals trained in youth suicide prevention (Outcome)	FY 2024: 100,744 Target: 220,000 (Target Not Met)	*	166,000	*
2.3.60 Number of youth screened (Output)	FY 2024: 113,357 Target: 110,000 (Target Exceeded)	*	83,000	*
2.3.62 Number of individuals trained in suicide prevention (Invalid measure type)	FY 2024: 214,791 Target: 75,000 (Target Exceeded)	*	75,000	*

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3.1.01 Number of individuals screened for mental health or related interventions (Intermediate Outcome)	FY 2024: 2,053,481.0 Target: 1,500,000.0 (Target Exceeded)	*	1,500,000	*
3.1.02 Number of individuals referred to mental health or related services (Intermediate Outcome)	FY 2024: 81,354.0 Target: 136,000.0 (Target Not Met)	*	100,000	*
3.2.37 Number of youth referred to mental health or related services (Output)	FY 2024: 30,565 Target: 96,000 (Target Not Met but Improved)	*	73,000	*

*Performance targets under development.

988 and Behavioral Health Crisis Services

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$519,618,000	*	$519,618,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Program Description

Immediate access to suicide prevention and crisis intervention services can prevent injuries and save the lives of individuals experiencing suicidal ideation and those at risk for overdoses. Implementation of the 988 Suicide & Crisis Lifeline has been and continues to strengthen and transform America's behavioral health crisis care system that saves lives by serving anyone, at any time, from anywhere across the nation. Recent data underscore the need for a comprehensive crisis care system that is integrated within the larger health systems of care and needed services. In 2023, according to the National Survey on Drug Use and Health (NSDUH), 5.0% of adults ages 18 years or older (or 12.8 million people) had serious thoughts of suicide, and among adolescents ages 12 to 17 years, 12.3% (or 3.2 million people) had serious thoughts of suicide. The NSDUH 2023 survey also demonstrated gaps in access to services: among the 14.6 million adults with serious mental illness in the past year, about one quarter (4.2 million people) did not receive mental health treatment in the past year.[1]

Prevention is a core principle of President Trump's commitment to Making America Healthy Again. On October 17, 2020, Congress passed and President Trump signed into law the National Suicide Hotline Designation Act of 2020 (Public Law 116-172) that designated 988 as the new national three-digit emergency number focused on suicide prevention and mental health crisis response. The 988 Lifeline offers a direct connection to immediate, culturally competent support and resources for anyone experiencing a mental health, suicide, or substance-use-related challenge. Numerous studies have shown that most Lifeline callers are significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful after speaking to a 988 Lifeline crisis counselor.[123,124,125] Only a small percentage of 988 Lifeline callers require activation of the 911 system, and many of those are done with the consent and cooperation of the caller. 988 offers individuals supportive connections to ongoing care that can prevent future

[123] Gould MS, Lake AM, Galfalvy H, et al. Follow-up with Callers to the National Suicide Prevention Lifeline: Evaluation of Callers' Perceptions of Care. *Suicide Life Threat Behav*. 2017;48(1):75-86. doi:10.1111/sltb.12339
[124] Gould MS, Kalafat J, Munfakh JLH, Kleinman M. An evaluation of crisis hotline outcomes part 2: Suicidal callers. *Suicide Life Threat Behav*. 2007;37(3):338-352. doi:10.1521/suli.2007.37.3.338
[125] Kalafat J, Gould MS, Munfakh JLH, Kleinman M. An evaluation of crisis hotline outcomes part 1: Nonsuicidal crisis callers. *Suicide Life Threat Behav*. 2007;37(3):322-337. doi:10.1521/suli.2007.37.3.322

crisis episodes, promotes health responses that diminish reliance on law enforcement, and allow first responders to focus on needed public safety functions.

988 Suicide & Crisis Lifeline builds directly on the original National Suicide Prevention Lifeline established in 2005. The 988 system operates 24 hours per day, 7 days per week and contains four primary elements:

- A network of 200+ independently operated crisis centers offering local response through call, chat, and/or text;
- A subset of centers supporting the national subnetworks, including a national backup system
- A single Lifeline administrator; and
- The Administration for a Healthy America 988 & Behavioral Health Crisis Coordinating Office (BHCCO).

The Administration for a Healthy America anticipates continued growth in the contact volume and in needed system capacity. In FY 2026, contacts —including calls, texts, and chats—are expected to increase to approximately 9 million within a year. This will be driven by historic annual volume growth, increased awareness, and diversion from 911 and local crisis lines. Volume will also depend greatly on the degree to which national marketing campaigns amplify the availability of this vital resource and promote help seeking behaviors. The budget continues investment in the 988 program to ensure there is sufficient funding to support 988 crisis center response and necessary service linkages to minimize repeated crisis events and/or law enforcement response to crisis encounters.

Budget Request

The FY 2026 Budget Request is $519.6 million. In FY 2026, the Administration for a Healthy America anticipates that contact volume – including calls, texts, and chats – will continue to increase, with capacity needed to respond to an estimated 9 million contacts, compared to approximately 5 million contacts in the first year of 988 implementation.

The FY 2026 request is based on the following estimated breakdown of funding needs:

- Lifeline administration and national subnetworks: Funding will be required to administer the Lifeline network, including technology infrastructure, and national subnetwork operations and capacity, and Spanish language services. This includes costs related to efforts to enhance access, geo-routing implementation, and work with state external platforms. The 988 Lifeline Administrator cooperative agreement is scheduled for renewal in FY 2026. To ensure the best use of federal funds and to ensure the required federal oversight of the 988 Suicide & Crisis Lifeline meets expectations of all stakeholders, the Administration for a Healthy America is engaged in an analysis to explore award vehicles that consider cost, risk, and effectiveness.
- Local response capacity: Funds will support local response capacity. Local capacity will be funded through a 988 state/territory grant program, 988 Tribal

response grant program and Lifeline crisis center follow up grant program. A portion of the cost to support local response will be borne by states and territories.

- Technical Assistance and Evaluation: Funds will support training and technical assistance activities that promote expanded implementation and sustainability of crisis services, including adoption of best and promising practices. This funding will also support a range of efforts to strengthen data collection across the crisis continuum and to work with grantees, federal and other external partners to address key evaluation questions related to access, utilization, outcomes and impact of crisis care.
- Communications: The program will continue promoting awareness of 988 through various communication channels to reach populations known to be at highest risk of suicide. At this funding level, the communication goals are to use tailored messages to build awareness for specific populations and not to build larger scale public awareness. As a result, we are not expecting this level of investment to affect our capacity modeling for FY 2026.
- The 988 & BHCCO: Funds will support the 988 & BHCCO including personnel, strategic planning, performance management, oversight, partnerships, convenings, and cross-entity coordination.

Funding History

FY	Amount
FY 2022 Final	---
FY 2023 Final	$501,618,000
FY 2024 Final	$519,618,000
FY 2025 Enacted	*
FY 2026 President's Budget	$519,618,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

Since 988 was implemented, there continues to be an increase in annual contacts. As of January 2025, the 988 Lifeline reached a milestone of over 12 million answered contacts (i.e., calls, chats, and texts). In January 2025 alone, the Lifeline answered 595,000 contacts, compared to 447,000 in June 2024 and 384,000 in June 2023. The Lifeline is on track to receive approximately 7.5 million contacts in FY 2025, excluding individuals directed to the Veterans Crisis Line by pressing "1."

The SAMHSA 988 & BHCCO worked closely with the 988 Lifeline Administrator to enhance access and improve the experience for all help seekers while strengthening security protocols. In April 2024, SAMHSA released the Saving Lives in America: 988 Quality and Services Plan that set forth national federal requirements for the 988 Suicide and Crisis Lifeline in the following areas: operations, data, privacy, cybersecurity, training, referrals, quality assurance, and

communications. Later that year, SAMHSA convened nearly 1,000 federal and state government officials, tribal leaders, and crisis organizations to discuss the latest developments in the implementation of 988 and local crisis services.

SAMHSA and the 988 Lifeline Administrator also partnered with telecom carriers to implement georouting in alignment with Federal Communications Commission directives. During the Fall of 2024, SAMHSA partnered with the Federal Communications Commission, the 988 Lifeline Administrator and two major national carriers to activate geo-routing for calls made to 988. When a person calls 988 from a phone using a carrier that has implemented georouting, they will be connected to the nearest 988 crisis center unless they select one of the specialized services offered through the national network. Individuals receive more localized support when connected to their community's crisis center. Local centers can provide connections to and knowledge about local resources and services, including follow-up care, that reduce the risk of suicidality in individuals in crisis. In the rare cases where emergency services may be deployed, geo-routing reduces delays in identifying the emergency provider nearest to the individual.

Additionally, the Administration for a Healthy America conducted national tests to shorten and humanize the initial phone welcome message, as well as introduce a "press 0" option to receive care more quickly. These changes resulted in 114,000 additional connections to care over the course of a year. Further, the Administration for a Healthy America continues to work with partners to monitor and improve wait times, even while volume increases. Average time to response across all communication channels was 45 seconds in January 2025, compared to 50 seconds in January 2024.

In addition, the Administration for a Healthy America 988 and BHCCO has recently launched a cross-site evaluation of crisis services as part of its national strategy on 988 and crisis services. This evaluation plans to address process, outcome and impact questions capturing information related to availability and access/us. Impact data will capture user experience, and clinical outcomes across these domains.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
The number of individuals contacted through program outreach efforts.	FY 2024: 122,464 Target: 39,219 (Target Exceeded)	*	176,347	*

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
The number of individuals screened for mental health or related interventions 1/.	FY 2024: 7,301,519 Target: 5,146,090 (Target Exceeded)	*	10,514,186	*
The number of individuals referred to mental health or related services.	FY 2024: 871,586 Target: 736,266 (Target Exceeded)	*	1,255,083	*

*Performance targets are under development.
1/ Includes Press 1 volume to the Veterans Crisis Line and calls to the Disaster Distress Helpline

Grants Awards Table

Number of Awards			
	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
988 Lifeline Administrator	4	*	1
Tribes	20	*	20
States/Territories	53	*	56
Crisis Center Follow Up	10	*	30
Total	**87**	*****	**107**

*Grant award estimates under development.

Practice Improvement and Training

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$7,828,000	*	$7,828,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grants/Contracts

Program Description

The Practice Improvement and Training (PIT) programs address the need for disseminating key information, such as evidence-based mental health practices, to the mental health delivery system. Two programs are funded with PIT: Historically Black Colleges and Universities Center of Excellence (HBCU-COE) and Transforming Lives through Supported Employment Program (SEP)

Historically Black Colleges and Universities Center of Excellence

The purpose of the HBCU-COE program is to network the 105 HBCUs throughout the United States and promote behavioral health workforce development by expanding knowledge of best practices, developing leadership, and encouraging community partnerships that enhance the participation of African Americans in substance use disorder treatment and mental health professions. The comprehensive focus of the HBCU-COE program simultaneously expands service capacity on campuses and in other treatment venues.

Transforming Lives through Supported Employment Program

Established in FY 2014, the purpose of SEP is to support state and community efforts to refine, implement, and sustain evidence-based practices. The SEP grant program aims to enhance state and community capacity to provide evidence-based supported employment programs for adults and youth with SMI, serious emotional disturbance (SED), or co-occurring disorders (COD). SEP grant recipients implement an evidence-based supported employment model, which involves providing specialized and individual support to individuals with SMI, SED, or COD, to choose, acquire, and maintain competitive employment. Grant recipients also provide comprehensive treatment and recovery support services for these individuals in conjunction with vocational services. The end goal of the program is to help individuals with SMI, SED, and COD achieve competitive employment and build paths to self-sufficiency and recovery.

Budget Request

The FY 2026 Budget Request for the Practice Improvement and Training program of $7.8 million. Funding will support the HBCU grant program to support workforce development, and Transforming Lives through Supported Employment Programs (SEP) grants and expects increase competitive employment for participating clients, increasing the number of individuals with a stable place to live, and increasing the number of participants who remain in the community.

Funding History

FY	Amount
FY 2022 Final	$7,811,000
FY 2023 Final	$7,828,000
FY 2024 Final	$7,828,000
FY 2025 Enacted	*
FY 2026 President's Budget	$7,828,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, five SEP grant continuations were supported, a new SEP cohort of two grants, and continued funding for the HBCU grant program to support workforce development. In FY 2024, 48.9 percent of participants of the SEP grant program were competitively employed at six-month follow-up, compared to 20.7 percent at intake (baseline), representing a 136 percent increase. Additionally, 89.7 percent reported having a stable place to live at follow-up, and 79.7 percent reported positive functioning at follow-up.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
1.2.23 Percentage of clients receiving services who are currently employed at 6 month follow-up. (Outcome)	FY 2024: 48.9% Target: 55% (Target Not Met)	*	55%	*

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
1.2.991 Number of clients served (Output)	FY 2024: 1,494 Target: 800 (Target Exceeded)	*	800	*

*Performance targets are under development.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	7	*	7
Average Award	$734,316	*	$758,919
Range of Awards	$800,000	*	$800,000

* Grant award estimates under development.

Consumer and Consumer-Supporter TA Centers

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$1,918,000	*	$1,918,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grants

Program Description

Since its inception in 1992, the Consumer and Consumer-Supporter Technical Assistance (TA) Centers program was designed to improve mental health systems for adults with serious mental illness (SMI). This is facilitated through enhanced collaboration between the people who use these services, their families, the service providers, and administrators overseeing systems. It is designed to reshape community mental health services into structures that are more influenced by the consumer and their families.

Consumer-centered services and supports, like those involving peer specialists, are crucial in enhancing health and behavioral healthcare for individuals with mental illness, including SMI. These strategies empower individuals by supporting their autonomy, fostering long-term recovery, and helping them engage more in their communities through employment, education, and social activities.

Budget Request

The 2026 Budget Request is $1.9 million. This funding request will provide technical assistance to facilitate the quality improvement of the mental health system by promoting consumer-directed approaches for adults with SMI and focus on coordination with the state-wide consumer network program and engaging people with lived experience of mental illness to improve mental health systems and supports and advance community recovery, and resilience.

Funding History

FY	Amount
FY 2022 Final	$1,901,200
FY 2023 Final	$1,918,000
FY 2024 Final	$1,918,000
FY 2025 Enacted	*
FY 2026 President's Budget	$1,918,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, SAMHSA funded five grant continuations. SAMHSA grant recipients trained 26,229 individuals and reached 469,562 people with mental health awareness activities. These trainings covered a range of topics, including peer support, peer-run crisis services, employment and education supports, Youth Advocate Leadership Academy, Occupational Resiliency, Psychiatric Advance Directives, and improving care for people with mental illness and intellectual or developmental disabilities.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	5	*	5
Average Award	$360,796	*	$356,748
Range of Awards	$359,000 – 361,000	*	$359,000 – 361,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Disaster Response

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$1,953,000	*	$1,953,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grants/Contracts

Program Description

Natural and human-caused disasters—including, wildfires, mass shootings, hurricanes, tropical storms, floods, and tornadoes—often strike unexpectedly, profoundly impacting individuals, families, and entire communities. In response, the Administration for a Healthy America's Disaster Behavioral Health Program is designed to prepare the nation to meet the behavioral health needs following such events.

This comprehensive effort includes three key programs: the Disaster Distress Helpline (DDH), the Crisis Counseling Assistance and Training Program (CCP), and the Disaster Technical Assistance Center (DTAC). Together, these programs provide essential disaster behavioral health expertise and support the development and dissemination of innovative public health initiatives and technologies. This support extends to communities, federal partners, and other stakeholders.

The Administration for a Healthy America's DDH is the nation's first permanent hotline dedicated to providing immediate disaster crisis counseling. Originally launched as the Oil Spill Distress Helpline in 2010 in response to the Deepwater Horizon Explosion/BP Oil Spill, it transitioned to the national Disaster Distress Helpline in February 2012. The DDH is a toll-free, multilingual crisis support service available 24/7 throughout the year. It can be reached by calling or texting 1-800-985-5990.

The Administration for a Healthy America administers the CCP through an interagency agreement with the Federal Emergency Management Agency (FEMA). Established in 1974 under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, the CCP is activated following a presidential disaster declaration. This act authorizes FEMA to fund mental health assistance and training activities in affected areas. The CCP supports community-based outreach, counseling, and other mental health services to survivors in areas designated as major disaster areas by the President. Funding is provided through two grant programs: the Immediate Services Program (ISP), which offers support for up to 60 days after the disaster declaration, and the Regular Services Program (RSP), which extends aid for up to nine months following the declaration.

Founded in 2002, and jointly funded by both the Administration for a Healthy America and FEMA, the DTAC assists states, U.S. territories, Tribes, and local providers in planning for and responding to behavioral health needs following disasters. DTAC offers technical assistance, strategic planning, consultation, and logistical support to communities and response personnel before, during, and after disasters. It also promotes collaboration among behavioral health authorities, federal agencies, and nongovernmental organizations, facilitating the exchange of information and best practices within the disaster behavioral health community. Additionally, the Disaster App, available on Apple and Android platforms, includes the Disaster Kit with evidence-informed and evidence-based resources, along with information on local mental health and substance use treatment facilities and other partner resources.

Budget Request

The FY 2026 Budget Request is $1.9 million. This funding will continue to support the nationally available disaster distress crisis counseling telephone line and the DTAC. The Administration for a Healthy America is committed to maintaining the established performance measure targets for FY 2026.

Funding History

Fiscal Year	Amount
FY 2022 Final	$1,936,200
FY 2023 Final	$1,953,000
FY 2024 Final	$1,953,000
FY 2025 Enacted	*
FY 2026 President's Budget	$1,953,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, DDH responded to 43,852 calls and managed 2,977 text sessions.

In 2024, SAMHSA's DTAC supported the core contract tasks, as well as an optional task that assists FEMA's CCP grants. The DTAC team responded to 123 CCP-related technical assistance (TA) requests and 68 disaster behavioral health requests. They also completed CCP Grants Application Training and advanced the rollout of the CCP Training of Trainers (ToT). Support was provided to 26 CCP grants in various stages, from pre-Immediate Services Program (ISP) to Regular Services Program (RSP) closeout, affecting 17 states, one territory, and one tribe. The team offered numerous services in response to disaster events, including TA, resource provision, and post-training reporting, particularly in response to severe tornadoes and storms in Iowa, Missouri, and Oklahoma.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	1	*	1
Average Award	$850,000	*	$850,000
Range of Awards	$850,000	*	$850,000

*Grant award estimates are under development.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
1.4.14 Number of calls answered by the Disaster Distress Hotline (Output)	FY 2024: 43,852 Target: 38,000 (Target Exceeded)	*	38,000	*
1.4.15 Number of text messages answered by the Disaster Distress Hotline (Output)	FY 2024: 2,977 Target: 17,000 (Target Not Met)	*	7,000	*

*Performance targets are under development.

National Child Traumatic Stress Network

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$98,887,000	$98,887,000	$98,887,000
FTE	**	**	556[1]

****FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method.....Competitive Grants/Contracts/Cooperatives Agreements

Program Description

Experiences of chronic and/or severe stress during childhood (including exposure to violence, childhood adversity, child maltreatment, and childhood trauma) have persistent and pervasive consequences for development.[126] While the effects of trauma and exposure to violence are found in all child and adolescent populations and service sectors, it is particularly prominent among youth with mental illness and/or drug/alcohol addiction involved in the child welfare, and juvenile justice systems. [127] Broad access to trauma-informed programs, community-based prevention, and structural reforms are urgently needed. Impact extends well beyond the family unit; influencing the broader community's capacity to respond to the needs of children who experienced trauma and establishing proven models for future initiatives and interventions.[128]

Since its establishment in 2000, the National Child Traumatic Stress Initiative (NCTSI) has been funded to increase access to effective trauma- and grief-focused treatment and services systems for children, adolescents, and their families, who experience traumatic events. The NCTSI grew into a national collaborative network of grantees and affiliates (formerly funded grantees) known as the NCTSN. The NCTSN has expanded from 17 to 184 centers and over 200 affiliate centers and individuals located nationwide in universities, hospitals, and a wide range of community-based organizations with thousands of national and local partners. A component of this work has been the development of resources and delivery of training and consultation to support trauma-informed child-serving systems.

All NCTSI grant recipients work together within and across diverse settings, including a wide variety of governmental and non-governmental organizations, and continue to be a principal source of child trauma information and training for the nation. The goal of the program is to expand access to trauma-focused treatments and services for children and their families nationwide, as well as to strengthen a trauma-informed continuum of accessible care. Grantees effectively collaborate to support clinicians, practitioners, researchers, and other related mental health providers in

[126]Smith KE, Pollak SD. (2020) Early life stress and development: potential mechanisms for adverse outcomes. *Journal of Neurodevelopmental Disorders.* 2020 Dec 16;12(1):34. doi: 10.1186/s11689-020-09337-y. PMID: 33327939; PMCID: PMC7745388.
[127] ibid
[128] Martin, R., Rajan, S., Shareef, F., Xie, K. C., Allen, K. A., Zimmerman, M., & Jay, J. (2022). Racial Disparities in Child Exposure to Firearm Violence Before and During COVID-19. *American journal of preventive medicine,* 63(2), 204–212. https://doi.org/10.1016/j.amepre.2022.02.007

mitigating and treating the wide-range effects of trauma in children and provide timely resources to those affected by trauma.

Budget Request

The FY 2026 Budget Request for the National Child Traumatic Stress Network program of $98.9 million is level with the FY 2025 Enacted level. At this funding level, the Administration anticipates supporting 67 grant continuations and award a new cohort of 82 grants. Across all NCTSI programs, it's anticipated approximately 13,000 children and adolescents will be served and 250,000 people in the mental health and related workforce will be trained.

Funding History

FY	Amount
FY 2022 Final	$81,887,000
FY 2023 Final	$93,887,000
FY 2024 Final	$98,887,000
FY 2025 Enacted	$98,887,000
FY 2026 President's Budget	$98,887,000

Program Accomplishments

In FY 2024, we awarded 207 grant continuations (170 with base budget authority, six with American Rescue Plan Act), and 21 with Bipartisan Safer Community Act (BSCA), along with introducing a new cohort of 10 grants. The NCTSN has been a pivotal resource since its inception, providing training on child trauma best practices to over two million participants nationwide. In FY 2024, grant recipients trained 352,392 child-serving professionals in providing trauma-informed services and served 18,243 individuals with trauma or mental health related needs and provided evidence-based services.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3.2.23 Unduplicated count of the number of children and adolescents receiving trauma-informed services (Outcome)	FY 2024: 18,243 Target: 13,000 (Target Exceeded)	13,000	13,000	Maintain
3.2.34 Number of child-serving professionals trained in providing trauma-informed services (Outcome)	FY 2024: 352,392 Target: 500,000 (Target Not Met but Improved)	250,000	250,000	Maintain

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	207	186	149
Average Award	$451,596	$470,074	$600,000
Range of Awards	$400,000 – 600,000	$400,000 – 600,000	$400,000 – 600,000

Certified Community Behavioral Health Clinics

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$385,000,000	$385,000,000	$385,000,000
FTE	**	**	556[1]

****FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method ..... Competitive Grants/Contracts

Program Description

In recent years, there has been a surge in demand for behavioral health services, including crisis services and overdose prevention and treatment. In 2023, among adults aged 18 or older, 22.8 percent (or 58.7 million people) had a mental illness and 5.7 percent (or 14.6 million people) had a serious mental illness (SMI) in the past year. Approximately 48.5 million people aged 12 or older (or 17.1 percent) had an SUD in 2023.[129] While effective treatment and supportive services exist, many individuals with behavioral health conditions do not receive the help they need.[130] When they do try to access services, they often face significant delays and/or have limited access to services,[131] and often, services are incomplete and uncoordinated. People who receive services, such as medication or psychotherapy, often do not get other supports they need, such as crisis management, supported employment, supportive housing, and care for co- occurring physical health problems. [132, 133, 134]

As a part of the Protecting Access to Medicare Act of 2014 (PAMA), Congress created the Certified Community Behavioral Health Clinics (CCBHC) model. The purpose of this program is to transform community behavioral health systems and provide comprehensive, coordinated behavioral health care by (a) enhancing and improving care at CCBHCs; (b) providing a comprehensive range of outreach, screening, assessment, treatment, care coordination, and recovery supports based on a needs assessment with fidelity to the CCBHC Certification

[129] Substance Abuse and Mental Health Services Administration. (2023). Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health (HHS Publication No. PEP2307-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf
[130] Ibid
[131] U.S. Government Accountability Office. (2022) Report to the Chairman, Committee on Finance, U.S. Senate Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts https://www.gao.gov/assets/gao-22-104597.pdf
[132] Substance Abuse and Mental Health Services Administration (2021) Uniform Reporting Summary Output Tables Executive Summary https://www.samhsa.gov/data/sites/default/files/reports/rpt39371/Alabama.pdf
[133] Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report
[134] Substance Abuse and Mental Health Services Administration (2025) National Behavioral Health Crisis Care Guidance website https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Criteria;[135] and (c) supporting recovery from mental illness and/or substance use disorders by providing access to high-quality mental health and substance use services, regardless of an individual's ability to pay.

CCBHCs serve all individuals across the lifespan in need of behavioral health services in the geographic catchment area served by the CCBHC. This includes individuals with SMI; SUD, including opioid use disorders; children and youth with SED; individuals with COD; and people experiencing a mental health or substance use related crisis. HHS established criteria for clinics to be certified as CCBHCs. These criteria encompassed six areas: (1) staffing; (2) availability and accessibility of services; (3) care coordination; (4) scope of services; (5) quality and other reporting; and (6) organizational authority. Crisis services are also required with the CCBHC model.

In 2022, the Bipartisan Safer Communities Act (BSCA) gave HHS the authority to add 10 states to the Section 223 CCBHC Medicaid Demonstration every two years starting in July of 2024 and provided a $40 million appropriation for planning grants. These planning grants support states to develop administrative, payment, certification, and data systems necessary to administer a state CCBHC demonstration program and to assist clinics to meet CCBHC standards. In March 2023, a cohort of 15 state planning grants was awarded to enable 10 additional states to join the Demonstration in 2024. Another cohort of 15 state planning grants were awarded in FY 2025.

Beginning in FY 2022, the CCBHC-E funding announcement requirements were revamped, including building two tracks into the CCBHC-E grant program. One track is for clinics that are interested in newly becoming CCBHCs [the CCBHC Planning, Development, and Implementation (CCBHC-PDI) Grants], and the other track is for clinics that are already established CCBHCs seeking to expand, improve, and advance their services [the CCBHC Improvement and Advancement (CCBHC-IA) Grants].

