

April 2024



FY25 Governmental Public Health Appropriations Book

Dear Members of Congress:

The Association of State and Territorial Health Officials (ASTHO) is the national professional society representing state, territorial, and freely associated states' public health agencies. ASTHO's members—the chief public health officials of these jurisdictions—are dedicated to formulating, influencing, and implementing sound, evidence-based public health policy and assuring excellence in state-based public health practice. This vital work is supported by a network of 19 affiliate organizations with the mission to promote and protect the public's health and prevent illness and injury. Public health depends on federal investment. It is critical that Congress provide increased, long-term, sustained, and flexible discretionary funding to support the public health workforce, modernize our data systems, and strengthen laboratory capacity, among many other priorities. Federal resources continue to account for nearly half of all state and territorial health department funding. ASTHO and its state affiliate organizations strongly urge Congress to prioritize funding for all public health programs in FY25 so that this important work can continue.

This book compiles top federal funding priorities and recommendations for public health associations in FY25, aiming to ensure that Congress appropriates the necessary resources for federal health promotion and protection agencies. It includes appropriations recommendations from the following organizations:

- Association of State and Territorial Health Officials
- Association of State and Territorial Dental Directors
- Association of Immunization Managers
- Association of Public Health Laboratories Association of Public Health Nurses
- Association of Maternal & Child Health Programs
- Council of State and Territorial Epidemiologists
- National Association of Chronic Disease Directors
- National Association for Public Health Statistics and Information Systems
- National Alliance of State and Territorial AIDS Directors
- National Coalition of STD Directors
- Safe States Alliance

We are ready to work with Congress to address the many public health challenges and opportunities impacting our nation's health.

If you have any questions or requests, please do not hesitate to contact ASTHO's Senior Director of Government Affairs, Jeffrey Ekoma (jekoma@astho.org).

Sincerely,



Carolyn Mullen
Senior Vice President, Government Affairs and Public Relations
ASTHO

Contents

ASPR Appropriations

ASTHO – Hospital Preparedness Program	1
---	---

CDC Appropriations

ASTHO – CDC-Wide Activities and Program Support.....	3
ASTHO – Office of Readiness and Response.....	5
ASTHO – Cross-Cutting Activities and Program Support.....	7
ASTHO – Chronic Disease Prevention and Health Promotion	9
Public Health Data Modernization	11
Epidemiology and Laboratory Capacity	13
Core State Injury Prevention Program.....	15
Firearm Injury and Mortality Prevention Research Program.....	17
Division of HIV Prevention.....	19
National Center for Health Statistics	21
National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity	23
National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health	25
National Center for HIV, Viral Hepatitis, STD and TB Prevention’s Division of STD Prevention	27
Section 317 Immunization Funding	29
Chronic Disease Prevention and Health Promotion, Safe Motherhood	31
National Center on Birth Defects and Developmental Disabilities, Surveillance for Emerging Threats to Mothers and Babies Network	33
Viral Hepatitis Programs	35

HRSA Appropriations

Bureau of Primary Health Care.....	37
Maternal and Child Health Bureau, Title V MCH Block Grant	39
Ryan White Part B.....	41



Organization name: Association of State and Territorial Health Officials

Topic area: Healthcare Readiness

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Administration for Strategic Preparedness and Response

Program, office, or center: Hospital Preparedness Program

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Hospital Preparedness Program Cooperative Agreement	\$240,000,000	\$240,000,000	\$240,000,000	\$500,000,000

Funding recommendation: Appropriate \$500 million, for the Administration for Strategic Preparedness and Response (ASPR)'s Hospital Preparedness Program (HPP), a \$260 million increase over the FY24 enacted level. At its height in FY03, funding for HPP was \$515 million. After adjusting for inflation, program funds were halved over the past decade.

Bill or report language: This funding is critical and provides grants to states to build healthcare coalitions that enhance regional and local hospital preparedness and improve overall surge capacity in public health emergencies. HPP must continue to fund existing awardees—all states, territories, freely associated states, and four directly funded large cities—as this program is essential to the foundational capabilities of healthcare preparedness.