Budget Request

The FY 2026 Budget Request for CCBHC program is $385 million, flat with the FY 2025 Enacted level. The funding will support 134 continuation grants and award a new cohort of 223 grants. We expect to serve approximately 819,000 individuals directly with grant-funded services, expanding CCBHC's services across the nation. The FY 2026 budget includes funding for a technical assistance center contract. The contract will support CCBHC expansion grant recipients, state CCBHCs outside of the expansion program, states in the CCBHC Demonstration program, states planning to be part of the Demonstration, states with CCBHC programs independent of the Demonstration, and states considering adopting the CCBHC model. The FY 2026 Budget Request will also support an evaluation contract that will assess the extent to which grant recipients develop, improve, implement, and sustain the CCBHC model and will assess the delivered services consistent with the CCBHC certification requirements to measure client outcomes and experiences with care.

[135] Substance Abuse and Mental Health Services Administration (2024) CCBHC Certification Criteria website https://www.samhsa.gov/certified-community-behavioral-health-clinics/ccbhc-certification-criteria

Funding History

FY	Amount
FY 2022 Final	$315,000,000
FY 2023 Final	$385,000,000
FY 2024 Final	$385,000,000
FY 2025 Enacted	$385,000,000
FY 2026 President's Budget	$385,000,000

Program Accomplishments

In FY 2024, a total of 368 grants, 361 continuation grants with base budget authority and seven new grants funded by the American Rescue Plan Act were awarded. Additionally, a training and technical assistance center and a CCBHC expansion grant evaluation contract were established. Also in FY 2024, the CCBHC-E grant program served more than 1.5 million people. Over the same period, after receiving 6 months of services, CCBHC-E clients had a 60.1 percent reduction in hospitalizations for mental health and a 55.3 percent reduction in Emergency Department visits in the previous 30 days compared to baseline. CCBHC- E grantees have increased the availability of critical services, improved staffing and training, reduced wait times, enhanced the integration of physical and behavioral health care, expanded addiction treatment capacity including Medication Assisted Treatment (MAT) for opioid use disorder.

In FY 2025, The Administration anticipates funding 360 continuation grants. In addition, the Administration anticipates funding the second $15.0 million appropriated from the Bipartisan Safer Communities Act as well as training and technical assistance center, and a CCBHC expansion grant evaluation contract.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3.5.10 Number of individuals served by the program (Output)	FY 2024: 1,566,410.0 Target: 700,000.0 (Target Exceeded)	700,000.0	700,000.0	Maintain

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	368	360	357
Average Award	$1,000,000	$998,726	$998,565
Range of Awards	$900,000 – 1,000,000	$900,000 – 1,000,000	$900,000 – 1,000,000

Children's Mental Health Services

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$130,000,000	*	$130,000,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grants/Contracts

Program Description

The Children's Mental Health Initiative (CMHI) was created in 1992 and provides grants to assist states, local governments, Tribes, and territories in their efforts to deliver evidence-based treatment and supports to meet the needs of children and youth, from birth through age 21, with serious emotional disturbances (SED) and those at risk for SED. CMHI grants are used to support "systems of care" (SOC), a conceptual framework for organizing and delivering mental health services and treatment.[136]

CMHI supports the implementation, expansion, and integration of the SOC approach by creating sustainable capacity building and services. This program intends to prepare children and youth at risk for or with SED for successful transition to adulthood and assumption of adult roles and responsibilities. This is achieved through building and delivering comprehensive and coordinated efforts to support youth and their families including, but not limited to; intensive home-based outreach and case management services for youth at risk of out-of-home placement; delivery of individualized care plans developed by multidisciplinary care teams, and therapeutic foster care services.

The National Training & Technical Assistance Center for Children, Youth, & Family Mental Health (NTTAC) provides resources that increase access to, effectiveness of, and dissemination of evidence-based mental health services for young people (birth to age 21) and their families, including young people experiencing serious mental illness (SMI) or SED. NTTAC supports CMHI grant recipients by providing an array of trainings, technical assistance, and resources to providers, organizations, and agencies from across the system of care.

[136] Stroul, B., & Friedman, R. (1986). A system of care for children and youth with severe emotional disturbances. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. https://www.ojp.gov/pdffiles1/Digitization/125081NCJRS.pdf

Budget Request

The FY 2026 Budget Request for the Children's Mental Health Program of $130. This funding will support grants and a technical assistance center. At this funding level, the Administration for a Healthy America expects to serve 9,100 children and to train 52,000 people in mental health activities and practices. These funds will increase access to services and supports children and youth with SED and improve the system of care for these children and their families.

Funding History

FY	Amount
FY 2022 Final	$125,000,000
FY 2023 Final	$130,000,000
FY 2024 Final	$130,000,000
FY 2025 Enacted	*
FY 2026 President's Budget	$130,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, we funded 50 CMHI continuation grants, funded one continuation award for the NTTAC and awarded a new cohort of 34 grants. In FY 2024, funding also supported 21 CHR-P continuation grants and a new cohort of six grants. In FY 2024, grant recipients trained 40,004 individuals in the mental health and related workforce in specific mental health- related practices/activities., and contacted 99,162 children, youth, or families through program outreach. CMHI and CHR-P grantees provided services to 9,586 children, youth or young adults.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3.2.16 Number of children with or at risk of SMI/SED that are receiving services from the Children's Mental Health Initiative (Output)	FY 2024: 9,586 Target: 9,100 (Target Exceeded)	*	9,100	*

3.2.27 Number of people in the mental health and related workforce trained in specific mental health-related practices/activities as a result of the program (Output)	FY 2024: 40,004 Target: 52,000 (Target Not Met)	*	52,000	*

*Performance targets are under development.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	111	*	95
Average Award	$1,102,161	*	$1,268,003
Range of Awards	$700,000 – 3,000,000	*	$700,000 – 3,000,000

*Grant award estimates are under development.

Projects for Assistance in Transition from Homelessness

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$66,635,000	*	$66,635,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method.....Formula Grant

Program Description

On a single night in 2023, roughly 653,100 people were experiencing homelessness in the United States. Six in 10 were staying in sheltered locations—emergency shelters, safe havens, or transitional housing programs—and four in 10 were in unsheltered locations such as on the street, in abandoned buildings, or in other places not suitable for human habitation. This represented an increase of 12 percent, or roughly 70,650 more people.[137] Data also suggest that at least 21 percent of individuals experiencing homelessness have a serious mental illness (SMI).[138] Mental illness affects individuals' abilities to maintain stable relationships, perform daily living activities, and maintain stable employment. Symptoms of mental illness can cause individuals to become estranged from family members and caregivers, leaving them without a support system. As a result, individuals with a mental illness are more likely to experience homelessness than those without mental illness and face greater challenges to regaining stable housing.

The Projects for Assistance in Transition from Homelessness (PATH) program was first authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. The PATH program provides annual grants to the 50 states, the District of Columbia, Puerto Rico, Guam, American Samoa, the United States Virgin Islands, and the Northern Mariana Islands. Each state or territory then solicits proposals and awards funds to local public or nonprofit organizations, known as PATH providers.

PATH funding is used to support community-based outreach, mental illness, and substance use disorder (SUD) treatment services, case management and other assistance with accessing housing, and other supportive services for individuals with SMI or SMI and a co-occurring disorder (COD) who are experiencing homelessness or at imminent risk of homelessness. PATH outreach workers are specialized in engaging those who are most vulnerable in their communities and who are least likely to seek out services on their own and can engage in extended trust building often necessary to work successfully with these individuals but that is often not billable under many conventional

[137] The U.S. Department of Housing and Urban Development, Office of Community Planning and Development. The 2023 Annual Homeless Assessment Report (AHAR) to Congress, Part 1. Available at: https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf
[138] The U.S. Department of Housing and Urban Development, 2023 CoC Homeless Populations and Subpopulations Reports Available at https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2023.pdf

funding sources such as insurance. The primary goal of the PATH program is to link and connect homeless individuals with SMI and COD with the treatment and supportive services that they need to access stable housing, treat their illness, build community connections, and progress in their recovery.

Budget Request

The FY 2026 Budget Request for the Projects for the Assistance in Transition from Homelessness program of $66.6 million is level with the FY 2025 Enacted level. It is expected that the FY 2026 budget request will maintain the current level of local PATH providers and current level of service, including serving 105,000 individuals through the PATH program.

Funding History

FY	Amount
FY 2022 Final	$64,635,000
FY 2023 Final	$66,635,000
FY 2024 Final	$66,635,000
FY 2025 Enacted	*
FY 2026 President's Budget	$66,635,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, the Administration funded all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. PATH providers are offering essential services in over 400 communities to support outreach workers and mental health specialists who are expected to engage over 100,000 individuals living with SMI or living with both SMI and drug/alcohol addiction and were homeless or at imminent risk of becoming homeless.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3.4.15a Percentage of enrolled homeless persons in the Projects for Assistance in Transition from Homelessness (PATH) program who receive community mental health services (Intermediate Outcome)	FY 2023: 38.5% Target: 64% (Target Not Met)	*	64%	*
3.4.16 Number of homeless persons contacted (Outcome)	FY 2023: 104,180 Target: 105,000 (Target Not Met but Improved)	*	105,000	*
3.4.17 Percentage of contacted homeless persons with serious mental illness who become enrolled in services (Outcome)	FY 2023: 55% Target: 57% (Target Not Met)	*	57%	*

*Performance targets are under development.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	56	*	56
Average Award	$1,126,896	*	$1,103,046
Range of Awards	$50,000 – 4,000,000	*	$50,000 – 4,000,000

*Grant award estimates under development.

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$40,000,000	*	$14,146,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method.....Formula Grants

Program Description

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program ensures that the most vulnerable individuals with serious mental illness (SMI) and significant emotional impairment, especially those residing in public and private residential care and treatment facilities, are free from abuse. This includes inappropriate restraint and seclusion, neglect, and rights violations while receiving appropriate mental illness treatment and discharge planning services.

The Protection and Advocacy for Individuals with Mental Illness Act of 1986, as amended by the Children's Health Act of 2000, extended the protections of the Developmental Disabilities (DD) Assistance Act of 1975 to individuals with significant mental illness (adults) and significant emotional impairments (children/youth) at risk for abuse, neglect, and rights violations while residing in public or private care treatment facilities; or living in a community setting, including their own homes. The PAIMI Act authorized the same governor-designated state protection and advocacy (P&A) systems established under the DD Assistance Act of 1975 to receive PAIMI Program formula grant awards from SAMHSA.

PAIMI supports legal-based advocacy services that are provided by the 57 governor-designated P&A systems, which include states, territories, and the District of Columbia. Each system is mandated to: (1) ensure that the rights of individuals with mental illness who are at risk of abuse, neglect, and rights violations while residing in public or private care or treatment facilities or living in a community setting are protected; (2) protect and advocate for the rights of these individuals through activities that ensure the enforcement of the Constitution and federal and state statutes; and (3) investigate incidents of abuse and/or neglect of individuals with mental illness. The priority for services is individuals who are an in-patient or residents of public or private care and treatment facilities for individuals with mental illness.

Budget Request

The FY 2026 Budget Request is $14.1 million. PAIMI programs will continue to focus on addressing abuse and neglect issues for vulnerable populations and advocate for the rights of

individuals with mental illness as well as continue to assist individuals with SMI increase access to treatment. At this funding level, the Administration for a Healthy America anticipates providing services to 4,000 individuals through the PAIMI program.

Funding History

FY	Amount
FY 2022 Final	$38,000,000
FY 2023 Final	$40,000,000
FY 2024 Final	$40,000,000
FY 2025 Enacted	*
FY 2026 President's Budget	$14,146,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, SAMHSA awarded 57 annual grants to states, District of Columbia, and territories. In 2024, PAIMI grantees served approximately 8,600 individuals.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3.4.12 Number of people served by the PAIMI program (Outcome)	FY 2024: 8,658 Target: 8,600 (Target Exceeded)	*	4,000	*
3.4.19 Number attending public education/constituency training and public awareness activities (Output)	FY 2024: 95,276 Target: 150,000 (Target Not Met)	*	50,000	*

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3.4.21 Percentage of complaints of alleged abuse, neglect, and rights violations substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making, elimination of other barriers to personal decision-making, as a result of Protection and Advocacy for Individuals with Mental Illness (PAIMI) involvement (Outcome)	FY 2024: 95% Target: 92% (Target Exceeded)	*	92%	*

*Performance targets are under development.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	57	*	56
Average Award	$701,754	*	$252,607
Range of Awards	$253,000 – 2,900,000	*	$50,000 – 200,000

*Grant award estimates are under development.

Assisted Outpatient Treatment for Individuals with Serous Mental Illness (SMI)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$21,420,000	*	$21,420,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grants/Contracts

Program Description

Assisted Outpatient Treatment (AOT) for Individuals with SMI is the practice of delivering outpatient treatment under a civil court order to adults with SMI who meet specific state civil commitment AOT criteria, such as a prior history of non-adherence to treatment, repeated hospitalizations, or arrest. AOT involves petitioning local courts through a civil process to order individuals to enter and remain in treatment within the community for a specified period.

AOT supports the implementation and evaluation of new AOT programs and the identification of evidence-based practices to help reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of individuals with a SMI. This program is designed to work with courts to allow these individuals to obtain treatment while continuing to live in the community and their homes.

Budget Request

The FY 2026 Budget Request for the Assisted Outpatient Treatment for Individuals with SMI program of $21.4 million. This funding will support 37 grant continuations.

Funding History

FY	Amount
FY 2022 Final	$21,420,000
FY 2023 Final	$21,420,000
FY 2024 Final	$21,420,000
FY 2025 Enacted	*
FY 2026 President's Budget	$21,420,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, six grant continuations and a new cohort of 22 grants were awarded. These efforts aim to improve health and social outcomes for individuals with SMI and include continued support for the technical assistance center. The program showed significant outcomes, including:

- **Cost Savings and Public Health Outcomes:** AOT participants experienced substantial reductions in hospitalization and emergency department visits for mental health issues. Only 8 percent of participants required hospitalization for mental health care in the past 30 days at their 6-month reassessment, a dramatic decrease from 65 percent at intake. The rate of emergency department visits dropped to 4 percent from 26 percent at intake.
- **Rates of Incarceration:** There was also a notable reduction in incarceration rates among participants; at their six-month reassessment, 5 percent of participants reported spending one or more nights in a correctional facility in the past 30 days, down from 14 percent at intake.
- **Patient and Family Satisfaction:** Satisfaction with the program remained high; a remarkable 93.5 percent of participants had a positive perception of the services they received, as reported in their 6-month reassessment.

In FY 2025, we anticipate funding 25 continuation grants and award a new cohort of 15 grants.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
3.4.31 Number of clients served (Output)	FY 2024: 1,583 Target: 1,100.0 (Target Exceeded)	1,100	1,100	Maintain

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	28	40	37
Average Award	$734,946	$519,014	$538,395
Range of Awards	$500,000 – 700,000	$500,000 – 700,000	$500,000 – 700,000

Substance Use Prevention

Drug Free Communities

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	*	*	$70,000,000
FTE	**	**	556[1]

*Funded in ONDCP prior to FY 2026.
**FY 2024 and FY 2025 FTE included in ONDCP FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grant

Program Description

Created in 1997, the Drug-Free Communities (DFC) Support Program funds community-based coalitions that engage multiple sectors of the community to prevent youth substance use. For FY 2026, we are proposing to move DFC from the Office of National Drug Control Policy (ONDCP) to the Administration for a Healthy America. This move will better align substance use prevention resources supported by DFC and increase efficiency in program operations and management and ultimately make a greater impact in communities across the nation.

The DFC Support Program provides grants up to $125,000 per year for five years to community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use. After five years, community coalitions may re-compete for another five-year cycle.

Recognizing that local problems need local solutions, DFC-funded coalitions engage multiple sectors of the community and employ a variety of environmental strategies to address local substance use problems, using the Strategic Prevention Framework. DFCs involve local communities in finding solutions and also helps youth at risk for substance use recognize the majority of our nation's youth choose not to use substances. As demonstrated by independent evaluations, the DFC Support Program significantly reduces substance use amongst youth, the target population.

DFC Coalitions consist of community leaders representing twelve sectors that organize to meet the local prevention needs of the youth and families in their communities. By funding these coalitions, the DFC Support Program ensures communities adopt a balanced and comprehensive approach to reducing substance use in their neighborhoods.

Budget Request

The FY 2026 Budget Request for the Drug Free Communities program is $70 million. This request will fund approximately 560 grant awards.

Funding History*

FY	Amount
FY 2022 Final	$106,000,000
FY 2023 Final	$109,000,000
FY 2024 Final	$109,000,000
FY 2025 Enacted	$109,000,000
FY 2026 President's Budget	$70,000,000

* Funded in ONDCP prior to FY 2026.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	---	---	560
Average Award	---	---	$125,000
Range of Awards	---	---	$125,000

Science and Service Activities

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$4,072,000	*	$4,072,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method.....Contracts

Program Description

The Substance Use Disorder Prevention Engagement Initiatives (SUDPEI) contribute to the agency's efforts to collaborate across sectors and with external partners to promote wider adoption and application of effective SUD prevention strategies across the continuum of care, with an emphasis on integrating prevention services into other systems, including the health system, through efforts such as partner engagement and training. The SUDPEI promotes the adoption of evidence-based policies, programs, and practices by developing materials, resources, and other engagement tools to strengthen state and community-based prevention efforts to address substance use. As part of its work, the SUDPEI develops communications resources for prevention professionals and community coalitions These resources highlight important trends from the National Survey on Drug Use and Health, along with other data sources, and promote evidence-based strategies for preventing substance use and related issues.

Another key SUDPEI activity, Communities Talk to Prevent Substance Use Disorders, is designed to raise awareness of SUD prevention issues as well as mobilize and support community awareness and action. Through this work, SUDPEI will continue to elevate community success stories via its podcast series, webinars, and prominent placement of stories on the Communities Talk website. Additionally, funding will be used to promote and amplify substance use data, research, and prevention resources related to alcohol and substance misuse by youth and youth adults. Other focus areas will include technical assistance in bridging prevention service delivery between substance misuse and mental health promotion as well as operationalizing innovation and data-driven methods in prevention service delivery.

The Science and Service Program also supports the Tribal Training and Technical Assistance Center. This Center provides critical training and technical assistance to tribes and tribal organizations to help advance their behavioral health goals.

Budget Request

The FY 2026 Budget Request is $4.1 million. Funding will continue to improve efforts to collaborate across sectors and with external partners to promote wider adoption and application of

effective SUD prevention strategies across the continuum of care and to help support community readiness in identified tribal communities through tribally focused and tribally specific technical assistance delivery.

Funding History

FY	Amount
FY 2022 Final	$4,072,000
FY 2023 Final	$4,072,000
FY 2024 Final	$4,072,000
FY 2025 Enacted	*
FY 2026 President's Budget	$4,072,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In 2024, the SUDPEI distributed more than 500 *Communities Talk* planning stipends to community-based organizations (CBOs), institutions of higher education (IHEs), and statewide or state-based organizations to plan activities that raise awareness and educate youth, families, and communities about the potentially harmful consequences of underage and problem drinking, and other substance misuse among individuals 12 to 25 years old. Community events and activities have been conducted in every state and territory.

To support community-based planning, a new web-based planning app is now available. Using an OMB-approved survey, data regarding community activities will be captured beginning in FY 2023. In addition, success stories are also developed and shared via the https://www.samhsa.gov/communities-talk website.

In addition, in FY 2024, The Tribal Technical Assistance Center (TTAC) conducted 59 training and technical assistance (TTA) events and trained 1,441 individuals. These TTA events included 20 broad and 15 focused trainings, five intensive TTA events, 15 988/Circle of Care events, and four opioid TTA events, including two opioid-specific Gathering of Native Americans (GONA) events.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
2.3.101 Number of individuals trained (Outcome)	FY 2024: 1,441 Target: 2,583 (Target Not Met)	*	2,583	*

*Performance targets are under development.

Federal Drug-Free Workplace

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$5,139,000	*	$5,139,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method ..... Interagency Agreements/Contracts

Program Description

The Federal Drug-Free Workplace Programs (DFWP) are the federal leader in regulated drug testing, setting the gold standard nationally and internationally. DFWP ensures that employees in critical federal and federally regulated positions are tested for illegal drug use and prescription drug misuse, using HHS-certified laboratories. DFWP's policies cover all executive branch employees. Not only does this initiative reduce health insurance costs, boost productivity, enhance workplace safety, and provide Employee Assistance Programs (EAP) for individuals struggling with substance misuse or substance use disorders, crucially, DFWP impacts the safety of all Americans by keeping U.S. airways, roads, and waterways safe through the Department of Transportation's regulatory programs. By leveraging cutting-edge technology for essential studies on drug impacts and emerging drug threats, DFWP integrates research findings into policy and practice through strong collaboration with civilian and federal entities and ensures continuous monitoring to effectively meet stakeholder needs and drive informed decision-making.

The Workplace Helpline supports the DFWP by providing a toll-free telephone service that answers drug testing questions from federal agencies, as well as the public and private sector workplaces. This service is designed to equip employees and their families with essential knowledge to resolve substance misuse and drug testing issues at work and/or in their personal lives. In addition, DFWP staff work closely with partners across the Executive Branch to maintain and update their testing programs.

Budget Request

The FY 2026 Budget Request is $5.1 million. The funding continues to support the DFWP with implementing and maintaining Mandatory Guidelines for urine and oral fluid in the federally regulated drug testing program. This includes costs associated with laboratory proficiency testing specimens, application fees, inspector training, HHS pre-inspections for applicant laboratories, and HHS laboratory certification for new oral fluid testing laboratories. Along with the implementation of the oral fluid testing program, the Administration for a Healthy America will continue to pursue the implementation of hair testing and oversight of the Executive Branch Agencies' DFWPs as

well as continue its oversight role for the inspection and certification of the HHS-certified laboratories.

Funding History

FY	Amount
FY 2022 Final	$4,894,000
FY 2023 Final	$5,139,000
FY 2024 Final	$5,139,000
FY 2025 Enacted	*
FY 2026 President's Budget	$5,139,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, SAMHSA focused on implementing the final, revised urine mandatory guidelines and supported laboratories and other partners to advance efforts to bring oral fluid testing to the DFWP, building on the FY 2023 initiatives. These efforts followed the issuance of the Final Mandatory Guidelines for both urine and oral fluid testing in October 2023, with implementation dates of October 10, 2023, and February 1, 2024, respectively.

In FY 2024, DFWP has (1) certified new laboratories nationwide to conduct federal and federally regulated drug tests, including urine tests; (2) analyzed and provided guidance on emerging issues such as opioids/synthetic opioids, polysubstance use, young adults, and high-risk workplaces; (3) enhanced Employee Assistance Programs (EAPs); and (4) supported the public and private drug testing industry through Helpline inquiry responses, research, and consultation on preventing substance use in the workplace, including a revised and updated Workplace Toolkit. Additionally, DFWP will continue supporting the implementation and maintenance of Mandatory Guidelines for oral fluid and continue the development of guidelines for hair testing in the federally regulated drug testing program. This includes funding for laboratory proficiency testing specimens, application fees, inspector training, HHS pre-inspections for applicant laboratories, and HHS laboratory certification for new oral fluid testing laboratories.

DFWP will continue to advance its efforts by addressing roadblocks in oral fluid implementation and preparing for future hair testing once the Mandatory Guidelines are published. The focus will include continuously monitoring the quality of urine testing by reducing adulteration and substitution and expanding certification of laboratories to include oral fluid testing. Enhancements to EAPs will address emerging substance use issues. DFWP also supports critical studies on these issues and advance technology adaptation to improve the program's deterrence effect. Collaboration with civilian and federal entities will expand to ensure findings are integrated into policy and practice, supported by continuous monitoring and evaluation to align the program with stakeholder needs and enhance decision-making. In addition, the Administration for a Healthy America will continue to oversee the Executive Branch Agencies' DFWP and maintain its role in inspecting and certifying 21 HHS-certified laboratories.

Center for the Application of Prevention Technologies

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$9,493,000	*	$9,493,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method.....Contracts

Program Description

The Prevention Technology Transfer Centers (PTTCs) Network is comprised of 10 Domestic Regional Centers, and a National Coordinating Center. Together the Network serves the 50 U.S. states, District of Columbia, Puerto Rico, U.S. Virgin Islands, the Pacific Islands of Guam, American Samoa, Republic of Palau, Republic of the Marshall Islands, Federated States of Micronesia, and the Commonwealth of Northern Mariana Islands.

The purpose of the PTTC Network is to improve implementation and delivery of effective substance misuse prevention strategies and interventions and provide training and technical assistance services to the substance use prevention field. The PTTC Network is the agency's largest technical assistance investment in supporting and advancing the prevention workforce. This is accomplished by developing and disseminating tools, strategies, and resources needed to improve the quality of substance use prevention efforts; providing intensive technical assistance and learning resources to prevention professionals to improve their understanding of prevention science, epidemiological data, and implementation of evidence-based and promising policies, programs, and practices; and developing tools and resources to engage the next generation of prevention professionals. Because of its regional structure, the PTTC Network is able to provide responsive supports based on the unique needs of each state and region. The PTTC Network also advances priority prevention topics by having each regional center establish a prevention subject area of special expertise. The agency emphasizes a "no wrong door" approach to delivering technical assistance through increased collaboration among other agency-funded technical assistance centers.

Budget Request

The FY 2026 Budget Request is $9.5 million. This program is a key component to expanding and enhancing the prevention workforce and prevention capacity across states and communities in the U.S. The program includes support for funding to continue the PTTC Network to ensure consistent high quality, easily accessible technical assistance and training resources are available to the prevention field. In FY 2026, the Administration for a Healthy America intends to continue to

advance key prevention knowledge transfer and workforce development through the PTTCs, including continued support of the prevention fellowship program and continued training of the prevention workforce. The Administration for a Healthy America anticipates grantees will provide trainings to approximately 39,774 participants.

Funding History

FY	Amount
FY 2022 Final	$7,493,000
FY 2023 Final	$9,493,000
FY 2024 Final	$9,493,000
FY 2025 Enacted	*
FY 2026 President's Budget	$9,493,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2024, SAMHSA awarded new funding to the PTTC network, including one National Coordinating Center (NCC) grant and ten regional PTTCs, as well as continued funding for two Centers of Excellence (COEs). The funding continued the Prevention Fellowship Program that provides early career prevention fellows in each region experience working with State alcohol and drug agencies. This program also helped develop leadership skills and proficiency in core competencies to prepare for certified prevention specialist exams and helped prepare the next generation of professionals for employment opportunities in the substance use prevention field. This funding also supported the development of an environmental scan of psychosocial resources that will aid government grants management and program management staff in connecting grant recipients to these resources as well as to help identify where gaps and needs exist.

During FY 2024, the PTTC Network completed 923 training and technical assistance events, in which 36,380 prevention participants attended. In addition, to support knowledge transfer, the PTTC Network has state-of-the-art working groups which are as follows: Cannabis Risk, Data Informed Decisions, Community Coalitions & Collaborators, Workforce Development, and Implementation Science. The Network also implemented the Prevention Fellowship Program, comprising 16 individuals across the regional centers. In collaboration with the Opioid Response Network, they created a strategic plan to support the professionalization and workforce of prevention.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
1.4.14 Number of people trained (Output)	FY 2024: 36,380 Target: 39,774 (Target Not Met)	*	39,774	*

*Performance targets are under review.

Substance Use Treatment

Opioid Treatment Programs/Regulatory Activities

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$10,724,000	*	$10,724,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grant/Contracts/Cooperative Agreements

Program Description

The Administration for a Healthy America works to close the gap between the number of people needing treatment for Opioid Use Disorder (OUD) and the capacity to treat them with Food and Drug Administration (FDA)-approved Medications for Opioid Use Disorder (MOUD) (buprenorphine, methadone, and naltrexone products). These medications are often used in combination with additional evidence-based treatment and recovery support services. The Administration for a Healthy America expands access to MOUD through regulating and supporting Opioid Treatment Programs (OTPs); provider support for those who provide MOUD with buprenorphine and naltrexone in office-based settings; and education and training of healthcare students and practitioners on the treatment of OUD, including with MOUD, through universities and professional organizations.

MOUD and Opioid Treatment Program Expansion

The Administration for a Healthy America is responsible for regulating and certifying the country's OTPs; providing direct support to OTPs, healthcare systems, states, and other federal agencies regarding certification, accreditation, and evidence-based OUD treatment; and overseeing accreditation of OTP programs. The Administration for a Healthy America approves all organizations that accredit OTPs (accreditation bodies), reviews the standards they apply in their accreditation of OTPs, and monitors their adherence to 42 CFR Part 8. The Administration for a Healthy America meets regularly with the State Opioid Treatment Authorities (SOTAs) and provides technical assistance, guidance, and support for issues related to OUD care, such as assisting them with application of the federal regulations for OTPs within their state and promoting evidence-based OUD treatment and related care. These responsibilities and interactions enable the Administration for a Healthy America to address barriers to treatment and expand access to services.

A key population of focus are individuals with OUD who are involved in the criminal justice system. To ensure access to MOUD for this high-risk population, work is done with multiple

federal and state partners to increase uptake of all three FDA-approved medications, including methadone. The Administration for a Healthy America meets regularly with the SOTAs to assist them in integrating MOUD into their state prisons, has hosted multiple Policy Academies to support their efforts, provides technical assistance directly to states, and supports efforts of the Department of Justice's (DOJ) Bureau of Justice Assistance (BJA) to integrate MOUD in county jails across the country.

Substance Use Disorder, including Opioid Use Disorder, Education and Training of Providers

In addition to expanding access to MOUD through OTPs, the Administration for a Healthy America is working to expand access to MOUD through general and specialty healthcare services. The Consolidated Appropriations Act of 2023 (PL 117-238) facilitated this goal as it removed the requirement that practitioners hold a waiver that certifies their qualification to prescribe buprenorphine in an office-based setting, as established in the Drug Addiction Treatment Act of 2000 (DATA 2000). This allows practitioners who hold DEA registrations for prescribing Schedule III-V medications to prescribe buprenorphine under their usual DEA registration, and as allowable by state law. PL 177-238 also included a provision that required that all practitioners seeking to apply for a new or renewed DEA registration to prescribe Schedule II-V controlled medications attest to having completed at least 8 hours of training on OUD or other SUD. Together, these policy changes expand the number of practitioners available to treat OUD and other SUDs and the number of practitioners requiring training and other practice support. Their implementation, which started in FY 2023, continues in FY 2026.

Healthcare providers play a pivotal role in educating their patients and colleagues about substance use and SUD; screening, diagnosing, and treating patients; and modeling positive attitudes to reduce the stigma attached to SUD and its treatment. Early career physicians have identified lack of preparedness to treat SUD as a barrier to prescribing MOUD,[139] and further research shows that lack of appropriate education fosters an unwillingness to prescribe MOUD.[140] Comprehensive and uniform training on SUDs and treatment and recovery modalities can overcome these deficits.

The Administration for a Healthy America promotes provider education through its unique grants and contracted programs, including the Providers Clinical Support System-University (PCSS-U), the Providers Clinical Support System-Medications for Opioid Use Disorder (PCSS-MOUD) programs, and the Providers Clinical Support System – Medications for Alcohol Use Disorder (PCSS-MAUD) program. PCSS-U promotes the integration of SUD education into professional healthcare schools and aims to engage students in treating SUD upon graduation and meet the requirements of PL 177-238. PCSS-MOUD expands the number of licensed providers completing training for prescribing MOUD and provides mentoring and other supports for practitioners treating OUD and other SUDs. PCSS-MAUD aims to increase the number of healthcare professionals who provide MAUD in their practice, provide training, coaching, consultation, and

[139] DeFlavio JR, Rolin SA, Nordstrom BR, Kazal LA, Jr. Analysis of barriers to adoption of buprenorphine maintenance therapy by family physicians. Rural & Remote Health. 201515:3019.

[140] Mackey K, Veazie S, Anderson J, Bourne D, and Peterson K. Evidence Brief: Barriers and Facilitators to Use of Medications for Opioid Use Disorder. Washington, DC: Evidence Synthesis Program, Health Services Research and Development Service, Office of Research and Development, Department of Veterans Affairs. 2019

other support services for a wide range of treatment providers, improve healthcare and AUD treatment outcomes, and decrease alcohol-related morbidity and mortality through use of MAUD.

There remains a significant need to continue to increase the number of healthcare practitioners providing treatment for OUD, AUD and other SUDs. The Administration for a Healthy America will continue to support the training of health professionals and to address the complex issues of SUD treatment in general and specialty healthcare settings.

Budget Request

The FY 2026 Budget Request for OTP of $10.7 million. During FY 2026, OTP activities will be maintained. The Administration for a Healthy America will maintain the rate of onsite visits to OTPs and corresponding medication units in the nation, to advance implementation of Part 8 regulations and to enhance its oversight of the work of the accreditation bodies. The Administration for a Healthy America will continue to work with SOTAs and the OTP community on implementation of the revised OTP regulations, continue to support the Federal Bureau of Prisons (FBOP) with MOUD integration, provide training and technical support to states as they continue to integrate MOUD in state prisons, and continue to work with other federal partners to improve the capacity of criminal justice systems to provide the full complement of MOUD. In FY 2026, based on performance data from FY 2024, the Administration for a Healthy America expects to provide training to a total of 55,000 participants through the PCSS components.

In addition, the Administration for a Healthy America plans to award PCSS-U grants, plus cooperative agreements for PCSS-MOUD and PCSS-MAUD.

Funding History

FY	Amount
FY 2022 Final	$8,724,000
FY 2023 Final	$10,724,000
FY 2024 Final	$10,724,000
FY 2025 Enacted	*
FY 2026 President's Budget	$10,724,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

MOUD in Opioid Treatment Programs

In FY 2024, the last year for which complete data is available, 142 new OTPs were certified. As of May 2025, there were 2,104 active OTPs across 49 states and two territories; collectively, these OTPs also operate 113 affiliated medication units and 64 mobile units. In FY 2025, the Administration continued to assist states and local jails in implementing MOUD in their criminal justice settings, including hosting a third Policy Academy in April 2025 to assist five additional states, bringing the total to 15 states that have participated in at least one such Policy Academy

and received ongoing technical assistance. Implementation of the revised OTP regulations will continue, including through in-depth meetings with SOTAs, Accreditation Bodies, and regional sessions with OTPs themselves and state authorities.

MOUD in Other Health Care Settings

In FY 2023, following passage of Sections 1262 and 1263 of the Consolidated Appropriations Act, 2023 (also commonly known as the Mainstreaming Addiction Treatment Act, or MAT Act, and Medication Access and Training Expansion Act, or MATE Act, respectively), educational and other resource materials were developed that explained these Acts to providers, patients and pharmacies, and these stakeholders were assisted in navigating the elimination of the waiver previously required to prescribe buprenorphine. The Administration for a Healthy America continues supporting healthcare practitioners in accessing SUD training in FY 2026.

MOUD Education and Training of Providers

The PCSS systems offer live webinars, roundtable discussions, self-paced webinars, and in-person trainings. During FY 2024, the last year for which data is available, the PCSS components significantly surpassed their training and mentorship targets, collectively providing training to a total of over 55,000 participants and provided support for 36 universities to incorporate SUD content into their education programs. The PCSS-MOUD and PCSS-MAUD programs provide mentoring services, enlisting the assistance of hundreds of nationally recognized experts as mentors to provide support to thousands of practitioners. Both of these programs maintain unique curriculum libraries that can be utilized by providers and education programs and develop toolkits and guidelines to support providers in their practices.

In FY 2024, the Administration funded 18 new and one continuation PCSS-U grants, two PCSS continuation cooperative agreements (MOUD and MAUD) and three contracts to support OTPs.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	21	*	23
Average Award	$397,000	*	$397,000
Range of Awards	$300,000-$1,500,000	*	$300,000-$1,500,000

*Grant award estimates are under development.

Addiction Technology Transfer Centers

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$9,046,000	*	$9,046,000
FTE	**	**	556[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Competitive Grants/Contracts/Cooperatives Agreements

Program Description

Substance use continues to exact a serious toll on the U.S. population. The estimated cost of substance use disorders (SUD) in the United States, including the use of illegal drugs, alcohol, and tobacco, is more than $740 billion a year and growing.[141] SUD and mental disorders are among the leading causes of disability in the United States. Among people aged 12 or older, about 17 percent had an SUD in the past year; almost one in four adults aged 18 or older had any mental illness in the past year.[142] Illicitly manufactured fentanyl continues to drive the majority of drug overdose deaths but mortality rates due to cocaine and other stimulants, such as methamphetamine, are also on the rise, both with and without the presence of fentanyl.[143] In addition, alcohol continues to exact a serious toll on the U.S. population.[144]

Despite the high prevalence of substance use and mental disorders, many people who require behavioral health services do not receive quality care, due in part to behavioral health workforce shortages, as well as deficiencies in knowledge, skills, and capacity across the behavioral health workforce to meet the unmet needs of underserved populations. Substantial shortages of addiction and mental health counselors, psychologists, and psychiatrists are projected in 2036.

In response to the aforementioned national crises, the purpose of the Technology Transfer Centers (TTCs) is to develop and strengthen the specialized behavioral healthcare and broad healthcare workforce who provide the continuum of prevention, public health interventions, treatment, and recovery support services for SUD and mental illness. The program's mission is to help practitioners and organizations incorporate effective evidence-based practices across the continuum of behavioral health. The TTCs are comprised of two networks, one of which is the long-standing Addiction Technology Transfer Centers (ATTC) network.

[141] Zhang, X., Wang, N., Hou, F., Ali, Y., Dora-Laskey, A., Dahlem, C. H., & McCabe, S. E. (2021). Emergency department visits by patients with substance use disorder in the United States. *Western Journal of Emergency Medicine*, *22*(5):1076–1085. https://doi.org/10.5811%2Fwestjem.2021.3.50839
[142] 2023-nsduh-main-highlights.pdf (samhsa.gov)
[143] Centers for Disease Control and Prevention. (2024). Provisional Drug Overdose Death Counts. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
[144] 2023-nsduh-main-highlights.pdf (samhsa.gov)

In 1993, the ATTC network was established, undergoing several maturations to evolve over time. The current iteration of the ATTC network includes ten regional ATTCs and a ATTC National Coordinating Office. Together, the ATTC network serves the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Islands of Guam, American Samoa, Palau, the Marshall Islands, Micronesia, and the Mariana Islands. The target audience of the ATTC network includes medical and behavioral health professionals, recovery specialists, addiction counselors, criminal justice professionals, administrators, and educators.

Specific activities that the ATTC network carries out include: providing custom technical assistance, building capacity to address regional, local and/or population-specific needs on a variety of topics; promoting and facilitating relationship building among stakeholders in behavioral health policy, research, and practice; serving as a continuous feedback loop for innovation and practice; focusing on consultation and implementation to achieve systems change; and continually adapting and growing to improve, advance, and expand treatment and recovery services.

Budget Request

The FY 2026 Budget Request for the Addiction Technology Transfer Centers program is $9.0 million. At this level, the Administration for a Healthy America will fund cooperative agreements.

Funding History

FY	Amount
FY 2022 Final	$9,046,000
FY 2023 Final	$9,046,000
FY 2024 Final	$9,046,000
FY 2025 Enacted	*
FY 2026 President's Budget	$9,046,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

The ATTCs have been improving and updating their programs to offer novel training and technical assistance options that include multiple learning components in new delivery formats focused on changing practices. The network has developed a robust virtual platform that has proven successful in supporting healthcare professionals with telehealth strategies and many adaptations of evidence-based interventions for virtual settings. Using this platform and other training modalities, the ATTC network will continue to respond to the differential impact of the evolving overdose crisis by addressing the needs of providers and continuing to develop resources to help to address the needs of all communities with a focus in the areas of contingency management; HIV, hepatitis C elimination, and sexually transmitted infections; the integration of primary and behavioral health care; recovery support; and trauma-informed approaches.

In FY 2024, the Administration funded 11 new ATTC cooperative agreements for 10 regional ATTCs and one ATTC National Coordinating Office.

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	11	*	11
Average Award	$777,850	*	$777,850
Range of Awards	$777,850	*	$777,850

*Grant award estimates under development.

Cross-Cutting Behavioral Health

Behavioral Health Innovation Block Grant

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	---	---	$4,125,650,000
FTE	---	---	556[1]

1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method.....Formula Grant

Program Description

The new formula-based Behavioral Health Innovation Block Grant (BHIBG) combines the Community Mental Health Services Block Grant (MHBG), the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG), and the State Opioid Response (SOR) grants into a single grant. This consolidation aims to maximize states' flexibility in supporting mental health and substance use services to better address local needs. The BHIBG aims to support states in addressing critical gaps and unmet needs in their mental health and substance use disorder systems, collectively under the umbrella of behavioral health. In addition, the grant provides seed funding to pilot and expand evidence-based and promising practices. States are encouraged to explore innovative solutions that improve access, engagement, and outcomes for individuals at-risk for or with behavioral health needs, fostering sustainable and transformative change across communities and systems.

Under this consolidated funding, states will have the ability to fund various activities most fitting the needs of their communities, including addressing mental illness, and substance use prevention, treatment, and recovery services. The BHIBG will provide a significant safety net source of funding for some of the most at-risk populations in communities across the country and will give each state the flexibility to address the unique needs of their populations in ways that are most impactful. In addition, the BHIBG will allow states to plan, implement and evaluate the development and delivery of services for serious mental illness and serious emotional disturbances, crisis response, substance use disorder prevention, treatment, recovery, and overdose response including the development of comprehensive strategies focused on preventing, intervening, and promoting recovery from issues related to opioid use disorder. This could also include the promotion of improved business practices and use of health information technology, as well as more specific activities previously funded under the MHBG, SUPTR BG, SOR, and other eliminated programs.

The BHIBG's flexibility will make it a foundational support for public mental health and substance use disorder prevention, treatment, and recovery systems. Grant recipients can use funds for a variety of behavioral health services, as well as for planning, administration, implementation, and educational activities across the behavioral health continuum. Funds are

expected to be used to ensure the development and support of behavioral health systems to adequately and efficiently provide services to more people in need.

Budget Request

The FY 2026 Budget Request for the Behavioral Health Innovation Block Grant is $4.1 billion. This funding will continue to provide services to people with serious mental illness, people with serious emotional disturbances, and those in need of substance use prevention, treatment, and recovery services. Funding will also continue to provide specialized mental health and substance use prevention, treatment and recovery services for individuals with opioid use disorder, pregnant women, parents with dependents, and individuals with HIV.

Funding History

FY	Amount
FY 2022 Final	---
FY 2023 Final	---
FY 2024 Final	---
FY 2025 Enacted	---
FY 2026 President's Budget	$4,125,650,000

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
2.3.14 Number of people served by the public mental health system	FY 2023: 8.3 million Target: 8.2 million (Target Met)	8.2 million	8.5 million	+300,000

Behavioral Health and Substance Use Disorder Resources for Native Americans

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	---	---	$80,000,000
FTE	---	---	556[1]

1\FY 2026 FTE represents entire Mental and Behavioral Health FTE total.

Allocation Method..... Formula grant

Program Description:

The Administration for Healthy America is proposing funding for a new program that will provide resources to any health program administered directly by the Indian Health Service (IHS), a Tribal health program, an Indian Tribe, a Tribal organization, an Urban Indian organization, and a Native Hawaiian health organization. The funds for this program would be used to provide services for the prevention, treatment, and recovery from mental health and substance use disorders among American Indians, Alaska Natives, and Native Hawaiians. Eligible entities have would have latitude to develop programs that fit their unique needs and tailored to their community. Funding would be provided to eligible entities based on a budget formula developed in consultation with Indian Tribes and Tribal organizations, conference with Urban Indian organizations, and engagement with a Native Hawaiian health organization.

Budget Request

The FY 2026 Budget Request is $80.0 million for this new program. Funding will be used to provide services for the prevention, treatment, and recovery from mental health and substance use disorders among American Indians, Alaska Natives, and Native Hawaiians and to maintain improvements in mental health and substance use services in identified tribal communities.

Funding History

FY	Amount
FY 2022 Final	---
FY 2023 Final	---
FY 2024 Final	---
FY 2025 Enacted	---
FY 2026 President's Budget	$80,000,000

AHA will also enhance its program integrity activities by supporting the integration of analytical tools such as electronic grants system, program data, grant and contract data sources, HHS sources, and government-wide sources. AHA aims to identify and address issues before they become audit findings. AHA plans to focus on a risk-based approach to grantee monitoring to focus on grantees at risk of noncompliance. AHA will also support the alignment of program integrity initiatives with planning and performance activities across planned AHA programs.

AHA will harness data solutions to enable secure data sharing and support high volume data processing and enhance multiple other reporting and case management systems to maximize efficiencies and increase program integrity.

Program Accomplishments

There are no accomplishments to report as AHA Program Management is new in FY 2026.

HEALTH WORKFORCE TAB

HEALTH WORKFORCE

National Health Service Corps

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
BA	$128,600,000	$128,600,000	$128,600,000	---
NHSC Mandatory	$432,904,109[145]	$258,041,096	---	-$258,041,096
NHSC Mandatory Proposed	---	---	$345,000,000	+$345,000,000
Total	**$561,504,109**	**$386,641,096**	**$473,600,000**	**+$86,958,904**
FTE	**	**	258[1]	

****FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Health Workforce FTE total.

Allocation Method..... Competitive Grant/Cooperative Agreement/Other (Competitive Awards to Individuals)

Program Description

Since its inception in 1972, the National Health Service Corps (NHSC) has increased access to care in underserved areas by supporting qualified health care providers working in urban, rural, and tribal areas. NHSC clinicians serve patients in Health Professional Shortage Areas (HPSAs) – areas that meet criteria identifying a greater need for primary medical, oral health, or behavioral health care providers. Using scholarships and loan repayment, the NHSC incentivizes primary care clinicians to serve in the more than 20,600 Primary Care, Dental, and Mental Health HPSAs across the nation.

The NHSC operates five programs and administers one state grant program to place clinicians at NHSC-approved sites in underserved communities. These health care delivery sites must meet certain requirements, including using a sliding fee schedule to provide care to individuals regardless of their ability to pay.

NHSC Scholarship Program: The NHSC Scholarship Program provides financial support through scholarships that cover tuition, other reasonable education expenses, and a monthly living stipend to health professions students committed to providing primary care in underserved

[145] Through sequential FY 2024 funding measures including the Consolidated Appropriations Act, 2024 (P.L. 118-42), the NHSC received a total mandatory appropriation of $432,904,109, available through December 31, 2024.

communities with the greatest need. Upon completion of training, NHSC scholars become salaried employees of NHSC-approved sites. NHSC scholars will provide a one-year service commitment for each year of scholarship support received. There is a two-year minimum service commitment, and awardees can receive a maximum of four years of scholarship support.

NHSC Loan Repayment Program: The NHSC Loan Repayment Program offers fully trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service at an NHSC-approved site. In 2024, for an initial two years of service, providers serving in a Primary Care HPSA were eligible to receive up to $75,000 in loan repayment assistance. Providers serving in a Mental Health or a Dental Health HPSA were eligible to receive up to $50,000 in loan repayment assistance. The NHSC Loan Repayment Program also offered participants in all HPSA types the option of continuing service for an additional $20,000 for each year until all eligible educational debt is satisfied.

The NHSC has historically received a dedicated appropriation to support clinicians in Indian Health Service facilities, tribally operated "638" health programs, and urban Indian health programs (ITUs). The NHSC has awarded all eligible loan repayment applicants serving in these facilities and programs.

NHSC Substance Use Disorder Workforce Loan Repayment Program: The NHSC receives a dedicated appropriation to expand and improve access to quality substance use disorder treatment in rural and underserved areas nationwide in a variety of settings, including Opioid Treatment Programs and Office-Based Opioid Treatment Facilities. In 2024, in exchange for three years of service at an NHSC-approved substance use disorder treatment facility, providers received up to $75,000 in loan repayment assistance to reduce their educational financial debt.

NHSC Rural Community Loan Repayment Program: A portion of the dedicated appropriation funds the NHSC Rural Community Loan Repayment Program for providers working to combat the opioid epidemic in rural communities. The program has made loan repayment awards in coordination with the Federal Office of Rural Health Policy's Rural Communities Opioid Response Program initiative to provide evidence-based substance use treatment, assist in recovery, and prevent overdose deaths across the nation. In 2024, providers were eligible to receive up to $100,000 in loan repayment assistance to reduce their educational financial debt in exchange for three years of service at rural NHSC-approved substance use disorder treatment facilities.

In 2024, the loan repayment programs described above also offered a one-time award supplement of up to $5,000 to providers who demonstrate Spanish language proficiency and actively deliver medical care in Spanish at sites that identify a recruitment need for providers capable of serving patients with limited English proficiency in HPSAs.

NHSC Students to Service Loan Repayment Program: In 2024, the NHSC Students to Service Loan Repayment Program provided loan repayment assistance of up to $120,000 to health professions 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. To address maternal health workforce needs, the Students to Service Loan Repayment Program offered a

supplemental award of up to $40,000 to NHSC-awarded maternity care health professionals providing health services in Maternity Care Target Areas, areas within existing Primary Care HPSAs that are experiencing a shortage of maternity care health professionals.

NHSC State Loan Repayment Program: The State Loan Repayment Program is a federal-state partnership grant program that requires a dollar-for-dollar match from the state for the federal funds it receives through the grant. The state uses the grant funds to enter 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 as states have discretion to focus on one, some, or all of the eligible primary care disciplines 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 licenses.

Current eligible entities for each NHSC program are as follows:

- **NHSC Scholarship Program and Students to Service Loan Repayment Program:** Participants must be enrolled or accepted for enrollment as a full-time student pursuing a degree in an NHSC-eligible discipline at an accredited health professions school or program located in a state, the District of Columbia, or a U.S. territory.

- **NHSC Loan Repayment Program:** Participants must be practicing in an NHSC-eligible discipline with qualified student loan debt for education that led to their degree.

- **NHSC Substance Use Disorder Workforce and Rural Community Loan Repayment Programs:** Participants must be working, or have accepted a position to work, at an NHSC-approved substance use disorder treatment facility.

- **NHSC State Loan Repayment Program:** The 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Republic of Palau, the Marshall Islands, and the Commonwealth of the Northern Mariana Islands.

Budget Request

The FY 2026 Budget Request for the NHSC is $473.6 million, and includes $345 million in mandatory funding. The investment supports an estimated 6,600 scholarships and loan repayment awards, and an anticipated field strength of nearly 12,800 primary care, behavioral health, and oral health providers serving in communities of greatest need. The NHSC will continue to support recruitment of a health workforce that is well prepared to meet patients' needs, including licensed substance use disorder treatment providers, participants providing primary care health services in American Indian health facilities, and participants addressing language access barriers to quality care. Funding provided for state-administered loan repayment grant initiatives will continue to align with the specific needs of their residents.

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

FY	Amount
FY 2022 Discretionary	$121,600,000
FY 2022 Mandatory	$292,330,000
FY 2023 Discretionary	$125,600,000
FY 2023 Mandatory	$292,330,000
FY 2024 Discretionary	$128,600,000
FY 2024 Mandatory[146]	$432,904,109
FY 2025 Discretionary	$128,600,000
FY 2025 Mandatory	$258,041,096
FY 2026 Discretionary	$128,600,000
FY 2026 Mandatory	$345,000,000

Program Accomplishments

As of September 30, 2024, there were more than 17,400 primary care, oral health, and behavioral health practitioners serving in the NHSC across the United States at NHSC-approved sites. There were 22,650 NHSC-approved sites across the country, including facilities such as Federally Qualified Health Centers and Look-Alikes, American Indian and Alaska Native health clinics, rural health clinics, school-based clinics, and community mental health centers. Approximately one in three NHSC clinicians were providing care in rural communities.

The discipline mix of the NHSC field strength reflects the efforts to respond to the demand for services in underserved communities as well as the NHSC's commitment to an interdisciplinary approach to patient care. With its dedicated appropriation to expand substance use disorder treatment nationwide, the NHSC continues to support behavioral health clinicians in high-need and rural areas through the Substance Use Disorder Workforce and Rural Community Loan Repayment Programs.

Retention among NHSC clinician alumni, a measure of participants who continue to provide care in a HPSA after their service commitment has ended, continues to be high. The two-year retention rate among NHSC participants who completed their service obligation in FY 2022 is 81 percent.[147]

[146] Through sequential FY 2024 funding measures including the Consolidated Appropriations Act, 2024 (P.L. 118-42), the NHSC received a total mandatory appropriation of $432,904,109 available through December 31, 2024.
[147] This two-year retention rate for NHSC alumni includes 3,571 clinicians tracked out of 4,554 total clinicians who completed service during FY 2022.

The FY 2024 NHSC field strength also reflects the continuation of previously funded scholarship and loan repayment awards made in FY 2021 and FY 2022. The NHSC prioritizes support for continuation awards to retain clinicians already serving high-need urban, rural, and tribal communities. With this level of funding, as these clinicians complete their service, the total NHSC field strength will decrease over time. Outcomes for Measures 2010.02 and 2010.03 in FY 2024 reflect this attrition of the NHSC field strength as well as the reduced patient panel capacity for the total number of serving clinicians. Additionally, adjustments to projected targets for these two measures consider this impact.