Justification: As the only source of federal funding for healthcare system preparedness and response, HPP promotes a consistent national focus to improve patient outcomes during emergencies and disasters and enables rapid recovery. HPP supports healthcare coalitions (HCC), networks of individual public and private organizations that are sometimes competitive entities that work together to respond to emergencies and disasters, ultimately increasing local and regional resilience. Despite modest annual appropriations increases, HPP remains stretched due to prolonged emergency responses and increased preparedness and response requirements, and annual discretionary funding has not kept pace with inflation.

Fast Facts:

- HPP prepares the nation's healthcare system to save lives during emergencies and disasters.
- ASPR data show that approximately 96% of participating hospitals feel that HPP support has improved their ability to decrease morbidity and mortality during disasters.

Role of the state health agency: State, territorial, and freely associated states' health agencies are critical to our nation's ability to prepare for, respond to, and recover from public health emergencies and threats. HPP provides leadership and funding through cooperative agreements to states, territories, freely associated states, and localities to improve the healthcare system's capacity to plan for and respond to large-scale emergencies and disasters. Awardees (typically a state or territory) disburse funds to incentivize diverse and often competitive healthcare organizations to work together to prepare for and respond to medical surge events by forming healthcare coalitions. These coalitions are organized at the local and regional levels to work together to prepare for, respond to, and recover from all-hazards threats and emergencies. Foundational to this program are building expertise and training grantees and responders with these resources.

How funds are allocated or used: According to law, each awardee must make nonfederal contributions of 10% or \$1 for each \$10 of federal funds provided in the cooperative agreement of the award. Funds for preparedness activities go to 62 state, local, and territorial public health systems from the ASPR Division of Grants Management. Awardees include state health departments, select large U.S. cities, eight U.S. territories, and the freely associated states.

Public health impacts: HPP has contributed to healthcare system progress throughout the years, allowing hospitals to share resources and information and coordinate via coalitions to increase the efficiency of their services to their communities. HPP also supports responses and readiness exercises for various events, including everything from fatal seasonal respiratory illnesses to active shooters, chemical explosions, and hurricanes. HPP supports regional healthcare coalitions to incentivize healthcare readiness, assessing risks and needs, training the workforce, and maintaining preparedness among organizations that might otherwise see each other as competitors. According to an ASPR survey, [96% of awardees](#) feel that HPP support has improved their ability to decrease morbidity and mortality during disasters.

For more information: See [ASTHO's preparedness web page](#) or ASPR's [HPP web page](#).

Contact information:

- Jeffrey Ekoma, *Senior Director of Government Affairs*, ASTHO
jekoma@astho.org, (443) 754-0393
- Catherine Jones, *Senior Analyst, Government Affairs*, ASTHO
cgjones@astho.org, (301) 283-8703
- Catherine Murphy, *Analyst, Government Affairs*, ASTHO
cmurphy@astho.org, (540) 855-4661

See updates to this paper at: www.astho.org/globalassets/pdf/astho-appropriations-book.pdf

Last revised: March 25, 2024



Organization name: Association of State and Territorial Health Officials and National Association of Chronic Disease Directors

Topic area: Preventive Health and Health Services

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: CDC-Wide Activities and Program Support

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Preventive Health and Health Services Block Grant	\$160,000,000	\$160,000,000	\$160,000,000	\$175,000,000

Funding recommendation: Appropriation of \$175 million for the Preventive Health and Health Services Block Grant, a \$15 million increase over FY24.

Justification: Chronic disease conditions contribute to early death, poor quality of life, reduction in economic output, increase in disability, increase in healthcare costs, reduction in military readiness, and increased risk of poverty. All these factors can be reduced or prevented through proven strategies whereby state health agencies lead local communities to healthier, more productive living. Therefore, increased funding is essential to maintaining and expanding current efforts in every state, territory, and freely associated state. Critical clinical community linkages and health promotion efforts are required to meet these goals, and a funding increase will support these public health efforts, which are proven to address many of the nation’s major causes of death and disability.

Role of the state health agency: Health agencies have a unique role in efforts to coordinate activities and steer resources to communities most in need, creating linkages across systems with healthcare providers, insurers, educators, and community organizations. State and territorial health agencies are experts at maximizing federal actions, efficiently mobilizing local organizations, and avoiding effort duplication. State and territorial health agencies are essential to providing healthcare, monitoring health insurance, managing all public health initiatives, and providing built-in linkages with local governments and provider communities, making these agencies the logical and most efficient vehicle to manage these critical public health programs.