NHSC Students in Pipeline by Program as of September 30, 2024

Program	**Students**
Scholarship Program	2,386
Students to Service Program	333
Total	**2,719**

NHSC Students in Pipeline by Discipline as of September 30, 2024

Discipline	**Students**
Allopathic/Osteopathic Physicians	1,008
Dentists	815
Nurse Practitioners	203
Physician Assistants	650
Certified Nurse Midwives	43
Total	**2,719**

NHSC Field Strength by Program as of September 30, 2024

Program	**Clinicians**
Scholarship Program Clinicians (NHSC Scholars)	1,085
Loan Repayment Program Clinicians	8.972
State Loan Repayment Program Clinicians	2,707
Substance Use Disorder Workforce Loan Repayment Program Clinicians	2,184
Rural Community Loan Repayment Program Clinicians	1,806
Students to Service Loan Repayment Program Participants	665
Total	**17,419**

NHSC Field Strength by Discipline as of September 30, 2024

Discipline	Clinicians
Allopathic/Osteopathic Physicians	1,821
Dentists	1,455
Dental Hygienists	397
Nurse Practitioners	3,475
Physician Assistants	1,723
Nurse Midwives	257
Behavioral Health Professionals	7.911
Other State Loan Repayment Program Clinicians	380
Total	**17,419**

Average NHSC New Award by Program as of September 30, 2024

Program	Service Requirement for Initial Contract	Average Award Amount for Initial Contract
Scholarship Program	2 – 4 years	$260,932
Students to Service Loan Repayment Program	3 years	$106,089
Loan Repayment Programs	2 – 3 years	$57,690

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
2010.01: Default rate of National Health Service Corps Scholarship and Loan Repayment Program participants (Efficiency)	FY 2024: 1.1% Target: ≤ 2.0% (Target Met)	≤ 2.0%	≤ 2.0%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
2010.02: Estimated number of patients served by National Health Service Corps clinicians (Outcome)	FY 2024: 18.29 million Target: 22 million (Target Not Met)	16.0 million	13.4 million	-2.6 million
2010.03: Field strength (participants in service) of the National Health Service Corps (Outcome)	FY 2024: 17,419 Target: 21,000 (Target Not Met)	15,000	13,000	-2,000
2010.04: Percentage of National Health Service Corps clinicians retained in service to the underserved for at least one year beyond the completion of their National Health Service Corps service commitment (Outcome)	FY 2024: 85% Target: 85% (Target Met)	85%	85%	Maintain
2010.05: Number of National Health Service Corps sites (Output)	FY 2024: 22,650 Target: 20,970 (Target Exceeded)	22,970	23,429	+459

Loan Repayment/Scholarship Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Loan Repayments	$289,334,749	$291,058,066	$294,251,715
State Loan Repayments	---	$20,000,000	$20,000,000
Scholarships	$49,365,224	$37,898,056	$38,541,622
Students to Service Loan Repayment	$ 20,177,753	$20,000,000	$20,000,000

NHSC Award By Year

Program	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024[148]**	**2025[149]**	**2026[149]**
Scholarships	181	222	200	251	1,192	1,199	180	172	138	139
Scholarship Continuations	7	7	11	12	7	25	48	61	13	11
Scholarships Subtotal	*188*	*229*	*211*	*263*	*1,199*	*1,224*	*228*	*233*	*151*	*150*
Loan Repayments	2,554	3,262	5,044	5,963	6,369	5,229	4,173	4,375	3,754	3,832
Loan Repayment Continuations	2,259	2,384	2,385	2,355	2,277	2,476	2,421	2,125	1,964	1,893
Loan Repayment Subtotal	*4,813*	*5,646*	*7,429*	*8,318*	*8,646*	*7,705*	*6,594*	*6,500*	*5,717*	*5,725*
State Loan Repayments	535	625	854	712	855	656[150]	1,047	2,057	608	608

[148] Beginning in FY 2024, award totals reflect a 50 percent increase in the maximum award available to eligible clinicians providing services in Primary Care HPSAs through the NHSC's two-year loan repayment program, as well as medical Spanish language award enhancements available to proficient loan repayment awardees serving active NHSC-approved sites demonstrating the need for this patient care competency. Finally, the NHSC began offering supplemental awards in the FY 2024 cycle to maternity health professions students committing to serve higher scoring MCTAs through the S2S LRP.

[149] Award levels for FY 2025 and FY 2026 are estimates and are subject to change.

[150] In late FY 2022, $100 million was provided in the American Rescue Plan Act to fully fund 3-year grants under the State Loan Repayment Program spanning FY 2022 through FY 2025. The FY 2022 reduction in total new awards reflects delays in awarding loan repayment contracts which appear in the higher-than-expected total in FY 2023.

Program	2017	2018	2019	2020	2021	2022	2023	2024[148]	2025[149]	2026[149]
Students to Service Loan Repayments	175	162	127	148	257	368	157	235	160	160
Total Awards	**5,711**	**6,662**	**8,621**	**9,441**	**10,957**	**9,953**	**8,026**	**9,025**	**6,637**	**6,643**

NHSC Field Strength By Year

Program	2017	2018	2019	2020	2021	2022	2023	2024	2025[151]	2026[151]
Scholars	405	463	506	573	671	701	806	1,085	745	603
Loan Repayment	8,362	8,849	10,221	13,122	16,613	16,853	14,450 [152]	12,962 [153]	11,422	10,539
Students to Service Loan Repayment	179	277	369	388	454	568	662	665	420	429
State Loan Repayment	1,233	1,350	1,957	2,146	2,246	2,093	2,417	2,707	2,665	1,216
Total Field Strength	**10,179**	**10,939**	**13,053**	**16,229**	**19,984**	**20,215**	**18,335**	**17,419**	**15,252**	**12,787**

[151] Field strength levels for FY 2025 and FY 2026 are estimates and are subject to change.
[152] In FYs 2023 and 2024, significant funding supported one-year continuation contracts for providers previously awarded multi-year initial contracts using American Rescue Plan Act funding.
[153] In FY 2024, funding supported a 50 percent increase in the maximum award available to eligible clinicians providing services in Primary Care Health Professional Target Areas through the NHSC's two-year loan repayment program. Funding also enabled new award enhancements available to eligible new awardees across all loan repayment programs to incentivize language-proficient and culturally competent care

Centers of Excellence

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$28,422,000	*	$28,422,000
FTE	**	**	258[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Health Workforce FTE total.

Allocation Method..... Competitive Grant

Program Description

The Centers of Excellence Program, established in 1987, provides grants to health professions schools and other public and nonprofit health or educational entities to assist schools in supporting programs of excellence in health professions education for under-represented minority individuals.

By statute, the Centers of Excellence Program awards funding to organizations to operate programs that establish, strengthen, and expand activities to enhance the academic performance of underrepresented minority students and improve information resources, clinical education, curricula, and cultural competence as they relate to minority health issues. Through strategic partnerships, grant recipients develop a large competitive applicant pool, provide stipends to students and faculty, and provide training to students at community-based health facilities. Additionally, the Centers of Excellence Program supports faculty and student research on health issues particularly affecting under-represented minority groups.

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

Budget Request

The FY 2026 Budget Request for the Centers of Excellence Program is $28.4 million. This request will support 26 existing grant recipients through continuation awards to train approximately 4,350 individuals in the health career pipeline.

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

Funding History

FY	Amount
FY 2022 Final	$24,422,000
FY 2023 Final	$28,422,000
FY 2024 Final	$28,422,000
FY 2025 Enacted	*
FY 2026 President's Budget	$28,422,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In the Academic Year 2023-2024, the most recent year for which data are available, the Centers of Excellence Program trained 4,351 high school, undergraduate, and graduate students progressing through the health professions pathway. A total of 3,065 students completed trainings such as high school enrichment or courses to help students succeed in medical, dental, or pharmacy school. Of graduates for which there are follow-up data, 88 percent continued progressing in the health professions pathway one year after completing their program.

The number of individuals in the health professions pathway trained by the Centers of Excellence increased by over 300 students between FY 2021 and FY 2023. In FY 2023, the program did not meet the target for Measure 2030.01. However, the FY 2023 target was established as an estimate based on a prior cohort of grant recipients. The FY 2023 results reflect the first year of a new cohort of grant recipients.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
2030.01 Number of individuals in the health career pipeline trained by the Centers of Excellence Program (Output)	FY 2023: 4,351 Target: 5,000 (Target Not Met)	*	4,350	*

* Performance targets under development.

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	26	*	26
Average Award	$1,026,317	*	$1,026,317
Range of Awards	$503,475 – $3,000,000	*	$503,475 – $3,000,000

* Grant award estimates under development.

The National Center for Health Workforce Analysis

Health Care Workforce Assessment

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$5,663,000	*	$5,663,000
FTE	**	**	258[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Health Workforce FTE total.

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

Program Description

The National Center for Health Workforce Analysis (NCHWA) is the primary federal entity that collects, analyzes, and reports on data and information regarding the U.S. health workforce. NCHWA also evaluates the effectiveness of the health workforce investment programs. NCHWA conducts the following activities:

- Collects health workforce data and provides timely analysis on current state and trends of the U.S. health workforce
- Develops and leads improvements in data collection by working with other federal agencies, states, professional associations, and academic and research institutions to generate and promote guidelines for collection and analysis
- Creates and improves tools for data management, analysis, and modeling to support health workforce research, policy analysis, and decision making
- Collects annual performance data for the agency's workforce programs and evaluates their effectiveness
- Translates data and research findings to inform policies, programs, and the public

NCHWA continues to enhance its workforce projection model to allow for even more sophisticated analysis and projection of health workforce supply and demand, taking into account changing national demographics, the demand for health care services, and the impact those changes have on the delivery of health care. These projections identify areas where there are projected shortages of providers.

The nation's health care system is constantly changing – and preparing new providers requires long lead times – thus, it is critical to have high quality, research-based evidence to support the planning to ensure a workforce of sufficient size and skills capable of meeting the nation's health care needs. Policy makers and other decision makers need information on the health care and health support workforce that incorporates up-to-date research, data, modeling, and trends.

Budget Request

The FY 2026 Budget Request for the National Center for Health Workforce Analysis is $5.6 million. This request will support data collection and analysis of the U.S. health workforce. Included in this request are several activities, including the implementation of the 2026 National Sample Survey of Registered Nurses (NSSRN). Additionally, the funding will enable continued work on health workforce projections and annual updates, as well as support for nine Health Workforce Research Centers to conduct timely research. The request will also support the development and annual publication of the Area Health Resources Files for use by policymakers and researchers and for enhancing data analytics for improved health care forecasting.

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

Funding History

FY	Amount
FY 2022 Final	$5,663,000
FY 2023 Final	$5,663,000
FY 2024 Final	$5,663,000
FY 2025 Enacted	*
FY 2026 President's Budget	$5,663,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In FY 2025, NCHWA released updated health care workforce projections for the years 2022–2037 for more than 100 occupations in a publicly accessible interactive projection visualization tool, as well as three projections briefs highlighting key trends in the nursing, physician, and long-term service and support workforces. NCHWA also published three briefs on current state of the health workforce. These included an updated brief on the Primary Care Workforce, a brief on the Behavioral Health Workforce, and a brief on the state of the U.S. Health Care Workforce with an emphasis on medicine, nursing, and oral health.

In FY 2025, NCHWA updated the Area Health Resources Files dashboard, which is one of the most comprehensive, publicly available sources of county, state, and national data on health care demographics. Users can access the entire Area Health Resources File dataset online to perform their own analyses. NCHWA continued to support nine Health Workforce Research Centers 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. Together, these nine centers examine a broad range of issues related to various sectors of the health care workforce. Research conducted by these centers

strengthen the evidence base for effective education and training program strategies that can enable and empower a health workforce capable of meeting the needs of the population. Researchers, policymakers, and members of the media, among others, benefit from the research and analyses by the research centers.

NCHWA continues work on the next administration of the National Sample Survey of Registered Nurses (NSSRN) which is released every four years. This survey is the largest and most comprehensive of the nation's largest health care occupation. NCHWA maintains the Nursing Workforce Dashboard that contains more than 400,000 unique data points on the nursing workforce including current counts by nursing occupation at both state and national levels, training, education, work environment, retirement plans, burnout and more. The dashboard also allows for comparisons between the 2018 and 2022 administrations of the survey.

Finally, in an effort to better understand and demonstrate the outcomes of the agency's workforce programs, NCHWA develops and publicly releases Program Accomplishment and Outcomes reports. In FY 2025, NCHWA focused on evaluating both the loan repayment and graduate medical education programs. Reports highlight how programs impact access, supply, distribution, and quality of the workforce.

Grants Awards Table

	FY 2024 Final	**FY 2025 Enacted**	**FY 2026 President's Budget**
Number of Awards	9	*	9
Average Award	$500,000	*	$500,000
Range of Awards	$447,164 – $900,000	*	$447,164 – $900,000

* Grant award estimates under development.

Behavioral Health Workforce Development

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$197,053,000	*	$129,300,000
FTE	**	**	258[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Health Workforce FTE total.

Allocation Method.....Competitive Grant/Other (competitive awards to individuals)

Program Description

The United States is facing a shortage of behavioral health providers. More than half of the U.S. population lives in a Health Professional Shortage Area for mental health. Furthermore, workforce shortages are projected through 2037 for addiction counselors, marriage and family therapists, mental health counselors, psychologists, and psychiatrists. Rural counties are more likely than urban counties to lack behavioral health providers.

The Behavioral Health Workforce Development Programs support the training of behavioral health students and providers and seek to place them in rural and underserved communities across the United States. These programs 1) expand the number of behavioral health professionals and paraprofessionals, 2) improve the quality of care by recruiting and training for interprofessional teams, and 3) promote the integration of behavioral health into primary care settings to increase access to behavioral health services. In addition, the Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program (LRP) improves access to substance use disorder treatment by providing loan repayment to medical, nursing, and behavioral health clinicians and paraprofessionals in exchange for service in areas experiencing high rates of overdose deaths and workforce shortages. Behavioral Health Workforce Development programs funding supports the following:

- **Behavioral Health Workforce Education and Training Programs for Professionals:** Provides grants to organizations to support behavioral health education, training, and field experiences to increase the supply, distribution, and quality of behavioral health professionals such as psychologists, psychiatrists, social workers, counselors, marriage and family therapists, and other mental health and addiction professionals, with a special focus on building knowledge and understanding of children, adolescents, and young adults at risk for behavioral health disorders.

- **Addiction Medicine Fellowship Program:** Provides grants to organizations to expand the number of fellows at accredited addiction medicine and addiction psychiatry fellowship programs who are trained as addiction medicine specialists to work in underserved, community-based settings that integrate primary care with mental health

and substance use disorder prevention and treatment services, including settings that serve pediatric populations.

- **Substance Use Disorder Treatment and Recovery Loan Repayment Program:** Recruits and retains medical, nursing, and behavioral health clinicians and paraprofessionals who provide direct treatment or recovery support to patients with or in recovery from substance use disorder. Participants receive an award of up to $250,000 for the repayment of eligible loans in return for an agreement to serve for 6 years of full-time employment in a job that involves direct substance use disorder treatment or recovery support for patients in a program-approved facility.

Current eligible entities for each Behavioral Health Workforce Development Program are as follows:

- **Behavioral Health Workforce Education and Training Programs for Professionals:** Accredited master's and doctoral level behavioral health institutions of higher education or professional training programs (field placements, internships and residencies) for psychiatry, psychology, behavioral pediatrics, psychiatric nursing, social work, marriage and family therapy, occupational therapy, or professional counseling. Other eligible entities include colleges and universities, state and local governments, community-based organizations and other non-profits, hospitals, rural health clinics, and tribal organizations.

- **Addiction Medicine Fellowship Program:** Accredited addiction medicine or addiction psychiatry fellowship programs; and consortium (i.e., teaching health center and at least one sponsoring addiction medicine or addiction psychiatry fellowship program).

- **Substance Use Disorder Treatment and Recovery Loan Repayment Program:** Fully licensed clinicians, credentialed in an eligible discipline and working at STAR LRP-approved facilities; and registered substance use disorder treatment professionals working at STAR LRP-approved facilities.

Budget Request

The FY 2026 Budget Request for the Behavioral Health Workforce Development Programs is $129.3 million. The request includes $40 million for the Substance Use Disorder Treatment and Recovery Loan Repayment program and $25 million for the Addiction Medicine Fellowship Program to support the training of physicians who specialize in the prevention, evaluation, and treatment of substance use disorder.

This investment will support the Behavioral Health Workforce Education and Training Program for Professionals Program and the Addiction Medicine Fellowship Program. In addition, this request will support approximately 300 new loan repayment awards to individuals through the STAR LRP.

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

Funding History

FY	Amount
FY 2022 Final	$162,053,000
FY 2023 Final	$197,053,000
FY 2024 Final	$197,053,000
FY 2025 Enacted	*
FY 2026 President's Budget	$129,300,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

In Academic Year 2023–2024, the most recent year for which data are available, the Behavioral Health Workforce Development programs trained 11,493 behavioral health providers and produced 7,199 graduates, including professionals such as addiction medicine physicians, psychiatric nurse practitioners, psychologists, school counselors, and social workers. At the time of graduation, 59 percent of graduates with employment data were working in medical underserved communities or rural areas.

A 2024 evaluation of the first three years of the Addiction Medicine Fellowship program (Academic Years 2020-2023) found the program increased the number of new addiction medicine physicians by 158 percent and addiction psychiatry physicians by 11 percent.[154]

The Behavioral Health Workforce Education and Training program did not meet targets for Measures 2120.01 and 2120.02 due outdated funding estimates. However, the program increased the number of trainees and graduates by over 40 percent between FY 2021 and FY 2023. Targets for these two measures were adjusted to reflect upcoming changes to the program and different funding levels.

As of September 30, 2024, the STAR LRP Program was supporting a total of 1,006 health professionals providing behavioral health services, all in communities where the mean drug overdose death rate is significantly higher than the national average. This includes 329 participants who entered into 6-year service contracts with the program in FY 2024.

[154] Health Resources and Services Administration. (2024). *Addiction Medicine Fellowship Program Evaluation.* U.S. Department of Health and Human Services. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/amf-evaluation.pdf

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
2120.01 Number of graduates from behavioral health degree or certificate programs supported by Bureau of Health Workforce Behavioral Health Workforce Education and Training Programs (Outcome)	FY 2023: 5,702 Target: 9,000 (Target Not Met)	*	2,500	*
2120.02 Number of students in behavioral health degree or certificate programs supported by Bureau of Health Workforce Behavioral Health Workforce Education and Training Programs (Output)	FY 2023: 8,596 Target: 20,000 (Target Not Met)	*	4,000	*
2120.05 Number of new addiction medicine and addiction psychiatry fellowship graduates entering the workforce (Outcome)	FY 2023: 159 Target: 63 (Target Exceeded)	*	135	*
2120.06 Number of providers offering behavioral health services to communities through the Substance Use Disorder Treatment and Recovery Loan Repayment Program (Output)	FY 2024: 1,006 Target: 800 (Target Exceeded)	*	1,395	*

* Performance targets under development.

Behavioral Health Workforce Development Programs Outputs	Year and Most Recent Result
Number trained through Bureau of Health Workforce Behavioral Health Workforce Development programs	AY 2023–2024: 11,493
Number of graduates from Bureau of Health Workforce Behavioral Health Workforce Development program	AY 2023-2024: 7,199

Grants Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	334	*	132
Average Award	$430,866	*	$600,000
Range of Awards	$100,587-$2,499,645	*	$400,000-$800,000

*Grant award estimates under development.

Substance Use Disorder Treatment and Recovery Loan Repayment Program Awards Table[155]

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	329	*	300
Average Award	$113,110	*	$113,000
Range of Awards[156]	$6,378 – $264,078	*	$8,300 – $265,000

* Grant award estimates under development.

[155] STAR LRP award estimates in the table made prior to the availability of actual fiscal year award data are based on a composite of prior fiscal year data.
[156] Award amounts reflect accommodations made for the federal tax burden.

Nurse Corps

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$92,635,000	*	$92,635,000
FTE	**	**	258[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Health Workforce FTE total.

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

Program Description

The Nurse Corps Program has strengthened the nursing workforce by providing scholarship and loan repayment to nursing students, professional nurses, and nurse faculty in exchange for working in Critical Shortage Facilities located in Health Professional Shortage Areas and other underserved communities throughout the nation or in eligible schools of nursing. As of September 30, 2024, more than three-quarters of the Nurse Corps providers were serving in community-based settings, and nearly 20 percent were serving in rural communities.

Nurse Corps Loan Repayment Program: The Nurse Corps Loan Repayment Program, assists in the recruitment and retention of professional registered nurses, including advanced practice registered nurses (i.e., nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists), who are dedicated to working in Critical Shortage Facilities or as faculty in eligible schools of nursing. The Nurse Corps Loan Repayment Program repays 60 percent of the principal and interest on nursing education loans in exchange for two years of full-time service at a Critical Shortage Facility or in academic nursing. For an optional third year of service (via a continuation contract), the Nurse Corps Loan Repayment Program will award participants an additional 25 percent of their original total qualifying educational loan balance.

Nurse Corps Scholarship Program: The Nurse Corps Scholarship Program provides scholarships to students in accredited schools of nursing in exchange for a service commitment of at least two years at a Critical Shortage Facility after graduation. The Nurse Corps Scholarship Program reduces the financial barrier to nursing education for all levels of professional nursing students and increases the pipeline of nurses who will serve in Critical Shortage Facilities.

Current eligible entities for each Nurse Corps program are as follows:

- **Nurse Corps Loan Repayment Program:** Participants must have a current license to practice as a registered nurse and be employed full-time at a public or private Critical Shortage Facility or at an accredited public or private school of nursing.

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

Budget Request

The FY 2026 Budget Request is $92.6 million and supports an estimated 238 scholarship (new and continuation) and 450 loan repayment (new and continuation) awards. The funds will increase the number of well-trained nurses available to provide services, such as mental/behavioral health and women's/maternal health services, in communities experiencing a shortage in nurses. In an effort to address the opioid epidemic and other substance use disorders across the nation, the Nurse Corps Program will continue to dedicate a portion of the scholarships and loan repayment awards to nurse practitioners specializing in psychiatric-mental health.

The funding request includes costs associated with the application and award cycle, follow-up performance reviews, and information technology as well as other program support costs.

Funding History

FY	Amount
FY 2022 Final	$88,635,000
FY 2023 Final	$92,635,000
FY 2024 Final	$92,635,000
FY 2025 Enacted	*
FY 2026 President's Budget	$92,635,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

As of September 30, 2024, the Nurse Corps Program was supporting 2,425 nurses and nurse faculty working in Critical Shortage Facilities located in Health Professional Shortage Areas or in academic institutions. In FY 2024, the Nurse Corps Program made 188 new scholarship awards to nursing students and 377 new loan repayment awards to nurses and nurse faculty working in Critical Shortage Facilities and in academic institutions. Among these, 117 awards supported nurse practitioners and students specializing in psychiatric-mental health.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
2180.01: Proportion of Nurse Corps Loan Repayment Program participants who receive additional loan repayment in exchange for working at a Critical Shortage Facility for an additional year. (Outcome)	FY 2024: 32% Target: 52% (Target Not Met)	*	41%	*
2180.02: Proportion of Nurse Corps Loan Repayment Program/Scholarship Program participants who elect to continue serving at a Critical Shortage Facility for at least one year after completing their Nurse Corps Loan Repayment Program/Scholarship Program commitment. (Outcome)	FY 2024: 93% Target: 89% (Target Met)	*	89%	*
2180.03: Proportion of Nurse Corps Scholarship Program awardees obtaining their baccalaureate degree or advanced practice degree in nursing. (Outcome)	FY: 2024: 60% Target: 85% (Target Not Met)	*	85%	*
2180.05: Default rate of Nurse Corps Loan Repayment Program participants.	FY 2024: 2% Target: 2% (Target Met)	*	2%	*
2180.06: Default rate of Nurse Corps Scholarship Program participants.	FY 2024: 4% Target: 4% (Target Met)	*	4%	*

* Performance targets under development.

Nurse Corps Loan Repayments/Scholarships Awards Table

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Loan Repayments	$61,756,667	*	$61,756,667
Scholarships	$30,878,333	*	$30,878,333

* Grant award estimates under development.

Nurse Corps Awards Table[157]

Fiscal Year	2019	2020	2021	2022	2023	2024	2025	2026
Scholarships								
New Awards	220	244	529	567	293	188	*	195
Continuation Awards	6	13	15	25	33	60	*	43
Loan Repayment								
New Awards	561	465	1,246	2,071	492	377	*	440
Continuation Awards	292	291	341	208	505	656	*	10
Total	**1,079**	**1,013**	**2,131**	**2,871**	**1,323**	**1,281**	*	**688**

*Award estimates under development.

Nurse Corps Field Strength Table[158]

Fiscal Year	2019	2020	2021	2022	2023	2024	2025	2026
Scholarship	450	415	400	412	512	672	*	632
Loan Repayment	1,279	1,293	1,907	3,171	2,823	1,599	*	718
Loan Repayment Nurse Faculty	199	135	214	349	293	154	*	80
Total	**1,928**	**1,843**	**2,521**	**3,932**	**3,628**	**2,425**	*	**1,430**

*Award estimates under development.

[157] FYs 2021, 2022, and 2023 awards and field strength include American Rescue Plan Act funding.
[158] Ibid.

Teaching Health Center Graduate Medical Education

	FY 2024 Final[159]	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Mandatory	$219,589,041	$130,890,411	---	-$130,890,411
Mandatory Proposed	---	---	$175,000,000	+$175,000,000
TOTAL	$219,589,041	$130,890,411	$175,000,000	+$44,109,589
FTE	**	**	258[1]	

* FY 2024 funds were appropriated through December 31, 2024
**FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Health Workforce FTE total.

Allocation Method.....Formula-Based Payment

Program Description

The Teaching Health Center Graduate Medical Education (THCGME) Payment program was established in 2010 to help communities grow their health workforce by training physicians and dentists in community-based settings with a focus on rural and underserved communities. This unique training model changes the physician training paradigm by focusing residency training in community-based outpatient settings where most people receive their health care. The program aims to increase physicians and dentists trained in community-based settings, improve health outcomes for members of underserved communities, and expand health care access in underserved and rural areas.

The program makes formula-based payments to organizations to support the educational costs incurred by new and expanded residency programs. Along with supporting resident training, THCGME funds may also be used to foster innovation and support curriculum enhancements aimed at improving the quality of patient care, such as the Patient-Centered Medical Home model, Electronic Health Record utilization, population health, telemedicine, and health care leadership. These activities ensure residents receive high-quality training and are well-prepared to practice in community-based outpatient care settings after graduation.

Eligible entities include community-based ambulatory patient care centers that operate an accredited primary care residency program or have formed a GME consortium that operates an accredited primary care residency program.

[159] Through sequential FY 2024 funding measures including the Consolidated Appropriations Act, 2024 (P.L. 118-42), THGME received a total mandatory appropriation of $219.589.041, available through December 31, 2024.

Budget Request

The FY 2026 Budget Request for the THCGME program of $175 million will fund up to 1,273 resident full-time equivalent (FTE) slots in academic year (AY) 2026-2027 (July 1, 2026 – June 30, 2027). This funding will support AY 2026-2027 FTEs in existing THCGME residency programs at a per-resident amount of $160,000. The estimated total cost of training a THCGME resident in AY 2024-2025 was $227,164,[160] suggesting THCGME payments cover approximately 70 percent of the total costs.

The funding request 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 2022 Final	$119,290,000
FY 2023 Final	$119,290,000
FY 2024 Final	$219,589,000
FY 2025 Enacted	$130,890,000
FY 2026 President's Budget	$175,000,000

Program Accomplishments

In Academic Year 2023-2024, the most recent year for which data are available, the Teaching Health Center Graduate Medical Education program funded 81 teaching health centers. These teaching health centers supported 1,100 resident full-time equivalent slots, which provided funding to 1,228 medical and dental residents,[161] 353 physicians and dentists completed their residencies. Since the program's inception 2,579 new physicians and 142 new dentists have entered the workforce.

A 2024 evaluation of the Teaching Health Center Graduate Medical Education program found that over the past five years (Academic Years 2018-2023), residents provided care to nearly 3.9 million patients and 85 percent of the 1,059 residents who graduated and provided employment data worked in a medical underserved community.[162]

160 Regenstein M, Trott J, Ku L, et al. A New Formula for Teaching Health Center Graduate Medical Education Payments Based on a Comprehensive Cost Evaluation. Academic Medicine. 2025;100(5):p 628-634.

161 Awardees may use one full-time equivalent slot to fund multiple residents at less than full time, meaning there are more residents trained than full-time equivalent slots.

162 Health Resources and Services Administration. (2024). *Teaching Health Center Graduate Medical Education Program Evaluation*. U.S. Department of Health and Human Services. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/thcgme-eval-nchwa.pdf

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
2200.01 Number of primary care medical and dental resident positions supported by Teaching Health Centers (Outcome)	FY 2023: 1,100 Target: 740 (Target Exceeded)	1,100	1,100	Maintain
2200.02 Percentage of Teaching Health Centers Graduate Medical Education-supported medical and dental residents training in rural and/or medically underserved communities (Outcome)	FY 2023: 96% Target: 80% (Target Exceeded)	88%	88%	Maintain

THCGME Program Outputs	Year and Most Recent Result
Number of primary care residents funded in whole or in part by THCGME residencies	AY 2023–2024: 1,228
Number of primary care residents completing training	AY 2023–2024: 353

Grant Awards Tables

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	90	87	87
Average Award	$2,268,444	$1,660,972	$1,745,977
Range of Awards	$160,000 - $8,880,000	$320,000 - $10,560,000	$245,000 - $8,098,000

National Practitioner Data Bank

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Offsetting Collections	$33,500,000	$32,910,000	$33,500,000	+$590,000
FTE	**	**	258[1]	

****FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Health Workforce FTE total.

Allocation Method..... User Fee Program

Program Description

The National Practitioner Data Bank (NPDB) is a workforce tool that improves health care quality, promotes patient safety, and deters fraud and abuse in the health care system by providing information about adverse actions of practitioners, providers, and suppliers to authorized health care entities and agencies. With more than 1.8 million reports since its inception in 1990, the NPDB collects and discloses information to authorized entities on medical malpractice payments, health care-related civil judgments and criminal convictions, adverse licensure and certification actions, exclusions from health care programs, and other adjudicated actions taken against health care providers, suppliers, and practitioners. Authorized health care entities use this information to make informed hiring, licensing, credentialing, and privileging decisions to determine whether, or under what conditions, it is appropriate for health care practitioners, providers, and suppliers to provide health care services.

Budget Request

The FY 2026 Budget Request for the NPDB of $33.5 million in user fees is $590,000 above the FY 2025 Enacted level. The level of revenue collected by the NPDB is a direct output of query volume. All NPDB revenue is reinvested in the program to make system enhancements that support the user experience, to automate manual tasks, to respond to increased user volumes, and to implement security requirements.

As mandated by the Health Care Quality Improvement Act, the NPDB does not receive appropriated funds and is financed exclusively by the collection of user fees. Annual appropriations act language requires that user fee collections cover the full cost of NPDB operations; therefore, there is no request for appropriations for operating the NPDB. User fees are established by forecasting query volume to result in adequate, but not excessive, revenues to cover all program costs to allow the NPDB to meet annual and long-term program performance goals.

The flat funding level historically provided for the NPDB's fiscal year revenue total previously served as a baseline estimate of the anticipated level of user fees collected annually. This request, and the updated funding history for the NPDB, reflect the actual level of revenue

collected, or expected to be collected, in each fiscal year. Moving forward, this alignment will provide transparency in the growth in query volume and support related needs for systemic enhancements.

Funding History

The table below provides the user fees (revenue) collected or expected to be collected by the NPDB in each fiscal year.

FY[163]	Amount
FY 2022 Final	$29,162,000
FY 2023 Final	$32,758,000
FY 2024 Final	$33,500,000
FY 2025 Enacted	$32,910,000
FY 2026 President's Budget	$33,500,000

Program Accomplishments

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

Since 2019 the NPDB has added more than 300,000 reports and increased the NPDB's report disclosures by 27 percent to approximately 2.5 million disclosures in FY 2024.

- In FY 2024, the NPDB responded to more than 14 million queries, a 19 percent increase over FY 2023, from authorized health care entities, practitioners, providers, and suppliers.

- Since 2019, the NPDB's continuous query enrollments have more than doubled, from 3.8 to 8.5 million. This increase is due in part to outreach efforts including hosting annual webinars attracting more than 10,000 attendees and deploying micro-training videos offering technical assistance on the NPDB.

- The NPDB enabled digitally certified self-query responses, providing a paperless process with faster response times and assurances that the responses are unaltered. Approximately 64 percent of self-queriers in FY 2024 opted for paperless responses.

- The NPDB continues to enhance web content and simplify user experience, allowing for more user transactions to be processed in the system without increasing calls or emails to the Customer Service Center. Transaction-to-case ratios have increased by 72 percent

[163] FY 2025 and FY 2026 revenue levels reflect the NPDB's estimated annual user fee collections associated with self-queries, one-time queries, and continuous queries.

over the past five fiscal years, from 179 transactions per case in FY 2019 to 308 transactions per case in FY 2024.

- Additionally, the NPDB implemented multi-factor authentication for all user accounts, and launched a phased deployment of identity verification, providing a more secure method to access the NPDB.

The NPDB has seen a rate of steady and significant continuous query[164] growth that is expected to slow in the coming years, although overall growth will continue. By encouraging the use of continuous query as an alternative to one-time query, queriers receive report notifications an average of 10 months sooner, increasing the likelihood that health care entities are informed when making important hiring, licensing, and credentialing decisions.

The measure of disclosures is important in measuring the effectiveness of the program, as it reflects that the NPDB is putting critical information about health care practitioners, providers, and suppliers into the hands of those making important hiring, licensing, and credentialing decisions.

In FY 2025, the NPDB will continue to improve its security posture by completing the rollout of identity verification for all users and moving interactive voice response service for customer service to a FedRAMP compliant solution. Additionally, the NPDB will make significant progress towards several projects designed to simplify and streamline the NPDB user experience for entity users as well as individual practitioners.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
2210.01: Number of practitioners enrolled by health care entities in the National Practitioner Data Bank's Continuous Query subscription service	FY 2024: 8,478,303 Target: 6,600,000 (Target Exceeded)	6,800,000	8,500,000	+1,700,000

[164] There are two types of query services available to health care organizations through the NPDB website, continuous query and one-time query. Continuous query on enrolled practitioners meets legal and accreditation requirements for querying the NPDB and allows organizations to receive a query response and all new or updated report notifications during the year-long enrollment for each practitioner. Continuous query is only for querying on practitioners, not health care organizations.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
2210.02: Number of disclosures of National Practitioner Data Bank reports to health care organizations	FY 2024: 2,495,758 Target: 2,130,000 (Target Exceeded)	2,230,000	2,630,000	+400,000

Pediatric Specialty Loan Repayment Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$10,000,000	$10,000,000	$10,000,000
FTE	**	**	258[1]

****FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Health Workforce FTE total.

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

Program Description

In FY 2023, the Pediatric Specialty (PS) Loan Repayment Program (LRP) was launched to support the pediatric health care workforce. This program provides loan repayment to a range of clinicians, including child and adolescent behavioral health professionals, pediatric subspecialists and physicians participating in an accredited pediatric medical subspecialty or pediatric surgical specialty residency or fellowship who work in a Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or who serve a Medically Underserved Population (MUP). The PS LRP provides eligible health professionals up to $100,000 in exchange for a three-year, full-time service commitment.

Eligible entities include clinicians who provide patient care as pediatric medical subspecialists; pediatric surgical specialists; and providers of child and adolescent behavioral health services, including substance use disorder prevention and treatment. Participants must be engaged in an accredited eligible residency or fellowship or full-time employment in or for a PS LRP-approved site serving a HPSA, MUA, or MUP.

Budget Request

The FY 2026 Budget Request for the PS LRP of $10 million will support approximately 85 new loan repayment awards to bolster the pediatric health care workforce, including pediatric medical specialists, pediatric surgical specialists, and child and adolescent behavioral health care providers.
The funding request also includes costs associated with the award process, follow-up performance reviews, information technology, and other program support costs.

Funding History

FY	Amount
FY 2022 Final	$5,000,000
FY 2023 Final	$10,000,000
FY 2024 Final	$10,000,000
FY 2025 Enacted	$10,000,000

FY	Amount
FY 2026 President's Budget	$10,000,000

Program Accomplishments

In FY 2024, the PS LRP completed its second application and award cycle and made 84 awards to pediatric providers at program-approved service sites who are helping increase children's access to vital care. As of September 30, 2024, the PS LRP supported a total of 199 pediatric clinicians who were providing health care services in high-need communities. This total reflects both new and previous awardees fulfilling a service obligation and includes pediatric medical, surgery, and behavioral health specialists, including specialists in substance abuse prevention and treatment.

In FY 2025, the program plans to fund approximately 85 new PS LRP awards.

Loan Repayment Awards Table

	FY 2024 Final[165]	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	84	85	85
Average Award	$102,674	$100,000	$100,000
Range of Awards[166]	$32,016 - $107,650	$32,016-$107,650	$32,016-$107,650

[165] Actual award amounts reflect accommodations made for federal tax burdens.
[166] Range of Award estimates made prior to the availability of actual fiscal year award data reference FY 2024 award data.

POLICY, RESEARCH, AND OVERSIGHT TAB

POLICY, RESEARCH, AND OVERSIGHT

Program Management

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$241,540,000	*	$201,539,000[1]
FTE	**	**	490[2]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in HRSA and SAMHSA FTE totals.
1\An additional $22 million in FY 2026 is planned to be allocated from the Policy, Research and Oversight account as part the MAHA Initiative, for a total of $223.5 million.
2\FY 2026 FTE represents entire Policy, Research, and Oversight FTE total.

Allocation Method ..... Other

Program Description

AHA will centralize the work of multiple federal agencies under a new organization to support data-driven, innovative, patient-centered, and transparent programs to transform the health of all Americans. To achieve its mission, AHA seeks to increase operational efficiency and strengthen program management across similar programs with the support of qualified AHA staff who are required to operate at maximum efficiency. AHA will focus on improving program customer satisfaction, enhancing staff engagement, integrating and implementing organizational systems and improvements, and eliminating duplication and redundancy. Program Management is the primary means of support for staff, business operations and processes, and overhead expenses such as rent, utilities, and miscellaneous charges for AHA.

AHA will rely on and will continue to seek out shared services to improve and simplify processes, including HHS-provided shared services such as human resources, information technology, financial management, grants, and procurement. Program Management will also support Enterprise Risk Management (ERM) activities to reduce programmatic risk and improve performance, business operations, and risk management activities to ensure a proactive and customer-focused suite of business operation services and risk management functions.

Budget Request

The FY 2026 Budget Request for Program Management is $201.5 million. An additional $22 million is planned to be allocated from the Policy, Research, and Oversight account as part of the MAHA Initiative, for a total of $223.5 million. This funding level supports program management activities to effectively and efficiently support AHA's operations, including the integration and streamlining of business processes, data solutions, and customer services. AHA is committed to improving quality at a lower cost and improving the operational effectiveness and efficiency.

The requested level will ensure the agency can efficiently and effectively support primary care, maternal and child health, mental and behavioral health, HIV/AIDS, environmental health, and workforce development.

AHA will also enhance its program integrity activities by supporting the integration of analytical tools such as electronic grants system, program data, grant and contract data sources, HHS sources, and government-wide sources. AHA aims to identify and address issues before they become audit findings. AHA plans to focus on a risk-based approach to grantee monitoring to focus on grantees at risk of noncompliance. AHA will also support the alignment of program integrity initiatives with planning and performance activities across AHA programs.

AHA will harness data solutions to enable secure data sharing and support high volume data processing and enhance multiple other reporting and case management systems to maximize efficiencies and increase program integrity.

Program Accomplishments

There are no accomplishments to report as AHA Program Management is new in FY 2026.

Health Surveillance (Mental and Behavioral Health)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$20,195,000	*	$20,195,000
PHS	$30,428,000	*	$30,428,000
FTE	**	**	490[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Policy, Research, and Oversight FTE total.

Allocation Method..... Contracts

Program Description

Health Surveillance programs are foundational to advancing the Administration for a Healthy America's vision to ensure that people with, affected by, or at risk for, mental health and substance use conditions receive care, thrive, and achieve well-being. In addition, they are essential for tracking progress and identifying emerging behavioral health trends.

National Survey of Drug Use and Health

The National Survey of Drug Use and Health (NSDUH) is an annual collection of behavioral health data on persons aged 12 or older of the U.S. civilian, non-institutionalized population. It is the nation's primary source of statistical information on the use of illicit drugs, alcohol, tobacco, the misuse of prescription medications, certain mental health issues, substance use disorders, co-occurring disorders, treatment for mental and substance use disorders, and recovery. NSDUH is paramount to meeting statutory requirements from Section 505 of the Public Health Service Act (42 U.S.C. 290aa-4), which include collection of data on mental health and substance use disorder treatment programs and demographics of people using these services and the care they receive.

NSDUH data provide estimates at the national, state, and sub-state levels and among demographic, socioeconomic, or geographic subgroups, as well as trend estimates over time. The public can readily access state-level NSDUH data via interactive online tools, specifically designed for customized analyses of substance use and mental health indicators, without needing to download any data. In addition, HHS disseminates data-based products in the form of annual reports, topical reports, data visualizations, slide decks, data tables and other types of reports. The NSDUH survey will be an important tool in understanding the scope and scale of behavioral health issues across the Nation as well as assisting in determining where to allocate resources and if those resources are improving the behavioral health status of our Nation.

Behavioral Health Services Informational System

The Administration for a Healthy America collects data on mental health and substance use disorder treatment services through the Behavioral Health Services Information System (BHSIS). BHSIS provides information on nationwide behavioral health treatment systems that provide people with substance use and mental health treatment services. Currently, BHSIS aligns with the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) and the Mental Health Block Grant (MHBG) to collect data from all states. BHSIS will be the primary source for performance measures and data for the new Behavioral Health Innovation Block Grant.

In addition, under BHSIS, the National Substance Use and Mental Health Services Survey (N-SUMHSS) collects substance use and mental health treatment facility census data called for in Section 505 of the Public Health Service Act (42 U.S.C. 290aa-4). The information collected by N-SUMHSS is used to populate FindTreatment.gov, the U.S. governments only centralized source of information for people searching for mental health or substance use disorder treatment services.

BHSIS also includes other data collection programs and information resources. The data collections comprise:

1) HHS maintains the Inventory of Substance Use and Mental Health Treatment Facilities (I-TF), an electronic national inventory of substance use and mental health facilities. I-TF contains all substance use and mental health treatment facilities in the United States and its territories known to HHS and serves as the frame for the N-SUMHSS. This careful curation ensures the reliability and credibility of the data collection process. The I-TF data are also used to characterize facilities-providing services using Block Grant funding.

2) FindTreatment.gov is the most comprehensive resource for persons seeking mental and substance use disorder treatment in the United States and its territories. FindTreatment.gov allows users to search for substance use and mental health facilities, health care centers, buprenorphine practitioners, and opioid treatment providers. FindTreatment.gov is authorized by the 21st Century Cures Act (Public Law 114-255, Section 9006; 42 U.S.C. 290bb-36d).

3) The Treatment Episode Data Set (TEDS) provides demographic, clinical, and substance use characteristics on publicly funded admissions and discharges from substance use disorder treatment facilities. The TEDS provides data for Congressional reporting. TEDS-A records the admissions, and TEDS-D records the discharges. The two datasets are separate but linkable. Information on admissions to and discharges from substance use treatment services are collected through state administrative systems and then reported to the Administration for a Healthy America by the Single State Agencies (SSAs). SSAs report TEDS data from all 50 states, the District of Columbia, and Puerto Rico.

4) The Mental Health Client-Level Data (MH-CLD) and the Mental Health Treatment Episode Data Set (MH-TEDS) systems provide information on demographic and socioeconomic characteristics, clinical attributes (including mental health diagnoses and substance use), and

National Outcome Measures (NOMs). States report the NOMS based on state definitions per the block grant statute, aligning with data reporting requirements as mandated by Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. §300x–52(a)).

5) The Uniform Reporting System (URS) provides a set of standardized data tables that states and territories submit annually as part of their Block Grant annual implementation reports. State Mental Health Agencies (SMHAs) use the URS to put together and report annual data. URS is part of an effort to use data in decision support and planning in public mental health systems. The effort also attempts to use data to support program accountability.

Behavioral Health Data Dissemination

The data webpage (https://www.samhsa.gov/data/) makes public-use data files available in a variety of formats that anyone can download, analyze, and explore. This activity also provides access to data visualization tools and to public- and restricted-use state and substate data through a web-based analytic tool. The Data webpage, makes reports, survey information, and supporting documentation available for multiple public audiences.

Budget Request

The FY 2026 Budget Request for the planned AHA's Health Surveillance programs is $50.6 million. At this funding level, AHA will explore the feasibility of modernizing FindTreatment.gov, AHA's treatment locator, to feature appointment capability to reduce barriers for individuals and families to access treatment and will continue the critical data collection systems described above.

Funding History

FY	Amount
FY 2022 Final	$48,623,000
FY 2023 Final	$50,623,000
FY 2024 Final	$50,623,000
FY 2025 Enacted	*
FY 2026 President's Budget	$50,623,000

*****Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

National Survey of Drug Use and Health

To ensure NSDUH is collecting the most timely, relevant, and highest quality data to address emerging and critical data needs related to mental health and substance use, key improvements to the NSDUH questionnaire have been made:

- In 2024, selected module introductions were revised to update and simplify language, a question asking about past year use of overdose reversal medicine (e.g., naloxone) was added, and the general anxiety disorder scale (GAD-7) was added to the mental health module for adults.
- Questions measuring sleep disorder and chronic pain were added for adults, and questions measuring non-suicidal self-harm were added for youth.

In a united effort to support broader use of restricted-use NSDUH data, researchers apply for, and obtain access to, restricted-use NSDUH data using a process that has been streamlined and expanded to facilitate easier and broader access to these data. AHA will promote data use by aiding researchers in navigating resources, accessing relevant substance use and mental health indicators, and completing important public health investigations, while also protecting privacy and minimizing disclosure risk. In addition, in FY 2025, HHS released a new data user guide to help interested parties optimally use the available NSDUH data. Findings from the research analytic activities have been instrumental in influencing program implementation of evidence-based interventions and strategies and understanding the evolving epidemiology of substance use and mental health in the U.S.

Behavioral Health Services Informational System

In FY 2023, the Behavioral Health Treatment Locator was renamed FindTreatment.gov. The site was redesigned to improve access and usability, and traffic increased by 700% in February 2023. In FY 2024, the Spanish version of FindTreatment.gov was released. In FY 2024, N-SUMHSS implemented the electronic health records (EHR) supplement for the Department of Health and Human Services and Veterans Affairs Supplement survey. In FY2024 and FY2025, data reports from BHSIS data systems were revised to be more topically focused and relevant for decisionmakers and the field.

Behavioral Health Data Dissemination

In FY 2025, Data Webpages are projected to receive over 2.2 million page views overall, with about 49% of the traffic comprised of new visitors to the website. It is projected for over 379,990 total files to be downloaded from the Data Webpages in FY 2025. NSDUH webpages within the Data Webpages are projected to receive around 1.1 million page views and close to 237,440 downloads in FY 2025. These actions are informing programmatic and policy planning for states, communities, tribes, territories, and nationally

Public Awareness and Support

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$13,260,000	*	$5,000,000
FTE	**	**	490[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Policy, Research, and Oversight FTE total.

Program Description and Accomplishments

An essential part of the Administration for a Healthy America focus is to increase public awareness of available services, education, and resources that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes. The AHA Office of Communications (OC) will ensure that the vital information, publications, and training materials produced are available to the healthcare workforce, people in treatment and recovery, people in crisis or in areas affected by disasters, planned AHA grantees, and the general public. Several channels are used to communicate this information, including digital media platforms, print, radio, and television media; the .gov websites, the subscription-based e-blast system; and inquiries received through the National Helpline. In addition, the OC assists in the development and dissemination of materials, products, and campaigns.

The OC media team receives, assesses, and responds to media inquiries; develops rollout plans; issues press releases, news bulletins, and media advisories. The team builds relationships with representatives of the media; and when necessary, works to add s life-saving resources to journalistic and entertainment products; supports broad HHS and administration communications priorities; and collaborates with departmental operating divisions. The media team also collaborates with agency staff when a disaster occurs to quickly disseminate relevant resources including the Disaster Distress Helpline. Designated writers and editors additionally support speechwriting for agency principals to communicate high-priority initiatives, publications, grant programs and other essential agency activities directly to stakeholders.
The following contract services are managed within the OC and provide various levels of support to enable the sharing of vital information to the public:

- Health Education and Campaign Communications: Provides OC with support to develop and disseminate a variety of national public health campaigns. The identified focus and target audiences of each campaign are data-driven but includes all phases of campaign management from research and development to strategic planning and monitoring and measuring outcomes.

- Materials Development and Editorial Services: Provides communication support services for media outreach, publications, digital products, and speeches. The Office of Communications also receives support with copyediting, design and layout for a variety of products, including but not limited to, reports, fact sheets, and presentations.

- Web Management and Support: Supports external websites, e-mail listserv and subscriber database system, and mobile applications. For its online publication library the OC has entered into an interagency agreement with the U.S. Government Publishing Office (GPO) to manage a customer-oriented fulfillment and distribution center, including a warehouse to store SAMHSA publications.

- Contact Center: Supports the National Helpline (1-800-662-HELP) and the 1-877-SAMHSA-7 information line. The National Helpline provides free, confidential treatment referral and information services in English and Spanish for individuals and families facing mental illness and/or substance use disorders via phone or text (HELP4U). It is operational 365 days-a-year, 24/7. The 1-877-SAMHSA-7 line is the single point of entry for HHS Mental Health related information services and is operated Monday through Friday, 8:00 am to 8:00 pm (except for federal holidays).

Budget Request

The FY 2026 Budget Request is $5 million. The Budget will be used to manage media relationships, maintain agency web and social media presence, manage critical helplines, deliver publications and resources, produce, and deliver PSAs, and conduct national campaigns.

Funding History

FY	Amount
FY 2022 Final	$13,000,000
FY 2023 Final	$13,260,000
FY 2024 Final	$13,260,000
FY 2025 Enacted	*
FY 2026 President's Budget	$5,000,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Performance and Quality Information Systems (Mental and Behavioral Health)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$10,200,000	*	$10,200,000
FTE	**	**	490[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in SAMHSA FTE totals.
1\FY 2026 FTE represents entire Policy, Research, and Oversight FTE total.

Program Description

The planned AHA will maintain Performance Measurement and Performance Systems (PQIS), Evidence-Based Programs and Practices and CBHSQ's Operations with PQIS funds.

AHA (previously SAMHSA) Performance Accountability and Reporting System

The AHA Performance Accountability and Reporting System (APARS) plays a crucial role in collecting and analyzing data on key output and outcome measures for AHA's Mental Health and Substance Use programmatic oversight and performance management of discretionary grant programs. APARS is a robust and user-friendly platform designed to enhance efficiency, accuracy, and productivity in data reporting and management. The data entry module allows grantees to seamlessly input grantee-specific performance data, while sophisticated data visualizations provide grantees and Government Project Officers (GPOs) with intuitive graphical representations for informed decision-making. APARS offers multiple resources for users to access live and pre-recorded training sessions, a Technical Assistance Request System to address inquiries related to data collection and analysis, and the Resource Library containing materials to aid data management for AHA grantees. Specifically, the Resources Library includes program-specific performance data collection tools, Frequently Asked Questions (FAQs), Question by Question (QxQ) guides, and data collection tool codebooks.

Evidence Based Programs and Practices

Section 7002 of the 21st Century Cures Act directs SAMHSA to promote access to reliable and valid information on evidence-based programs and practices and share information on the strength of evidence associated with such programs and practices related to mental illness and drug/alcohol addiction. To fulfill this charge, SAMHSA developed the Evidence-Based Practices Resource Center (EBPRC). The EBPRC, provides states, local communities, clinicians, policymakers, and others in the field with the information and tools that they need to incorporate evidence-based practices in their communities or clinical settings. As part of this effort, SAMHSA developed and disseminated resources, such as new or updated guidebooks, advisories, Treatment Improvement Protocols, guidance documents, clinical practice policies,

toolkits, systematic reviews, data reports, and other actionable materials that incorporate the latest evidence on mental health and substance use. The EBPRC enabled SAMHSA to collaborate with experts in the field and to rapidly translate science into action. In particular, SAMHSA disseminated the evidence-based practices listed in the EBPRC through various avenues including through regional and locally based training and technical assistance efforts to ensure that communities and practitioners are equipped to bring about the improvements in mental health, substance use prevention and treatment, and recovery that our Nation requires.