Fast Facts:

- Currently, around half of the U.S. population has at least one chronic disease, creating an epidemic, and 86% of healthcare costs are attributable to chronic disease.
- Much of the human and financial toll of chronic diseases is preventable.

How funds are allocated or used: Funds are targeted to support state and territorial actions to lead and evaluate activities and, in turn, grant funds to local health agencies and nonprofit partner organizations. The Preventive Health and Health Services Block Grant allows grantees to address emerging health issues and gaps by focusing on their specific needs at the state level. States and territories use this funding to reduce premature deaths and disabilities by focusing on the leading preventable risk factors in their specific populations. This flexibility allows grantees to address the social determinants of health with the aim of achieving health equity in the long term.

Public health impacts: These programs target long-term reductions in population rates of chronic conditions and related costs, along with subsequent increases in productivity and independence.

Background information: A century ago, the major causes of death and disease were markedly different from those of today. For example, modern challenges from infectious diseases have been far surpassed by those from chronic diseases such as diabetes, heart disease, stroke, long COVID, and cancer. Significantly, seven out of ten people today die of chronic disease, and those who die of chronic diseases before age 65 now lose a potential third of their lives. But death alone doesn't convey the full impact of chronic disease. These serious, often lifelong, conditions are treatable but not curable, bringing with them the challenges of disability and diminished quality of life.

Supporting organizations: ASTHO and the National Association of Chronic Disease Directors work closely with many national partners—including the American Diabetes Association, the American Heart Association, and the YMCA of the USA—to assure high-quality and consistent approaches to addressing these public health challenges.

For more information: See CDC's [2022 Public Health and Health Services Block Grant Evaluation Report](#).

Contact information:

- Jeffrey Ekoma, *Senior Director of Government Affairs*, ASTHO
jekoma@astho.org, (443) 754-0393
- Catherine Jones, *Senior Analyst, Government Affairs*, ASTHO
cgjones@astho.org, (301) 283-8703
- Catherine Murphy, *Analyst, Government Affairs*, ASTHO
cmurphy@astho.org, (540) 855-4661
- Amy Souders, *Principal and Director*, Cornerstone Government Affairs
asouders@cgagroup.com

See updates to this paper at:

- [ASTHO's website](#)
- [National Association of Chronic Disease Directors' website](#)

Last revised: March 25, 2024



Organization name: Association of State and Territorial Health Officials

Topic area: State and Local Readiness

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: Office of Readiness and Response

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Public Health Emergency Preparedness	\$735,000,000	\$735,000,000	\$735,000,000	\$1,000,000,000

Funding recommendation: Appropriate \$1 billion, for the Public Health Emergency Preparedness Cooperative Agreement (PHEP), a \$265 million increase over FY24 enacted levels. At its height in FY03, funding for PHEP was \$939 million. Therefore, a funding level of at least \$1 billion will bring this program back to prior levels.

Bill or report language: The committee provides increased investments to continue to enhance public health departments in developing and maintaining capable, flexible, and adaptable public health systems to respond to public health emergencies. America's public health preparedness systems need increased and stable base funding to rebuild, improve, and continue preparing for future public health emergencies.

Justification: According to CDC data, as of January 2023, PHEP funds supported more than 70% of state and local public health labs and more than 5,800 state, local, tribal, and territorial (SLTT) personnel, of which federal funds wholly support approximately 2,300 positions. The COVID-19 pandemic response demonstrated the need to invest in these programs to rebuild and bolster the United States' preparedness response. America's public health preparedness systems will need increased and stable base funding for years to rebuild, improve and ensure our country is safe from health threats.

Role of the state health agency: State and territorial health agencies are critical to our nation's ability to prepare for, respond to, and recover from public health emergencies and threats. Principally, they ensure the public health of their jurisdictions through their inherent and often legal authority to protect and promote the health, safety, and general welfare of their populations. Thanks to PHEP funding, over the last several decades virtually all state and territorial health agencies have developed the infrastructure needed for a 24/7 readiness posture in partnership with responsible individuals, communities, other governmental and nongovernmental organizations, and the private sector. This stable and dependable infrastructure is vital to our economic prosperity, and increased base funding for this program should be commensurate with this need.