Budget Request

The FY 2026 Budget Request is $10.2 million. This funding will be used to sustain the operation and maintenance of APARS and to support the Agency's ongoing efforts to make incremental enhancements in the performance arena. Additionally, these funds will continue to support evidence-based practices to advance the quality of behavioral health services across the nation. These enhancements will ensure that AHA continues to meet evolving data, reporting, and performance monitoring needs and align with the requirements of the Evidence Act.

This funding will also be used to sustain the operation and maintenance of the EBPRC and undertake new activity to develop resources on topics related to the intersection of behavioral health and chronic disease in order to make America Healthy Again.

Funding History

FY	Amount
FY 2022 Final	$10,000,000
FY 2023 Final	$10,200,000
FY 2024 Final	$10,200,000
FY 2025 Enacted	*
FY 2026 President's Budget	$10,200,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishment

The APARS platform, formerly SPARS platform, has undergone significant enhancements to improve user experience and optimize data management for AHA Mental Health and Substance Use discretionary grant programs. A key achievement was the implementation of performance tools which streamline performance measurement and support data-driven decision-making. The platform now offers a modernized, user-centric experience featuring a consistent and intuitive interface across all Divisions. Customizable functionality ensures users can efficiently access relevant information based on their roles and needs. Additionally, these improvements have facilitated the development of Statistical Data Profiles for AHA Mental Health and Substance Use discretionary grants. These profiles provide comprehensive data insights, enhancing analysis and reporting capabilities to better evaluate program outcomes.

The EBPRC provides communities, clinicians, policy-makers and others with the information and tools to incorporate evidence-based practices into their communities or clinical settings. The EBPRC has created advisories, guidebooks, practical guides and documents to promote the use of evidence-based practices. Recently, the EBPRC has produced key products such as a practical guide that provides key considerations for guiding people in the appropriate use of 988 and 911 and an advisory that advisory highlights the need for primary substance use prevention programs for young adults ages 18 to 25 with disabilities.
The products are downloaded for free from our website. In 2024, the EBPRC sent out the EBPRC E-Newsletter to over 170,000 subscribers.

The Assistant Secretary for Health and the Office of the Surgeon General (Previously within the Office of the Assistant Secretary for Health)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Budget Authority	$17,675,000	*	$19,588,000
PHS Evaluation Funds	$4,885,000	*	$4,885,000
FTE	**	**	490[1]

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.
**FY 2024 and FY 2025 FTE included in OASH FTE totals.
1\FY 2026 FTE represents entire Policy, Research, and Oversight FTE total.

Allocation Method..... Contracts, Direct Federal

Program Description

The Assistant Secretary for Health (ASH) serves as an advisor to the Secretary on public health and science and reports to the Administrator of AHA. The ASH provides advice and counsel to the Secretary and Administration on cross cutting priorities to improve outcomes for public health. AHA oversees the Public Health Service Commissioned Corps.

The Surgeon General is the Nation's Doctor and provides Americans with the best scientific information available on how to improve their health, prevent chronic disease, and reduce the risk of illness and injury.

Public Health Reports (PHR) is the official journal of the Office of the U.S. Surgeon General (OSG) and the Public Health Service (USPHS). PHR is a scholarly, Medline-indexed peer-reviewed scientific journal, published continuously electronically and bimonthly in print. Published since 1878, PHR is the oldest US public health journal, and the only federal government health journal for the public. The journal supports HHS priorities by facilitating translation of science into public health policy and practice to positively influence health and wellness of the American public.

The Office of Regional Health Operations (ORHO) promotes and advances the public health and safety of the American people by connecting people, convening local partners, establishing networks, and programming recommendations that best address the needs of the population. OHRO provides support for public health projects and events in the HHS regional offices and serves as liaison for the Secretary, Assistant Secretary for Health, and Surgeon General with Federal, State, and local officials.

AHA includes the innovative program LymeX which advances solutions for Lyme disease and tick-borne illnesses and supports the priorities of the Administration.

Budget Request

The FY 2026 Budget Request for Assistant Secretary for Health and Surgeon General is $19.6 million. Funding will support communication with the American public to address the President's priorities and to amplify the Make America Healthy Again initiative through engagement events, calls to action, advisories, and public health awareness campaigns in support of the President's and Departmental priorities.

Additionally, this funding will allow the PHR journal to lead gold standard science with a focus on emerging public health concerns and topics, such as disease surveillance, chronic disease prevention, substance use disorders, mental health, and tobacco use in support of enhancing the health and well-being of all Americans. Finally, the funding will continue the activities and functions of ORHO.

Funding Table

FY	Amount
FY 2022 Final	$17,291,000
FY 2023 Final	$15,675,000
FY 2024 Final	$17,675,000
FY 2025 Enacted	*
FY 2026 President's Budget	$19,588,000

*Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

Program Accomplishments

The Assistant Secretary for Health is the Secretary's designee on scheduling substances and worked in collaboration with FDA, NIH, and others across HHS to assess the current state of science assist with scheduling recommendations to the DEA.

The Assistant Secretary for Health implemented an evidence-based strategy to address a historical care gap for maternal-infant dyads with opioid exposure and published recommendations on standardizing the clinical definition of opioid withdrawal in the neonate.

Public Health Reports recent accomplishments include reducing the timeline from manuscript receipt to first and final publishing decisions, increasing content quality and editorial board membership, and expanding readership. It increased peer reviewer recruitment and achieving the journal's highest 5-year impact factor of 3.5.

Vaccine Injury Compensation Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Claims BA	$261,497,000	$266,727,000	$272,062,000
Admin BA	$15,200,000	$15,200,000	$15,200,000
Total	$276,697,000	$281,927,000	$287,262,000
FTE	**	**	490[1]

******FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Policy, Research, and Oversight FTE total

Allocation Method ..... Other

Program Description

The National Vaccine Injury Compensation Program (VICP) was established under the National Childhood Vaccine Injury Act and began accepting claims in 1988. It was created to provide a fair and efficient process for individuals who believe they have been injured by certain vaccines. Instead of pursuing traditional legal action, individuals can file a claim through the program, which offers an alternative path to compensation. VICP covers vaccines recommended by the Centers for Disease Control and Prevention (CDC) for routine use in children or pregnant women and listed on the Vaccine Injury Table. Legal proceedings take place in the U.S. Court of Federal Claims. The Department of Justice (DOJ) represents the Department of Health and Human Services (HHS) in these proceedings, where the court determines whether compensation should be awarded.

Individuals who believe they or their loved ones have experienced a vaccine-related injury or death can file a petition with the U.S. Court of Federal Claims, naming the Secretary of HHS as the respondent. Petitioners may include individuals themselves, parents, legal guardians, or representatives of estates. When a claim is filed, VICP coordinates a review conducted by medical professionals with pediatric and adult medicine expertise to assess whether the injury may be linked to a covered vaccine. In addition to in-house reviewers, VICP contracts with independent medical specialists to provide further evaluations and expert testimony when needed. Based on these reviews, VICP prepares a preliminary recommendation regarding whether the petitioner may qualify for compensation.

The DOJ, representing HHS, incorporates VICP's medical findings into a report submitted to the Court. The Court then determines the outcome of the case. If compensation is awarded, VICP is responsible for processing payments to petitioners and their attorneys in accordance with the Court's decision.

VICP also publishes public notices in the Federal Register listing claims received and manages updates to the Vaccine Injury Table, a list of recognized injuries and conditions associated with

certain vaccines. Additionally, VICP provides administrative support to the Advisory Commission on Childhood Vaccines (ACCV), which advises the HHS Secretary on policy and operation of the VICP. The ACCV comprises nine voting members, including healthcare professionals, legal representatives, parents of individuals affected by vaccine-related injuries, and non-voting representatives from HHS.

Vaccine Injury Compensation Trust Fund

Congress annually appropriates funding from the Vaccine Injury Compensation Trust Fund (Trust Fund) for VICP administration and compensation for vaccine-related injuries or death claims for covered vaccines administered on or after October 1, 1988. As of September 30, 2024, the Trust Fund had a balance of over $4.6 billion. The Department of Treasury maintains the Trust Fund through a $0.75 excise tax on covered vaccines. The excise tax applies to each disease prevented per vaccine dose. For example, the influenza vaccine is taxed at $0.75 because it prevents one disease, while the measles-mumps-rubella vaccine, which prevents three diseases, is taxed at $2.25. The Department of Treasury collects the excise taxes and manages the Trust Fund investments.

VICP Administration

VICP claims have increased by 48% from FY 2015 to FY 2024. In FY 2017, VICP began experiencing a backlog of vaccine injury claims awaiting medical review since the volume of claims exceeded the resources available to conduct timely medical reviews. The cumulative claims backlog was 1,106 by the end of FY 2022, resulting in a 9 – 12-month backlog for VICP medical review. Due to increased administrative funding from FY 2022 through FY 2024, the VICP contracted with companies and medical reviewers to reduce the backlog of claims awaiting medical review by more than 85 percent

Table 1. 10-Year Trend in Number of Claims Filed and Administrative Costs
(*dollars in millions)*

Fiscal Year	Number of Claims Filed	Administrative Funding
2015	803	$7.50
2016	1,120	$7.50
2017	1,243	$7.75
2018	1,238	$9.20
2019	1,282	$9.20
2020	1,192	$10.20
2021	2,057[1]	$11.20
2022	1,029	$13.20
2023	1,167	$15.20
2024	1,185	$15.20

1/Significant influx of 800 claims in January 2021 due to the expected implementation of the final rule proposed to remove Shoulder Injury Related to Vaccine Administration (SIRVA) from the Vaccine Injury Table, which led to a sudden surge in claims and required additional resources for processing.

Budget Request

VICP Claims Compensation
The FY 2026 Budget Request for VICP of $272.1 million is $5.3 million above the FY 2025 Enacted level. This request will provide the funds necessary to compensate up to 1,335 claims, including payments to petitioners for unreimbursed past and future medical expenses, lost earnings, pain and suffering, and to attorneys for attorneys' fees and costs for claims filed on a reasonable basis and in good faith.

VICP Administration
The FY 2026 Budget Request for VICP of $15.2 million equals the FY 2025 Enacted level. This request will support administrative expenses necessary to continue the prompt review of claims, to prevent a future backlog of claims awaiting medical review, and to process expected incoming claims in FY 2026. This request will also support timely claims adjudication by providing funding for medical review staff, contractors to conduct timely medical reviews, medical experts for reviews, and expert testimony given during Court proceedings. Finally, this request will support information technology, including automation for more timely review of claims, improved communication modalities with stakeholders, operations, and maintenance for the newly implemented claims management system, and costs associated with the claims award processes, follow-up performance reviews, and other program requirements.

Five Year Funding History - *VICP Claims*

FY	**Amount**
FY 2022 Final	$316,778,000
FY 2023 Final	$256,370,000
FY 2024 Final	$261,497,000
FY 2025 Enacted	$266,727,000
FY 2026 President's Budget	$272,062,000

Five Year Funding History - *VICP Admin*

FY	**Amount**
FY 2022 Final	$13,200,000
FY 2023 Final	$15,200,000
FY 2024 Final	$15,200,000
FY 2025 Enacted	$15,200,000
FY 2026 President's Budget	$15,200,000

Program Accomplishments

In FY 2023 and FY 2024, VICP implemented business process reengineering to eliminate the backlog of pending medical reviews. These process improvements reduced the backlog of claims awaiting medical review by more than 85%. Furthermore, wait-times for claims activated by the

Court awaiting VICP medical review dropped from more than 365 days at the beginning of FY 2022 to fewer than 50 days at the end of FY 2024.

VICP uses three performance measures to assess the efficiency of conducting medical claims reviews and issuing court order payments. In FY 2024, VICP aimed to issue court-ordered lump sum payments within four days of receiving all necessary documentation. It exceeded this goal by averaging payment issuance in just 1.4 days. VICP also set a goal to complete 93 percent of medical reviews within 90 days of assignment. It reviewed 91 percent of claims within that timeframe, narrowly missing the target.

In addition, VICP aimed to assign 80 percent of claims for medical review within nine months of court activation. In FY 2024, VICP exceeded this goal by assigning 100 percent of claims within that timeframe.

Finally, in FY 2024, VICP issued the highest number of petitioner awards in VICP history (1,221). Table 2 shows the number of petitioners awarded compensation and vaccine injury compensation provided over the last five years.

Table 2. Growth in Families and Individuals Receiving Compensation

Fiscal Year	No. of Petitioners	Compensation ($ in millions)
2020	733	$218
2021	719	$245
2022	927	$230
2023	885	$174
2024	1,221	$203

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
9000.03 Average time that lump sum only awards are paid from the receipt of all required documentation to make a payment. (Efficiency)	FY 2024: 1.5 days Target: 4 days (Target Exceeded)	3 days	3 days	Maintain
9000.07 Percentage of medical reports that are completed within 90 days of the date the claim is assigned to a medical reviewer (Efficiency)	FY 2024: 91% Target: 93% (Target Not Met)	94%	94%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/- FY 2025 Target
9000.08 Percentage of filed claims assigned for medical review within 9 months of the date the claim is activated by the Court (Efficiency)	FY 2024: 100% Target: 75% (Target Exceeded)	80%	85%	+5 percentage points

Countermeasures Injury Compensation Program

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	$7,000,000	$7,000,000	---
FTE	**	**	490[1]

****FY 2024 and FY 2025 FTE included in HRSA FTE totals.
1\FY 2026 FTE represents entire Policy, Research, and Oversight FTE total.

Allocation Method ..... Other

Program Description

The Countermeasures Injury Compensation Program (CICP) provides benefits to individuals who suffer serious physical injuries or death as a result of certain countermeasures used during a public health emergency. The program began operations in fiscal year 2010, established under the Public Readiness and Emergency Preparedness (PREP) Act of 2005, which authorizes the Secretary of Health and Human Services (HHS) to issue declarations identifying specific countermeasures covered under the CICP. These countermeasures may include vaccines, medications, devices, or other products recommended to diagnose, prevent, or treat conditions during a declared pandemic, epidemic, or national security threat. Once a declaration is in effect, individuals who believe a covered countermeasure has injured them may apply for compensation.

The CICP provides three primary types of benefits:

- Reimbursement for unreimbursed medical expenses related to the covered countermeasure injury,
- Compensation for lost employment income due to the inability to work as a direct result of the countermeasure injury, and
- Death benefits to eligible survivors if the countermeasure-related injury results in death.

To be eligible, an individual must submit documentation showing that a covered injury was sustained as the direct result of the administration or use of a covered countermeasure within one year of receiving or using the covered countermeasure. All claims are reviewed through an administrative process that requires claimants to provide compelling, reliable, and valid medical and scientific evidence to support that an injury or death was directly caused by a covered countermeasure.

In 2020, the Secretary of HHS issued a PREP Act declaration for medical countermeasures against COVID-19. Following the issuance of the PREP Act declaration, eligible individuals began to submit Request for Benefits claiming injuries from COVID-19 countermeasures, including COVID-19 vaccines. As a result, CICP received more than 13,700 COVID-19 claims as of April 1, 2025. Prior to 2020, CICP received fewer than 500 claims since it began processing claims in 2010. The CICP budget supports *both* the administration of CICP and

compensation to eligible individuals found to have serious injuries or deaths directly caused by the administration or use of covered countermeasures.

From FY 2022 to FY 2024, CICP processed an average of 1,100 claims, resulting in the review of over 3,300 COVID-19 claims during this timeframe. Approximately 2% of the claims filed were found to have compelling, reliable, and valid medical and scientific evidence to support that an injury or death was the direct cause of a covered countermeasure. As of April 1, 2025, the CICP has provided over $9 million in compensable benefits.

Budget Request

The FY 2026 Budget Request for CICP is a $7 million decrease from the FY 2025 Enacted level. The program has carryover funding that will support the reviewing and processing an estimated 2,000 claims, or 22.2 percent of the current backlog. It would provide an estimated $3 million in compensation in FY 2026, which includes paying claimants for unreimbursed medical expenses, lost employment income, and a death benefit. Carryover funding will be used to administratively support (1) the Program's analysis of claims, (2) the CICP information technology infrastructure to better facilitate claims processing; (3) process efficiencies in the review and management of claims; and (4) seamless communication with requesters.

Funding History

FY	Amount
FY 2022 Final	$5,000,000
FY 2023 Final	$7,000,000
FY 2024 Final	$7,000,000
FY 2025 Enacted	$7,000,000
FY 2026 President's Budget	---

Program Accomplishments

In FY 2024, 2,114 claims were reviewed and determinations made, a 50 percent increase compared to FY 2023 and a significant increase in compensable funds distributed to eligible requesters. CICP will utilize carryover funding to continue building on these efficiency gains. The program measures its efficiency by the speed at which claims are processed after all required documentation has been received. CICP has consistently met its goal of issuing all payments within 180 days of confirming receipt of all required documentation.

From FY 2023 to FY 2024, CICP increased its claims decisions by 92 percent. As of April 1, 2025, CICP has completed 4,111 determinations for COVID-19-related claims. The program has adopted improvements in information technology and project management practices to enhance program efficiency. This includes modernizing the injury compensation system to process claims and implementing automation to facilitate claim review. These improvements will continue in FY 2026.

Make America Healthy Again Initiative

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
BA	---	---	$260,000,000[1]
FTE	---	---	490[2]

1\This funding will be allocated across multiple programs, as discussed in more detail in the appropriate sections above.
2\FY 2026 FTE represents entire Policy, Research, and Oversight FTE total.

Budget Request

Building on the efforts of the President's Make America Healthy Again (MAHA) Commission, the Budget includes $260 million to support MAHA initiatives. This funding will be distributed across multiple programs to address critical public health challenges, including chronic disease and childhood obesity, through a Prevention Innovation Program. It also provides resources to prevent childhood lead poisoning and exposure, supports the integration of telehealth and digital health technologies into chronic disease prevention strategies, and advances efforts related to Alzheimer's disease.

The allocation table and a brief description of the initiatives are provided below. Additional details are available in the respective program narratives.

Program/Activity	**FY 2026 President's Budget** *(dollars in thousands)*
Prevention Innovation program	$119,000
Office for the Advancement of Telehealth - Chronic Care Telehealth Centers of Excellence	$20,000
Office for the Advancement of Telehealth - Telehealth Nutrition Services Network Grant	$8,000
Alzheimer's Disease program	$35,000
Childhood Lead Poisoning Prevention	$51,000
Lead Exposure Registry	$5,000
Program Management	$22,000
Total, MAHA Initiative funding	**$260,000**

The Prevention Innovation Program will improve the overall health of Americans by promoting reliable broadband technology integration, ensure access to nutrition services and physical activity venues, and reduce dependence on medication.

The Chronic Care Telehealth Centers of Excellence and Telehealth Nutrition Services Network Grant Program will integrate telehealth and digital health technologies into chronic care disease prevention and management and nutrition services.

The Childhood Lead Poisoning Prevention Program and Lead Exposure Registry will offer expertise to assist states during lead-related crises, establish critical infrastructure, and address the disproportionate burden of lead poisoning in low-income communities.

The Alzheimer's Disease program will improve outcomes and promote early assessment and diagnosis, and the additional resources for program management will ensure the Administration for a Healthy America (AHA) has sufficient resources to properly manage operations for the proposed organization.

SUPPLEMENTARY TABLES

TAB

Budget Authority By Object Class
ADMINISTRATION FOR A HEALTHY AMERICA
DIRECT FUNDING TOTAL

OBJECT CLASS	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY2026+/- FY 2025
Full-time permanent (11.1)	$761,971	$758,251	$626,071	-$132,180
Other than full-time permanent (11.3)	71,500	72,532	51,436	-21,096
Other personnel compensation (11.5)	26,671	26,547	19,845	-6,702
Military personnel (11.7)	63,486	62,334	59,688	-2,646
Special personnel services payments (11.8)	12,231	12,545	12,132	-412
Subtotal personnel compensation	**$935,859**	**$932,209**	**$769,173**	**-$163,036**
Civilian benefits (12.1)	310,433	309,891	260,975	-48,916
Military benefits (12.2)	10,279	10,187	11,570	+1,383
Benefits to former personnel (13.1)	1,133	27,186	1,689	-25,497
Total Pay Costs	**$1,257,704**	**$1,279,472**	**$1,043,407**	**-$236,066**
Travel and transportation of persons (21.0)	19,832	19,653	10,902	-8,751
Transportation of things (22.0)	2,145	2,159	1,078	-1,081
Rental payments to GSA (23.1)	17,470	17,471	16,324	-1,147
Rental payments to Others (23.2)	237	237	163	-74
Communication, utilities, and misc. charges (23.3)	5,137	5,155	1,620	-3,536
Printing and reproduction (24.0)	1,554	1,554	2,111	+558
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	537,297	535,127	216,430	-318,697
Other services (25.2)	561,246	487,174	480,512	-6,662
Purchase of goods/services from government accounts (25.3)	319,089	313,947	207,865	-106,082
Operation and maintenance of facilities (25.4)	21,299	21,457	8,452	-13,005
Research and Development Contracts (25.5)	123,921	126,467	81,799	-44,668
Medical care (25.6)	6,080	6,044	4,491	-1,553
Operation and maintenance of equipment (25.7)	28,125	26,732	14,889	-11,843
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	18,699	16,970	9,635	-7,335
Subtotal Other Contractual Services	**1,615,756**	**1,533,917**	**1,024,073**	**-509,844**
Equipment (31.0)	35,944	35,117	19,305	-15,812
Land and Structures (32.0)	4,080	4,127	2,587	-1,540
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	17,981,727	17,079,845	11,719,822	-5,360,023
Insurance Claims and Indemnities (42.0)	79,456	79,457	79,338	-119
Interest and Dividends (43.0)	-	-	-	-
Refunds (44.0)	43	43	43	-
Evaluations (94.0)	144,125	144,125	137,470	-6,655
Total Non-Pay Costs	**19,907,507**	**18,922,861**	**13,014,837**	**-5,908,024**
Total Budget Authority by Object Class	**$21,165,211**	**$20,202,333**	**$14,058,243**	**-$6,144,090**

PRIMARY CARE

OBJECT CLASS	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY2026+/- FY 2025
Full-time permanent (11.1)	$261,797	$263,231	$272,935	+$9,704
Other than full-time permanent (11.3)	13,802	13,822	13,956	+134
Other personnel compensation (11.5)	8,899	8,896	8,479	-417
Military personnel (11.7)	17,900	18,534	24,901	+6,367
Special personnel services payments (11.8)	466	466	483	+17
Subtotal personnel compensation	**$302,863**	**$304,949**	**$320,755**	**+$15,806**
Civilian benefits (12.1)	102,917	103,065	94,562	-8,503
Military benefits (12.2)	3,485	3,557	4,611	+1,054
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$409,265**	**$411,571**	**$419,927**	**+$8,357**
Travel and transportation of persons (21.0)	8,064	8,064	3,256	-4,808
Transportation of things (22.0)	226	226	94	-132
Rental payments to GSA (23.1)	5,742	5,742	5,742	-
Rental payments to Others (23.2)	116	116	110	-6
Communication, utilities, and misc. charges (23.3)	44	44	19	-25
Printing and reproduction (24.0)	285	285	88	-197
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	359,946	358,981	136,650	-222,331
Other services (25.2)	172,477	172,716	164,051	-8,665
Purchase of goods/services from government accounts (25.3)	92,906	92,370	46,287	-46,083
Operation and maintenance of facilities (25.4)	196	193	175	-18
Research and Development Contracts (25.5)	1,615	1,615	580	-1,036
Medical care (25.6)	3,789	3,789	3,788	-1
Operation and maintenance of equipment (25.7)	7,339	7,339	3,669	-3,670
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	1,066	1,066	529	-537
Subtotal Other Contractual Services	**639,335**	**638,070**	**355,729**	**-282,341**
Equipment (31.0)	9,980	9,980	5,572	-4,408
Land and Structures (32.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	3,227,464	3,226,423	2,002,002	-1,224,421
Insurance Claims and Indemnities (42.0)	79,294	79,294	79,294	-
Interest and Dividends (43.0)	-	-	-	-
Refunds (44.0)	-	-	-	-
Evaluations (94.0)	44,378	44,378	44,378	-
Total Non-Pay Costs	**4,014,928**	**4,012,622**	**2,496,284**	**-1,516,338**
Total Budget Authority by Object Class	**$4,424,193**	**$4,424,193**	**$2,916,212**	**-$1,507,981**

ENVIRONMENTAL HEALTH
LABOR-HHS

OBJECT CLASS	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY2026+/- FY 2025
Full-time permanent (11.1)	$172,308	$172,608	$91,509	-81,100
Other than full-time permanent (11.3)	49,333	50,552	31,455	-19,097
Other personnel compensation (11.5)	6,611	6,684	2,993	-3,691
Military personnel (11.7)	12,884	12,926	1,895	-11,031
Special personnel services payments (11.8)	11,742	12,057	11,636	-420
Subtotal personnel compensation	**$252,878**	**$254,827**	**$139,488**	**-$115,339**
Civilian benefits (12.1)	86,195	87,544	82,527	-5,017
Military benefits (12.2)	1,915	1,918	1,792	-127
Benefits to former personnel (13.1)	-	2,144	1,050	-1,094
Total Pay Costs	**$340,987**	**$346,433**	**$224,856**	**-$121,576**
Travel and transportation of persons (21.0)	6,137	5,970	2,227	-3,742
Transportation of things (22.0)	1,554	1,567	638	-929
Rental payments to GSA (23.1)	328	328	74	-255
Rental payments to Others (23.2)	104	105	37	-68
Communication, utilities, and misc. charges (23.3)	4,869	4,886	1,346	-3,540
Printing and reproduction (24.0)	713	713	136	-577
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	78,777	78,085	11,335	-66,750
Other services (25.2)	50,605	42,171	29,959	-12,212
Purchase of goods/services from government accounts (25.3)	101,861	97,304	45,264	-52,040
Operation and maintenance of facilities (25.4)	20,479	20,642	7,666	-12,976
Research and Development Contracts (25.5)	122,249	124,795	81,163	-43,632
Medical care (25.6)	2,285	2,248	698	-1,550
Operation and maintenance of equipment (25.7)	14,233	12,840	6,528	-6,312
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	16,407	14,678	7,963	-6,715
Subtotal Other Contractual Services	**406,895**	**392,764**	**190,577**	**-202,187**
Equipment (31.0)	17,668	16,841	5,664	-11,177
Land and Structures (32.0)	4,080	4,127	2,587	-1,540
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	597,500	607,102	247,700	-359,402
Insurance Claims and Indemnities (42.0)	-	-	-	-
Interest and Dividends (43.0)	-	-	-	-
Refunds (44.0)	43	43	43	-
Evaluations (94.0)	-	-	-	-
Total Non-Pay Costs	**1,039,892**	**1,034,446**	**451,030**	**-583,417**
Total Budget Authority by Object Class	**$1,380,879**	**$1,380,879**	**$675,886**	**-$704,993**

ENVIRONMENTAL HEALTH
INTERIOR SUPERFUND

OBJECT CLASS	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY2026+/- FY 2025
Full-time permanent (11.1)	$1,373	$1,411	$1,418	+7
Other than full-time permanent (11.3)	52	54	54	-
Other personnel compensation (11.5)	26	26	27	+1
Military personnel (11.7)	-	-	-	-
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$1,451**	**$1,491**	**$1,499**	**+8**
Civilian benefits (12.1)	567	590	601	+11
Military benefits (12.2)	-	-	-	-
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$2,017**	**$2,082**	**$2,100**	**+$19**
Travel and transportation of persons (21.0)	43	32	22	-10
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	-	-	-	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	76	77	-	-77
Other services (25.2)	2,540	1,889	1,330	-560
Purchase of goods/services from government accounts (25.3)	216	220	50	-169
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	-	-	-	-
Subtotal Other Contractual Services	**2,831**	**2,186**	**1,380**	**-806**
Equipment (31.0)	-	-	-	-
Land and Structures (32.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	74,822	75,414	48,311	-27,103
Insurance Claims and Indemnities (42.0)	-	-	-	-
Interest and Dividends (43.0)	-	-	-	-
Refunds (44.0)	-	-	-	-
Evaluations (94.0)	-	-	-	-
Total Non-Pay Costs	**77,696**	**77,632**	**49,714**	**-27,918**
Total Budget Authority by Object Class	**$79,714**	**$79,714**	**$51,814**	**-$27,900**

OBJECT CLASS	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY2026+/- FY 2025
Full-time permanent (11.1)	$42,061	$42,519	$36,337	-$6,182
Other than full-time permanent (11.3)	955	958	921	-37
Other personnel compensation (11.5)	1,356	1,365	1,263	-102
Military personnel (11.7)	4,783	3,560	5,780	+2,220
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$49,155**	**$48,402**	**$44,301**	**-$4,101**
Civilian benefits (12.1)	15,220	15,378	13,248	-2,130
Military benefits (12.2)	715	601	1,155	+554
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$65,090**	**$64,381**	**$58,704**	**-$5,677**
Travel and transportation of persons (21.0)	791	791	753	-38
Transportation of things (22.0)	30	30	30	-
Rental payments to GSA (23.1)	718	718	718	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	1	1	1	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	33,538	33,321	31,518	-1,803
Other services (25.2)	46,934	46,933	49,704	+2,770
Purchase of goods/services from government accounts (25.3)	7,433	7,433	7,455	+22
Operation and maintenance of facilities (25.4)	338	338	328	-10
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	813	813	813	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	437	437	437	-
Subtotal Other Contractual Services	**89,493**	**89,276**	**90,255**	**+979**
Equipment (31.0)	4,901	4,901	4,901	-
Land and Structures (32.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	3,438,034	3,438,960	2,516,478	-922,482
Insurance Claims and Indemnities (42.0)	-	-	-	-
Interest and Dividends (43.0)	-	-	-	-
Refunds (44.0)	-	-	-	-
Evaluations (94.0)	53,276	53,276	53,276	-
Total Non-Pay Costs	**3,587,245**	**3,587,954**	**2,666,413**	**-921,541**
Total Budget Authority by Object Class	**$3,652,335**	**$3,652,335**	**$2,725,117**	**-$927,218**

MATERNAL AND CHILD HEALTH

OBJECT CLASS	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY2026+/- FY 2025
Full-time permanent (11.1)	$59,261	$60,353	$77,816	+$17,463
Other than full-time permanent (11.3)	2,165	2,196	1,766	-430
Other personnel compensation (11.5)	2,032	2,054	1,679	-375
Military personnel (11.7)	2,525	2,503	2,242	-261
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$65,983**	**$67,106**	**$83,503**	**+$16,397**
Civilian benefits (12.1)	22,879	23,292	16,290	-7,002
Military benefits (12.2)	447	486	427	-59
Benefits to former personnel (13.1)	30	30	30	-
Total Pay Costs	**$89,339**	**$90,914**	**$100,249**	**+$9,336**
Travel and transportation of persons (21.0)	1,300	1,300	972	-328
Transportation of things (22.0)	54	54	36	-18
Rental payments to GSA (23.1)	2,268	2,268	1,368	-900
Rental payments to Others (23.2)	3	3	3	-
Communication, utilities, and misc. charges (23.3)	-	-	-	-
Printing and reproduction (24.0)	300	300	202	-98
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	64,830	64,532	36,797	-27,735
Other services (25.2)	12,821	12,781	12,412	-369
Purchase of goods/services from government accounts (25.3)	27,195	27,141	23,241	-3,900
Operation and maintenance of facilities (25.4)	180	178	178	-1
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	7	7	5	-2
Operation and maintenance of equipment (25.7)	2,557	2,556	709	-1,847
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	443	443	274	-168
Subtotal Other Contractual Services	**108,033**	**107,638**	**73,615**	**-34,023**
Equipment (31.0)	1,457	1,457	1,248	-209
Land and Structures (32.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	1,569,401	1,568,221	899,752	-668,468
Insurance Claims and Indemnities (42.0)	6	6	4	-2
Interest and Dividends (43.0)	-	-	-	-
Refunds (44.0)	-	-	-	-
Evaluations (94.0)	14,861	14,861	8,206	-6,655
Total Non-Pay Costs	**1,697,683**	**1,696,108**	**985,407**	**-710,701**
Total Budget Authority by Object Class	**$1,787,022**	**$1,787,022**	**$1,085,656**	**-$701,366**

OBJECT CLASS	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY2026+/- FY 2025
Full-time permanent (11.1)	$37,695	$37,695	$31,215	-$6,480
Other than full-time permanent (11.3)	354	354	293	-61
Other personnel compensation (11.5)	2,078	2,078	1,721	-357
Military personnel (11.7)	3,792	3,792	4,534	+742
Special personnel services payments (11.8)	-	1	-	-1
Subtotal personnel compensation	**$43,919**	**$43,920**	**$37,763**	**-$6,157**
Civilian benefits (12.1)	13,914	13,914	11,522	-2,392
Military benefits (12.2)	438	438	467	+29
Benefits to former personnel (13.1)	-	5,129	-	-5,129
Total Pay Costs	**$58,271**	**$63,401**	**$49,752**	**-$13,649**
Travel and transportation of persons (21.0)	338	338	513	+175
Transportation of things (22.0)	-	1	-	-1
Rental payments to GSA (23.1)	-	-	-	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	223	223	253	+30
Printing and reproduction (24.0)	114	114	1,544	+1,430
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	129,556	129,556	45,979	-83,577
Purchase of goods/services from government accounts (25.3)	40,259	40,259	41,290	+1,031
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	2,022	2,022	2,008	-14
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	29	29	115	+86
Subtotal Other Contractual Services	**171,866**	**171,866**	**89,392**	**-82,474**
Equipment (31.0)	103	103	85	-18
Land and Structures (32.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	6,859,454	6,854,322	5,535,677	-1,318,645
Insurance Claims and Indemnities (42.0)	115	116	-	-116
Interest and Dividends (43.0)	-	-	-	-
Refunds (44.0)	-	-	-	-
Evaluations (94.0)	-	-	-	-
Total Non-Pay Costs	**7,032,213**	**7,027,083**	**5,627,464**	**-1,399,619**
Total Budget Authority by Object Class	**$7,090,484**	**$7,090,484**	**$5,677,216**	**-$1,413,268**

HEALTH WORKFORCE

OBJECT CLASS	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY2026+/- FY 2025
Full-time permanent (11.1)	$23,008	$23,249	$9,390	-$13,860
Other than full-time permanent (11.3)	439	444	179	-264
Other personnel compensation (11.5)	582	588	238	-351
Military personnel (11.7)	3,012	2,552	931	-1,621
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**$27,041**	**$26,833**	**$10,738**	**-$16,096**
Civilian benefits (12.1)	8,568	8,657	3,496	-5,161
Military benefits (12.2)	436	369	135	-235
Benefits to former personnel (13.1)	-	-	-	-
Total Pay Costs	**$36,045**	**$35,860**	**$14,369**	**-$21,491**
Travel and transportation of persons (21.0)	504	504	504	-
Transportation of things (22.0)	-	-	-	-
Rental payments to GSA (23.1)	904	904	904	-
Rental payments to Others (23.2)	5	5	5	-
Communication, utilities, and misc. charges (23.3)	-	-	-	-
Printing and reproduction (24.0)	1	1	1	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	34,837	34,837	34,837	-
Purchase of goods/services from government accounts (25.3)	38,546	38,546	38,546	-
Operation and maintenance of facilities (25.4)	10	10	10	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	943	943	943	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	1	1	1	-
Subtotal Other Contractual Services	**74,336**	**74,336**	**74,336**	-
Equipment (31.0)	1,614	1,614	1,614	-
Land and Structures (32.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	1,259,358	1,259,543	271,278	-988,265
Insurance Claims and Indemnities (42.0)	-	-	-	-
Interest and Dividends (43.0)	-	-	-	-
Refunds (44.0)	-	-	-	-
Evaluations (94.0)	31,609	31,609	31,609	-
Total Non-Pay Costs	**1,368,331**	**1,368,516**	**380,251**	**-988,265**
Total Budget Authority by Object Class	**$1,404,376**	**$1,404,376**	**$394,620**	**-$1,009,756**

POLICY, RESEARCH, AND OVERSIGHT

OBJECT CLASS	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY2026+/- FY 2025
Full-time permanent (11.1)	$164,470	$157,184	$105,452	-$51,733
Other than full-time permanent (11.3)	4,400	4,152	2,810	-1,342
Other personnel compensation (11.5)	5,087	4,856	3,447	-1,409
Military personnel (11.7)	18,591	18,467	19,405	+938
Special personnel services payments (11.8)	23	21	13	-8
Subtotal personnel compensation	**$192,570**	**$184,680**	**$131,127**	**-$53,554**
Civilian benefits (12.1)	60,174	57,451	38,729	-18,722
Military benefits (12.2)	2,843	2,817	2,984	+166
Benefits to former personnel (13.1)	1,103	19,883	609	-19,274
Total Pay Costs	**$256,689**	**$264,832**	**$173,448**	**-$91,384**
Travel and transportation of persons (21.0)	2,655	2,655	2,655	-
Transportation of things (22.0)	281	281	280	-1
Rental payments to GSA (23.1)	7,510	7,510	7,518	+8
Rental payments to Others (23.2)	8	8	8	-
Communication, utilities, and misc. charges (23.3)	1	1	1	-
Printing and reproduction (24.0)	141	141	141	-
Other Contractual Services: 25.0	-	-	-	-
Advisory and assistance services (25.1)	130	130	130	-
Other services (25.2)	111,476	46,290	142,240	+95,950
Purchase of goods/services from government accounts (25.3)	10,674	10,674	5,731	-4,943
Operation and maintenance of facilities (25.4)	96	96	96	-
Research and Development Contracts (25.5)	56	56	56	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	220	220	220	-
Subsistence and support of persons (25.8)	-	-	-	-
Discounts and Interest (25.9)	-	-	-	-
Supplies and materials (26.0)	315	315	315	-
Subtotal Other Contractual Services	**122,967**	**57,781**	**148,788**	**+91,007**
Equipment (31.0)	220	220	220	-
Land and Structures (32.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	955,694	49,860	198,623	+148,763
Insurance Claims and Indemnities (42.0)	41	41	40	-1
Interest and Dividends (43.0)	-	-	-	-
Refunds (44.0)	-	-	-	-
Evaluations (94.0)	-	-	-	-
Total Non-Pay Costs	**1,089,518**	**118,498**	**358,274**	**+239,776**
Total Budget Authority by Object Class	**$1,346,208**	**$383,330**	**$531,722**	**+$148,392**

Detail of Full-Time Equivalent

Program[1]	FY 2026 Base Estimates[2]		
	Civilian	Military	Total
Primary Care:			
Total, Direct:	219	36	255
Total, Mandatory	219	28	247
Total FTE, Primary Care	**438**	**64**	**502**
Environmental Health:			
Total, Direct:	838	6	844
Total, Mandatory	74	11	85
Total FTE, Environmental Health	**912**	**17**	**929**
HIV/AIDS:			
Total, Direct:	194	18	212
Maternal and Child Health Bureau:			
Total, Direct:	138	3	141
Total, Mandatory	46	1	47
Total FTE, Maternal and Child Health	**184**	**4**	**188**
Mental and Behavioral Health:			
Total, Direct	501	55	556
Health Workforce:			
Total, Direct	44	6	50
Total, Reimbursable:	30	-	30
Total, Mandatory	153	25	178
Total FTE, Health Workforce	**227**	**31**	**258**
Policy, Research, and Oversight			
Total, Direct	431	59	490
Subtotal Direct (non-add)	2,365	183	2,548
Subtotal Reimbursable (non-add)	30	-	30
Subtotal Mandatory (non-add)	492	65	557
Total, AHA FTE	**2,887**	**248**	**3,135**

1\FY 2024 and FY 2025 FTE were included in FTE totals for HRSA, SAMHSA, CDC, NIH-NIEHS, and OASH

2\FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Programs Proposed for Elimination in the FY 2026 Budget

Rationale: The Budget proposes to eliminate the following programs for FY 2026 in an effort to streamline the bureaucracy, reset the proper balance between federal and state responsibilities, and save taxpayer funds.

(dollars in millions)

Program	FY 2025 Enacted
Primary Care:	
Rural Hospital Flexibility Grants	$64.277
State Offices of Rural Health	$12.500
Rural Hospital Stabilization Pilot Program	*
Tobacco and Prevention Control - BA	*
Tobacco and Prevention Control - PPHF	$125.850
Nutrition, Physical Activity, and Obesity	*
School Health	*
All Other Chronic Disease/Health Promotion Activities-BA	*
All Other Chronic Disease/Health Promotion Activities-PPHF	$19.750
Million Hearts (non-add)	$5.000
National Early Child Care Collaboratives (non-add)	$5.000
Hospitals Promoting Breastfeeding (non-add)	$9.750
Prevention Research Centers	*
Heart Disease and Stroke - BA	*
Heart Disease and Stroke - PPHF	$29.255
Diabetes - BA	*
Diabetes - PPHF	$66.412
National Diabetes Prevention Program	*
Cancer Prevention and Control	*
Oral Health	*
Safe Motherhood/Infant Health	*
Arthritis	*
Epilepsy	*
National Lupus Patient Registry	*
Racial and Ethnic Approaches to Community Health	*
Social Determinants of Health	*
Youth Violence Prevention	*
Adverse Childhood Experiences	*
Firearm Injury and Mortality Prevention Research	*
Traumatic Brain Injury	*
Elderly Falls	*

Program	FY 2025 Enacted
Drowning	*
Other Injury Prevention Activities	*
Injury Control Research Centers	*
Environmental Health:	
Trevor's Law	*
Amyotrophic Lateral Sclerosis Registry	*
Climate and Health	*
Environmental and Health Outcome Tracking Network	*
Asthma	*
National Occupational Research Agenda	*
Education and Research Centers	*
Personal Protective Technology	*
Other Occupational Safety and Health Research	*
Health Workforce:	
Loan Repayment/Faculty Fellowships	*
Scholarships for Disadvantaged Students	*
Health Careers Opportunity Program	*
Primary Care Training and Enhancement	*
Oral Health Training Programs	*
Medical Student Education	$60.000
Area Health Education Centers	*
Geriatric Programs	*
Public Health/Preventative Medicine	*
Advanced Nursing Education and Nurse Practitioner Optional Fellowship Program	*
Nursing Workforce Diversity	*
Nurse Education, Practice, and Retention	*
Nurse Faculty Loan Repayment	*
Children's Hospital Graduate Medical Education	*
HIV/AIDS:	
Minority Aids	*
AIDS Education and Training Centers – Part F	*
Dental Reimbursement Program Part F	*
Special Projects of National Significance	*
CDC Domestic HIV Prevention and Research	*
Maternal and Child Health:	
Early Hearing Detection and Intervention	*
Emergency Medical Services for Children	*
Healthy Start	*
Heritable Disorders	*
Family Planning	$286.479

Program	FY 2025 Enacted
Mental and Behavioral Health:	
Mental Health Awareness Training (MHAT)	*
Healthy Transitions	*
Children and Family Programs	*
Consumer and Family Network Grants	*
Mental Health System Transformation and Health Reform	*
Project LAUNCH	*
Primary and Behavioral Health Care Integration and Primary and Behavioral Health Care Integration Training and Technical Assistance (TTA)	*
Mental Health Crisis Response Partnership Pilot Program	*
Homelessness Prevention Programs	*
Criminal and Juvenile Justice Program	*
Assertive Community Treatment for Individuals with SMI	*
Minority AIDS Initiative (Mental Health)	*
Minority Fellowship (Mental Health)	*
Seclusion and Restraint	*
Tribal Behavioral Health Grants (Mental Health)	*
Infant and Early Childhood Mental Health	*
Interagency Task Force on Trauma-Informed Care	*
Strategic Prevention Framework	*
Sober Truth on Preventing Underage Drinking (STOP Act)	*
Tribal Behavioral Health Grants (Prevention)	*
Minority AIDS Initiative (Prevention)	*
Minority Fellowship Program (Prevention)	*
Screening, Brief Intervention and Referral to Treatment (SBIRT)	*
Targeted Capacity Expansion	*
Pregnant and Postpartum Women	*
Improving Access to Overdose Treatment	*
Building Communities of Recovery	*
Recovery Communities Service Program	*
Children and Families (YFTREE)	*
Treatment Systems for Homelessness	*
Criminal Justice Activities	*
Minority AIDS Initiative (Treatment)	*
Minority Fellowship Program (Treatment)	*
Grants to Prevent Prescription Drug/Opioid Overdose-Related Death	*
Peer Support TA Center	*
Treatment, Recovery and Workforce Support	*
Emergency Department Alternatives to Opioids	*

Program	FY 2025 Enacted
Comprehensive Opioid Recovery Centers	*
First Responder Training (FR-CARA)	*
Youth Prevention and Recovery Initiative	*
Policy, Research and Oversight	
Kidney X	$5.000
Sexual Risk Avoidance	$35.000
Teen Pregnancy Prevention (TPP)	$101.000
Office of Adolescent Health (OAH)	$0.463

* Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025, and is rolled up within the account.

FTEs Funded by P.L. 111-148 and Any Supplementals

(*Dollars in Thousands*)

		FY 2013		FY 2014		FY 2015		FY 2016		FY 2017		FY 2018	
Program	**Section**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**
Community Health Center Fund:													
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(1)	1,500,000	60	2,144,716	95	3,509,111	122	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	3,600,000	240	3.510.661	225	3,800,000	174
Health Centers - Facilities Construction	H.R. 3590, Section 10503(c)	-	-	-	-	-	-	-	-	-	-	-	-
School-Based Health Centers-Facilities	H.R. 3590, Section 4101	47,500	8	-	9	-	7	-	7	-	9	-	9
National Health Service Corps:													
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(2)	300,000	229	283,040	219	287,370	214	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	-	-	-	-	310,000	226	288,610	225	310,000	206
GME Payments Teaching Health Centers:	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	126,500	10
Family to Family Health Information Centers:													
Non-P.L. 111-148 Mandatory	H.R. 3590, Section 5507	5,000	-	5,000	1	5,000	1	5,000	1	4,655	1	6,000	1
Home Visiting Program:													
P.L. 111-148 Mandatory	H.R. 3590, Section 2951	379,600	22	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		-	-	371,200	22	400,000	25	400,000	37	372,400	44	400,000	42
Total		**2,232,100**	**325**	**2,803,956**	**351**	**4,201,481**	**373**	**4,375,000**	**519**	**4,232,186**	**512**	**4,642,500**	**442**

		FY 2019		FY 2020		FY 2021		FY 2022		FY 2023		FY 2024	
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		4,000,000	177	4,000,000	203	4,000,000	285	3,905,348	270	3,905,348	284	5,345,753	285
Health Centers - Facilities Construction	H.R. 3590, Section 10503(c)	-	-	-	-	-	-	-	-	-	-	-	-
School-Based Health Centers-Facilities	H.R. 3590, Section 4101	-	8	-	4	-	-	-	-	-	-	-	-
National Health Service Corps:													
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(2)	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		310,000	209	310,000	205	310,000	222	292,330	216	292,330	236	432,904	213
GME Payments Teaching Health Centers:	H.R. 3590, Section 5508												
P.L. 111-148 Mandatory		-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		126,500	7	126,500	8	126,500	8	119,290	11	119,290	10	219,589	11
Family to Family Health Information Centers:													
Non-P.L. 111-148 Mandatory	H.R. 3590, Section 5507	6,000	1	6,000	1	5,658	1	5,658	1	5,658	1	5,658	-
Home Visiting Program:													
P.L. 111-148 Mandatory	H.R. 3590, Section 2951	-	-	-	-	-	-	-	-	-	-	-	-
Non-P.L. 111-148 Mandatory		400,000	39	376,40000	38	377,200	41	377,200	50	500,000	55	518,650	47
Total		**4,818,900**	**441**	**4,819,358**	**441**	**4,819,358**	**557**	**4,699,826**	**557**	**4,822,626**	**586**	**6,522,554**	**556**

Program	Section	FY 2025 Total Funding	FY 2025 FTE	FY 2026 Total Funding	FY 2026 FTE
Community Health Center Fund:					
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(1)	-	-		
Non-P.L. 111-148 Mandatory		5,345,753	280	4,260,000	247
Health Centers - Facilities Construction	H.R. 3590, Section 10503(c)	-	-		
School-Based Health Centers-Facilities	H.R. 3590, Section 4101	-	-		
National Health Service Corps:					
P.L. 111-148 Mandatory	H.R. 3590, Section 10503(b)(2)	-	-		
Non-P.L. 111-148 Mandatory		258,041	205	345,000	168
GME Payments Teaching Health Centers:	H.R. 3590, Section 5508				
P.L. 111-148 Mandatory		-	-		
Non-P.L. 111-148 Mandatory		130,890	10	175,000	10
Family to Family Health Information Centers:					
Non-P.L. 111-148 Mandatory	H.R. 3590, Section 5507	6,000	1	6,000	1
Home Visiting Program:					
P.L. 111-148 Mandatory	H.R. 3590, Section 2951	-	-		
Non-P.L. 111-148 Mandatory		565,800	46	612,950	46
Total		**4,146,978**	**542**	**5,398,950**	**472**

State Tables
ADMINISTRATION FOR A HEALTHY AMERICA

Rape Prevention and Education Funding to State Health Departments
Discretionary State/Formula Grants

STATE/TERRITORY	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Alabama	$658,979	*	*
Alaska	$224,295	*	*
Arizona	$874,476	*	*
Arkansas	$455,079	*	*
California	$4,155,379	*	*
Colorado	$734,900	*	*
Connecticut	$515,296	*	*
Delaware	$250,286	*	*
District of Columbia	$219,854	*	*
Florida	$2,331,904	*	*
Georgia	$1,235,159	*	*
Hawaii	$297,425	*	*
Idaho	$336,309	*	*
Illinois	$1,447,958	*	*
Indiana	$837,301	*	*
Iowa	$473,197	*	*
Kansas	$447,619	*	*
Kentucky	$606,459	*	*
Louisiana	$621,849	*	*
Maine	$288,012	*	*
Maryland	$775,777	*	*
Massachusetts	$862,158	*	*
Michigan	$1,170,874	*	*
Minnesota	$728,090	*	*
Mississippi	$444,986	*	*
Missouri	$773,517	*	*

STATE/TERRITORY	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Montana	$259,836	*	*
Nebraska	$348,708	*	*
Nevada	$464,000	*	*
New Hampshire	$289,549	*	*
New Jersey	$1,091,012	*	*
New Mexico	$364,513	*	*
New York	$2,196,467	*	*
North Carolina	$1,207,551	*	*
North Dakota	$228,925	*	*
Ohio	$1,345,331	*	*
Oklahoma	$551,098	*	*
Oregon	$579,251	*	*
Pennsylvania	$1,456,073	*	*
Rhode Island	$261,169	*	*
South Carolina	$668,517	*	*
South Dakota	$239,823	*	*
Tennessee	$850,096	*	*
Texas	$3,102,555	*	*
Utah	$481,428	*	*
Vermont	$215,146	*	*
Virginia	$1,024,000	*	*
Washington	$930,576	*	*
West Virginia	$331,711	*	*
Wisconsin	$747,057	*	*
Wyoming	$208,437	*	*
Subtotal	**$41,209,967**	*	*
Indian Tribes	$0	*	*
American Samoa	$0	*	*
Guam	$0	*	*
Marshall Islands	$0	*	*
Micronesia	$0	*	*
Northern Mariana Islands	$0	*	*

STATE/TERRITORY	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Palau	$0	*	*
Puerto Rico	$482,872	*	*
Virgin Islands	$40,000	*	*
Subtotal	**$522,872**	*	*
TOTAL RESOURCES	**$41,732,839**	*	*

* Grant award estimates under development.

National Violent Death Reporting System
Discretionary State/Formula Grants

STATE/TERRITORY	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Alabama	$330,224	*	*
Alaska	$204,513	*	*
Arizona	$370,210	*	*
Arkansas	$273,123	*	*
California	$962,085	*	*
Colorado	$333,405	*	*
Connecticut	$234,676	*	*
Delaware	$183,314	*	*
District of Columbia	$184,398	*	*
Florida	$709,468	*	*
Georgia	$432,712	*	*
Hawaii	$195,908	*	*
Idaho	$212,021	*	*
Illinois	$469,526	*	*
Indiana	$352,671	*	*
Iowa	$240,432	*	*
Kansas	$254,240	*	*
Kentucky	$288,180	*	*
Louisiana	$330,086	*	*
Maine	$195,056	*	*
Maryland	$459,044	*	*

STATE/TERRITORY	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Massachusetts	$266,816	*	*
Michigan	$434,523	*	*
Minnesota	$279,049	*	*
Mississippi	$265,229	*	*
Missouri	$369,064	*	*
Montana	$203,175	*	*
Nebraska	$202,245	*	*
Nevada	$277,984	*	*
New Hampshire	$196,896	*	*
New Jersey	$288,454	*	*
New Mexico	$255,091	*	*
New York	$469,614	*	*
North Carolina	$423,840	*	*
North Dakota	$182,151	*	*
Ohio	$450,824	*	*
Oklahoma	$312,737	*	*
Oregon	$280,256	*	*
Pennsylvania	$477,710	*	*
Rhode Island	$180,387	*	*
South Carolina	$319,523	*	*
South Dakota	$192,173	*	*
Tennessee	$363,381	*	*
Texas	$780,580	*	*
Utah	$265,822	*	*
Vermont	$178,505	*	*
Virginia	$354,585	*	*
Washington	$331,969	*	*
West Virginia	$238,720	*	*
Wisconsin	$311,848	*	*
		*	*
Wyoming	$181,687	*	*
Subtotal	**$16,550,130**	*	*
Indian Tribes	$0	*	*

STATE/TERRITORY	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
American Samoa	$0	*	*
Guam	$0	*	*
Marshall Islands	$0	*	*
Micronesia	$0	*	*
Northern Mariana Islands	$0	*	*
Palau	$0	*	*
Puerto Rico	$282,935	*	*
Virgin Islands	$0	*	*
Subtotal	**$282,935**	*	*
TOTAL RESOURCES	**$16,833,065**	*	*

* Grant award estimates under development.

Overdose Data to Action
Discretionary State/Formula Grants

STATE/TERRITORY	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Alabama**	$5,176,572	*	*
Alaska	$2,692,878	*	*
Arizona**	$10,140,261	*	*
Arkansas	$2,155,910	*	*
California**	$18,203,718	*	*
Colorado**	$6,115,253	*	*
Connecticut**	$7,647,235	*	*
Delaware	$3,327,587	*	*
District of Columbia	$3,945,761	*	*
Florida**	$15,191,039	*	*
Georgia	$4,245,286	*	*
Hawaii	$2,748,281	*	*
Idaho	$2,041,935	*	*
Illinois**	$8,003,582	*	*
Indiana**	$7,879,814	*	*
Iowa	$2,507,303	*	*
Kansas	$2,685,279	*	*

STATE/TERRITORY	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Kentucky	$5,407,419	*	*
Louisiana	$4,688,805	*	*
Maine	$2,920,497	*	*
Maryland**	$7,078,982	*	*
Massachusetts**	$5,565,517	*	*
Michigan	$4,261,805	*	*
Minnesota	$4,199,924	*	*
Mississippi	$2,540,192	*	*
Missouri**	$7,076,686	*	*
Montana	$2,169,512	*	*
Nebraska**	$3,371,533	*	*
Nevada**	$5,059,687	*	*
New Hampshire	$2,697,194	*	*
New Jersey	$4,653,462	*	*
New Mexico	$4,322,929	*	*
New York**	$9,309,205	*	*
North Carolina	$4,950,273	*	*
North Dakota	$0	*	*
Ohio**	$14,925,337	*	*
Oklahoma	$2,453,381	*	*
Oregon	$3,854,849	*	*
Pennsylvania**	$12,940,739	*	*
Rhode Island	$3,453,142	*	*
South Carolina	$4,587,985	*	*
South Dakota	$1,865,943	*	*
Tennessee**	$6,664,201	*	*
Texas**	$8,403,697	*	*
Utah**	$3,600,977	*	*
Vermont	$3,272,032	*	*
Virginia	$4,066,658	*	*
Washington**	$8,158,431	*	*
West Virginia	$5,339,590	*	*
Wisconsin	$4,483,777	*	*

STATE/TERRITORY	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Wyoming	$1,952,533	*	*
Subtotal	**$278,644,388**	*	*
Indian Tribes	$0	*	*
American Samoa	$0	*	*
Guam	$0	*	*
Marshall Islands	$0	*	*
Micronesia	$0	*	*
Northern Mariana Islands	$0	*	*
Palau	$0	*	*
Puerto Rico	$1,005,610	*	*
Virgin Islands	$0	*	*
Subtotal	**$1,005,610**	*	*
TOTAL RESOURCES	**$279,649,998**	*	*

* Grant award estimates under development.

**Indicates state receives 'Overdose Data to Action in States' funding and 'Overdose Data to Action: LOCAL' funding in one or more localities.

Projects for Assistance in Transition from Homelessness

MANDATORY STATE/FORMULA GRANTS

CFDA NUMBER/PROGRAM NAME: 93.150/PATH

State or Territory	FY 2024 Final	FY 2025 Enacted*	FY 2026 President's Budget
Alabama	$629,485	*	$659,095
Alaska	$300,000	*	$300,000
Arizona	$1,385,438	*	$1,450,758
Arkansas	$312,085	*	$379,587
California	$9,049,232	*	$8,465,558
Colorado	$1,046,424	*	$1,128,514
Connecticut	$820,789	*	$706,643
Delaware	$300,000	*	$300,000
District of Columbia	$300,000	*	$300,000
Florida	$4,450,466	*	$4,479,310

State or Territory	FY 2024 Final	FY 2025 Enacted*	FY 2026 President's Budget
Georgia	$1,714,755	*	$1,802,644
Hawaii	$300,000	*	$300,000
Idaho	$300,000	*	$300,000
Illinois	$2,777,673	*	$2,530,520
Indiana	$1,038,604	*	$1,097,331
Iowa	$343,522	*	$457,780
Kansas	$387,502	*	$482,598
Kentucky	$481,466	*	$600,925
Louisiana	$752,686	*	$757,102
Maine	$300,000	*	$300,000
Maryland	$1,305,602	*	$1,201,635
Massachusetts	$1,600,631	*	$1,457,953
Michigan	$1,775,906	*	$1,682,287
Minnesota	$832,715	*	$931,940
Mississippi	$300,000	*	$311,451
Missouri	$917,726	*	$971,454
Montana	$300,000	*	$300,000
Nebraska	$300,000	*	$325,359
Nevada	$632,440	*	$663,713
New Hampshire	$300,000	*	$300,000
New Jersey	$2,195,438	*	$1,978,681
New Mexico	$300,000	*	$358,655
New York	$4,336,282	*	$4,013,620
North Carolina	$1,416,574	*	$1,582,423
North Dakota	$300,000	*	$300,000
Ohio	$2,039,720	*	$2,045,098
Oklahoma	$464,965	*	$581,330
Oregon	$647,917	*	$774,994
Pennsylvania	$2,430,315	*	$2,258,664
Rhode Island	$300,000	*	$300,000
South Carolina	$698,446	*	$790,190
South Dakota	$300,000	*	$300,000
Tennessee	$934,145	*	$1,039,983
Texas	$5,129,414	*	$5,543,969
Utah	$607,323	*	$667,371

State or Territory	FY 2024 Final	FY 2025 Enacted*	FY 2026 President's Budget
Vermont	$300,000	*	$300,000
Virginia	$1,511,659	*	$1,483,268
Washington	$1,364,781	*	$1,459,575
West Virginia	$300,000	*	$300,000
Wisconsin	$859,068	*	$898,300
Wyoming	$300,000	*	$300,000
American Samoa	$50,000	*	$50,000
Guam	$50,000	*	$50,000
Northern Mariana Islands	$50,000	*	$50,000
Puerto Rico	$914,996	*	$685,912
Virgin Islands	$50,000	*	$50,000
Total Allotments	**$63,106,190**	*	**$63,106,190**
Total Administrative Costs	**$3,528,810**	*	**$3,528,810**
Total Appropriations Amount	**$66,635,000**	*	**$66,635,000**

* Grant award estimates are under development.

Protection and Advocacy for Individuals with Mental Illness (PAIMI)
FY 2026 MANDATORY STATE/FORMULA GRANTS

CFDA NUMBER: 93.138/PROGRAM NAME: PAIMI

State or Territory	FY 2024 Final	FY 2025 Enacted*	FY 2026 President's Budget
Alabama	$510,798	*	$183,336
Alaska	$473,700	*	$167,500
Arizona	$695,410	*	$247,019
Arkansas	$473,700	*	$167,500
California	$3,205,722	*	$1,140,617
Colorado	$492,538	*	$173,209
Connecticut	$473,700	*	$167,500
Delaware	$473,700	*	$167,500
District of Columbia	$473,700	*	$167,500
Florida	$1,962,308	*	$716,656
Georgia	$1,029,222	*	$375,056
Hawaii	$473,700	*	$167,500
Idaho	$473,700	*	$167,500
Illinois	$1,099,584	*	$388,118
Indiana	$644,339	*	$230,610
Iowa	$473,700	*	$167,500
Kansas	$473,700	*	$167,500
Kentucky	$473,700	*	$167,500
Louisiana	$473,700	*	$167,500
Maine	$473,700	*	$167,500
Maryland	$525,556	*	$187,287
Massachusetts	$549,237	*	$195,377
Michigan	$951,561	*	$337,596
Minnesota	$498,712	*	$177,086
Mississippi	$473,700	*	$167,500
Missouri	$590,413	*	$205,857
Montana	$473,700	*	$167,500
Nebraska	$473,700	*	$167,500
Nevada	$473,700	*	$167,500
New Hampshire	$473,700	*	$167,500

State or Territory	FY 2024 Final	FY 2025 Enacted*	FY 2026 President's Budget
New Jersey	$755,359	*	$270,695
New Mexico	$473,700	*	$167,500
New York	$1,618,491	*	$569,535
North Carolina	$1,001,911	*	$362,298
North Dakota	$473,700	*	$167,500
Ohio	$1,111,335	*	$395,226
Oklahoma	$473,700	*	$167,500
Oregon	$473,700	*	$167,500
Pennsylvania	$1,149,796	*	$410,112
Rhode Island	$473,700	*	$167,500
South Carolina	$511,115	*	$187,032
South Dakota	$473,700	*	$167,500
Tennessee	$659,977	*	$237,505
Texas	$2,713,408	*	$984,513
Utah	$473,700	*	$167,500
Vermont	$473,700	*	$167,500
Virginia	$755,026	*	$266,736
Washington	$643,098	*	$229,120
West Virginia	$473,700	*	$167,500
Wisconsin	$542,894	*	$192,668
Wyoming	$473,700	*	$167,500
American Indian Consortium	$253,800	*	$0
American Samoa	$253,800	*	$89,700
Guam	$253,800	*	$89,700
Northern Mariana Islands	$253,800	*	$89,700
Puerto Rico	$578,703	*	$196,653
Virgin Islands	$253,800	*	$89,700
Total Allotments	$38,855,413	*	$13,741,217
Total Administrative Costs	$1,144,587	*	$404,783
Total Appropriations Amount	$40,000,000	*	$14,146,000

* Grant award estimates are under development.

Maternal and Child Health Block Grant
FY 2026 Discretionary State/Formula Grants

CFDA NUMBER/PROGRAM NAME: 93.994

STATE/TERRITORY	FY 2024 Final[167]	FY 2025 Enacted*	FY 2026 President's Budget[168]
Alabama	12,021,137	*	12,145,812
Alaska	1,154,022	*	1,155,186
Arizona	7,883,506	*	7,470,153
Arkansas	7,394,830	*	7,386,780
California	41,139,508	*	40,475,059
Colorado	7,627,571	*	7,625,428
Connecticut	4,982,344	*	4,970,173
Delaware	2,123,731	*	2,099,396
District of Columbia	7,009,331	*	6,982,494
Florida	21,475,758	*	21,337,584
Georgia	18,117,111	*	18,047,302
Hawaii	2,278,565	*	2,292,263
Idaho	3,390,854	*	3,400,981
Illinois	22,018,052	*	21,985,565
Indiana	12,714,489	*	12,779,225
Iowa	6,775,530	*	6,812,479
Kansas	4,979,554	*	4,955,362
Kentucky	11,744,786	*	11,796,842
Louisiana	13,291,582	*	13,266,165
Maine	3,378,997	*	3,363,403
Maryland	12,377,354	*	12,432,937
Massachusetts	11,455,403	*	11,563,154
Michigan	19,631,928	*	19,719,098

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

[168] The poverty-based allocation for FY 26 uses 3-year poverty data from the American Community Survey, 2021, 2022, and 2023

STATE/TERRITORY	FY 2024 Final[167]	FY 2025 Enacted*	FY 2026 President's Budget[168]
Minnesota	9,456,167	*	9,450,128
Mississippi	9,765,660	*	9,658,348
Missouri	12,742,189	*	12,653,479
Montana	2,370,243	*	2,352,037
Nebraska	4,107,911	*	4,169,196
Nevada	2,470,662	*	2,479,249
New Hampshire	2,013,385	*	1,996,683
New Jersey	12,310,688	*	12,525,052
New Mexico	4,389,490	*	4,370,812
New York	39,813,564	*	40,293,286
North Carolina	18,401,714	*	18,254,020
North Dakota	1,790,674	*	1,814,724
Ohio	23,362,319	*	23,394,126
Oklahoma	7,749,201	*	7,850,690
Oregon	6,323,054	*	6,314,600
Pennsylvania	25,014,563	*	25,006,034
Rhode Island	1,697,848	*	1,661,424
South Carolina	12,067,113	*	12,072,330
South Dakota	2,273,172	*	2,287,553
Tennessee	12,546,108	*	12,524,147
Texas	38,864,189	*	39,150,619
Utah	6,242,404	*	6,241,345
Vermont	1,661,063	*	1,661,447
Virginia	13,041,322	*	13,078,077
Washington	9,189,709	*	9,244,314
West Virginia	6,298,984	*	6,346,219
Wisconsin	11,213,179	*	11,202,623
Wyoming	1,257,966	*	1,285,081
Subtotal	**553,400,484**	*	**553,400,484**
American Samoa	516,923	*	516,923
Guam	798,359	*	798,359
Marshall Islands	241,229	*	241,229

STATE/TERRITORY	FY 2024 Final[167]	FY 2025 Enacted*	FY 2026 President's Budget[168]
Micronesia	545,642	*	545,642
Northern Mariana Islands	488,206	*	488,206
Palau	155,078	*	155,078
Puerto Rico	16,644,919	*	16,644,919
Virgin Islands	1,568,000	*	1,568,000
Subtotal	**20,958,356**	*	**20,958,356**
TOTAL RESOURCES	**574,358,840**	*	**574,358,840**

*Grant award estimates are under development

Disability and Health Grants[169,170,171,172]
Discretionary State/Formula Grants

STATE/TERRITORY	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Alabama	-	*	*
Alaska	-	*	*
Arizona	-	*	*
Arkansas	-	*	*
California	-	*	*
Colorado	-	*	*
Connecticut	-	*	*
Delaware	-	*	*
Florida	-	*	*
Georgia	$584,494	*	*
Hawaii	-	*	*
Idaho	-	*	*
Illinois	-	*	*
Indiana	-	*	*
Iowa	-	*	*
Kansas	-	*	*
Kentucky	-	*	*

[8]This State Table is a snapshot of selected programs that fund states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/.

[9] http://www.cdc.gov/ncbddd/disabilityandhealth/programs.html

[10] CFDA number 93.184

11 The difference in funding amounts across states is the result of some states requesting lower than the full award amount available.

Louisiana	-	*	*
Maine	-	*	*
Maryland	-	*	*
Massachusetts	$585,000	*	*
Michigan	$585,000	*	*
Minnesota	-	*	*
Mississippi	-	*	*
Missouri	$585,000	*	*
Montana	$572,500	*	*
Nebraska	-	*	*
Nevada	-	*	*
New Hampshire	$572,500	*	*
New Jersey	-	*	*
New Mexico	-	*	*
New York	$585,000	*	*
North Carolina	-	*	*
North Dakota	-	*	*
Ohio	$572,500	*	*
Oklahoma	-	*	*
Oregon	$585,000	*	*
Pennsylvania	-	*	*
Rhode Island	-	*	*
South Carolina	-	*	*
South Dakota	-	*	*
Tennessee	-	*	*
Texas	-	*	*
Utah	$585,000	*	*
Vermont	-	*	*
Virginia	-	*	*
Washington	-	*	*
West Virginia	-	*	*
Wisconsin	-	*	*
Wyoming	-	*	*
Territories	-	*	*
America Samoa	-	*	*
Guam	-	*	*
Marshall Islands	-	*	*
Micronesia	-	*	*
Northern Marianas	-	*	*
Puerto Rico	-	*	*
Palau	-	*	*
Virgin Islands	-	*	*
Subtotal, States	$5,811,994	*	*
Subtotal, Territories	$0	*	*
Total Resources	$5,811,994	*	*

Health and Development for People with Disabilities: Early Hearing Detection and Intervention[173, 174, 175]

	FY 2024 Actual	FY 2025 Enacted	FY 2026 Target Level
Alabama	$160,000	*	*
Alaska	$169,000	*	*
Arizona	-	*	*
Arkansas	$160,000	*	*
California	-	*	*
Colorado	-	*	*
Connecticut	-	*	*
Delaware	-	*	*
Florida	$160,000	*	*
Georgia	$160,000	*	*
Hawaii	$169,000	*	*
Idaho	$169,000	*	*
Illinois	$169,000	*	*
Indiana	$169,000	*	*
Iowa	$169,000	*	*
Kansas	$158,151	*	*
Kentucky	$0	*	*
Louisiana	$169,000	*	*
Maine	$169,000	*	*
Maryland	$169,000	*	*
Massachusetts	$160,000	*	*
Michigan	$169,000	*	*
Minnesota	$169,000	*	*
Mississippi	-	*	*
Missouri	$169,000	*	*
Montana	-	*	*
Nebraska	$169,000	*	*
Nevada	$169,000	*	*
New Hampshire	$160,000	*	*
New Jersey	$169,000	*	*
New Mexico	$169,000	*	*
New York	$30,380	*	*

[173] This State Table is a snapshot of selected programs that fund states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit.https://www.cdc.gov/funding/funding-profiles/

[174] CFDA number 93.314

[175] Any difference in funding amounts across states is the result of some states requesting lower than the full increase amount available.

North Carolina	$0	*	*
North Dakota	$169,000	*	*
Ohio	-	*	*
Oklahoma	$160,000	*	*
Oregon	$169,000	*	*
Pennsylvania	-	*	*
Rhode Island	$169,000	*	*
South Carolina	$0	*	*
South Dakota	-	*	*
Tennessee	$169,000	*	*
Texas	$169,000	*	*
Utah	$169,000	*	*
Vermont	$169,000	*	*
Virginia	$169,000	*	*
Washington	$169,000	*	*
Washington, D.C.	-	*	*
West Virginia	-	*	*
Wisconsin	-	*	*
Wyoming	$169,000	*	*
Territories		*	*
America Samoa	-	*	*
Guam	-	*	*
Marshall Islands	-	*	*
Micronesia	-	*	*
Northern Marianas	-	*	*
Puerto Rico	$168,165	*	*
Palau	-	*	*
Virgin Islands	-	*	*
Subtotal, States	**$5,702,531**	*	*
Subtotal, Territories	**$168,165**	*	*
Total Resources	**$5,870,696**	*	*

RWHAP Part B - FY 2024 State Grants[176]

Discretionary State/Formula Grants

RWHAP Part B Grantee	FY 2024 Final Base Award	FY 2024 Final ADAP Award	FY 2024 Final ADAP Suppl. Award	FY 2024 Final EC Award	FY 2024 Final MAI Award	Total FY24 Part B Award
Alabama	$8,912,064	$10,490,415	$0	$318,823	$0	$19,832,015

[176] Awards include prior year unobligated balances. Does not include Emergency Relief funding or Supplemental funding.

RWHAP Part B Grantee	FY 2024 Final Base Award	FY 2024 Final ADAP Award	FY 2024 Final ADAP Suppl. Award	FY 2024 Final EC Award	FY 2024 Final MAI Award	Total FY24 Part B Award
Alaska	$500,000	$560,344	$0	$0	$0	$1,055,445
Arizona	$4,771,242	$12,294,781	$0	$0	$0	$17,040,320
Arkansas	$3,776,396	$4,553,332	$0	$0	$0	$8,352,918
California	$36,566,268	$101,654,726	$0	$195,203	$0	$139,873,050
Colorado	$3,669,166	$9,273,484	$0	$0	$0	$13,113,431
Connecticut	$2,643,635	$7,563,222	$0	$0	$0	$10,434,756
Delaware	$2,024,065	$2,382,533	$0	$175,727	$0	$4,641,631
District of Columbia	$3,419,187	$10,565,270	$0	$0	$0	$14,441,772
Florida	$32,595,433	$84,895,726	$0	$466,352	$0	$119,527,043
Georgia	$16,814,905	$40,208,624	$9,015,850	$181,904	$9,015,850	$65,527,249
Hawaii	$1,541,972	$1,815,059	$0	$0	$0	$3,427,379
Idaho	$638,955	$752,116	$0	$0	$0	$1,353,479
Illinois	$9,934,900	$27,829,008	$6,404,994	$0	$4,000,000	$44,645,446
Indiana	$4,104,833	$8,757,340	$1,990,969	$0	$2,598,466	$14,724,644
Iowa	$1,655,227	$1,948,373	$0	$0	$0	$3,559,098
Kansas	$1,260,234	$2,583,572	$0	$0	$0	$3,873,740
Kentucky	$4,804,581	$5,655,485	$0	$302,907	$0	$10,731,656
Louisiana	$7,119,959	$16,596,457	$0	$0	$0	$24,064,083
Maine	$791,578	$931,768	$0	$0	$0	$1,764,764
Maryland	$7,971,582	$23,538,025	$0	$0	$0	$32,399,260
Massachusetts	$5,342,449	$14,644,520	$0	$0	$0	$20,480,380
Michigan	$5,530,661	$13,078,978	$0	$0	$0	$18,706,186
Minnesota	$2,316,887	$6,371,956	$0	$0	$0	$8,657,751
Mississippi	$6,272,977	$7,626,671	$0	$264,971	$0	$14,215,178
Missouri	$3,839,472	$9,941,477	$0	$0	$0	$13,719,688
Montana	$500,000	$365,008	$0	$0	$0	$871,504
Nebraska	$1,392,983	$1,639,684	$0	$0	$486,525	$3,001,308
Nevada	$2,611,434	$7,285,902	$0	$0	$0	$9,682,886
New Hampshire	$500,000	$906,817	$0	$0	$0	$1,414,638
New Jersey	$10,170,444	$27,165,292	$3,857,327	$0	$0	$41,815,727
New Mexico	$2,109,461	$2,483,052	$0	$0	$0	$4,710,966
New York	$32,319,156	$89,451,914	$0	$534,375	$0	$125,885,235
North Carolina	$12,650,692	$23,329,856	$0	$312,282	$0	$36,463,395
North Dakota	$500,000	$338,630	$0	$0	$0	$832,398
Ohio	$7,921,086	$17,057,707	$0	$357,122	$0	$25,390,029
Oklahoma	$4,197,119	$4,940,440	$0	$252,180	$0	$9,230,074
Oregon	$1,923,686	$4,732,984	$0	$0	$0	$6,655,582
Pennsylvania	$10,974,111	$25,432,217	$0	$268,823	$0	$37,594,154
Puerto Rico	$5,465,439	$12,862,254	$3,036,777	$0	$3,036,777	$22,144,286
Rhode Island	$1,551,662	$1,826,466	$0	$181,686	$0	$3,621,361
South Carolina	$10,933,327	$13,120,326	$0	$551,672	$0	$24,942,307
South Dakota	$500,000	$496,183	$0	$0	$0	$978,682
Tennessee	$5,694,032	$13,866,026	$0	$0	$0	$19,632,229
Texas	$27,999,681	$72,110,465	$16,393,832	$0	$21,396,514	$116,599,331

RWHAP Part B Grantee	FY 2024 Final Base Award	FY 2024 Final ADAP Award	FY 2024 Final ADAP Suppl. Award	FY 2024 Final EC Award	FY 2024 Final MAI Award	Total FY24 Part B Award
Utah	$2,022,854	$2,381,107	$540,901	$0	$706,518	$4,903,752
Vermont	$500,000	$362,869	$0	$0	$0	$870,055
Virginia	$7,682,224	$17,911,769	$0	$373,473	$0	$26,181,764
Washington	$4,032,786	$9,918,664	$0	$0	$0	$14,010,675
West Virginia	$1,247,338	$1,571,958	$0	$0	$0	$2,703,195
Wisconsin	$3,960,282	$4,685,933	$0	$262,500	$0	$8,916,954
Wyoming	$500,000	$251,656	$0	$0	$0	$748,393
Guam	$200,000	$81,984	$0	$0	$0	$281,832
Virgin Islands	$500,000	$464,102	$0	$0	$0	$953,782
American Samoa	$1	$0	$0	$0	$0	$50,000
Marshall Islands	$32,300	$1	$0	$0	$0	$50,724
Mariana Island	$45,967	$9,981	$0	$0	$0	$60,863
Republic of Palau	$1	$0	$0	$0	$0	$56,518
F. States Micronesia	$50,000	$713	$0	$0	$0	$50,000
TOTALS	$339,506,694	$783,565,222	$41,240,650	$5,000,000	$41,240,650	$1,181,466,961

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

TAB

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

(Dollars in Thousands)

	FY 2024 Actuals	FY 2025 (revised estimates)	FY 2026 Request
Retirement Payments	679,096	721,635	773,413
Survivor's Benefits	43,635	45,990	50,222
Medical Care Benefits	150,953	100,190	100,398
Subtotal	873,684	867,814	924,033
Accrued Health Care Benefits*	36,366	39,836	41,924
Total	910,050	907,651	965,956

*The funding levels for the accrued health care benefits are estimates and subject to change.

FY 2026 Authorization.....Indefinite.

Rationale for Budget

This appropriation provides for retirement payments to Public Health Service (PHS) Commissioned Corps officers to include active-duty regular officers who are retired for age, disability, or a specific length of service as well as payments to survivors of deceased retired officers who had elected to receive reduced retirement payments.

This appropriation also funds the provision of medical care to PHS officers and retired members of the Corps under the age of 65, dependents of active duty and retired members, and dependents of deceased members. This account includes payments to the DoD Medicare-Eligible Retiree Healthcare Fund for the accrued costs of health care for beneficiaries over the age of 65.

The Accrued Health Care Benefits amount is an estimate provided by DoD Office of the Actuary. The PHS FY 2025 per capita is $6,951 (full-time members) and $2,523 (part-time members). The PHS FY 2026 per capita is $7,961 (full-time members) and $2,877 (part-time members) as of September 17, 2024. The total budget is estimated by multiplying the per capita amount with the average number of active-duty positions.

The FY 2026 estimate reflects increased costs in medical benefits, an annualization of amounts paid to retirees and survivors in FY 2025 and a net increase in the number of retirees and survivors.

(Dollars in thousands)	**FY 2027**	**FY 2028**	**FY 2029**	**FY 2030**	**FY 2031**
Retirement Payments	828,907	888,383	952,126	1,020,443	1,093,662
Survivor's Benefits	54,842	59,887	65,397	71,413	77,983
Medical Care Benefits	100,606	100,816	101,025	101,235	101,445
Subtotal	984,355	1,049,086	1,118,548	1,193,091	1,273,090
Accrued Health Care Benefits	44,263	46,732	49,339	52,091	54,997
Total	1,028,618	1,095,817	1,167,886	1,245,182	1,328,087