Fast Facts:

- There are 62 PHEP cooperative agreement awardees: all 50 states, four metropolitan areas (Chicago, Los Angeles County, New York City, and Washington, D.C.), and eight U.S. territories and freely associated states that have developed strong public health emergency preparedness and response capabilities.
- Fully functional emergency operations centers, robust risk communication capabilities, and a nationwide laboratory and epidemiologic system are just a few readiness accomplishments achieved thanks to this federal investment.

How funds are allocated or used: Broadly, PHEP covers the entire U.S. population and the public health systems within the United States and its territories and freely associated states. Specifically, Congress intends for the funds to support the needs of any community impacted by a public health emergency or disaster and to ensure that public health systems are ready and capable of keeping their communities safe and mitigating the impacts of any public health emergency. Additionally, there is a particular emphasis on ensuring the health needs of tribal populations, at-risk populations, and individuals with disabilities or access and functional needs to ensure that plans and processes are in place pre-event and during an event to address the unique needs of these populations. The 2019-2024 funding opportunity provides fiscal resources to 62 SLTT public health agencies to advance their ability to demonstrate response readiness. It requires states to make available nonfederal contributions of 10% (\$1 for each \$10 of federal funds provided in the cooperative agreement) of the award. PHEP recipients must also increase or maintain their levels of effectiveness across six key public health preparedness domains and focus efforts on strengthening preparedness and response capabilities to prevent or reduce morbidity and mortality. Subject to funding availability, CDC may introduce future projects through PHEP that support the development of critical public health preparedness capabilities in high-population cities during the 2019-2024 performance period. Furthermore, CDC plans to work closely with state, local, and territorial health departments to apply lessons learned from the program to identify and develop potential reforms, as noted in the [Public Health Response Readiness Framework](#).

Public health impacts: PHEP has collaborated with SLTT health departments to prepare and plan for emergencies, resulting in measurable improvement. Such emergencies include responses to COVID-19 and natural disasters like hurricanes and wildfires. Over the years, this program has helped bolster healthcare preparedness efforts to bring forward a more robust public health preparedness stance. PHEP funds programs that strengthen the SLTT public health preparedness and response capability through a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action. An effective public health response prevents or reduces morbidity and mortality from public health threats whose scale, rapid onset, or unpredictability stresses the public health system and ensures the earliest possible recovery and return of the system to pre-incident levels or improved functioning, and PHEP ensures that the U.S. is prepared to successfully do this work.

For more information: ASTHO's [Preparedness web page](#) and CDC's [Emergency Preparedness Program and Guidance web page](#).

Contact information:

- Jeffrey Ekoma, *Senior Director of Government Affairs*, ASTHO
jekoma@astho.org, (443) 754-0393
- Catherine Jones, *Senior Analyst, Government Affairs*, ASTHO
cgjones@astho.org, (301) 283-8703
- Catherine Murphy, *Analyst, Government Affairs*, ASTHO
cmurphy@astho.org, (540) 855-4661

See updates to this paper at: [ASTHO's website](#).

Last revised: March 25, 2024



Organization name: Association of State and Territorial Health Officials

Topic area: Core Public Health Capabilities

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: Cross-Cutting Activities and Program Support

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Public Health Infrastructure and Capacity	\$350,000,000	\$350,000,000	\$350,000,000	\$1,000,000,000

Funding recommendation: Appropriate \$1 billion for public health infrastructure and capacity, a \$650 million increase over FY24 enacted levels.

Justification: State and territorial public health departments currently operate under boom-and-bust funding cycles. The “boom” occurs during a public health emergency, such as the COVID-19 pandemic, when policymakers increase emergency supplemental public health funding to mobilize a response. The ensuing “bust” follows when supplemental funding expires and the acute public health threat subsides. This practice has a significant impact on the ability of jurisdictions to maintain workforce capacity and capabilities and often results in the shuttering of critical public health programs and services.

Increasing funding for public health infrastructure and capacity will disrupt this cycle by supporting agency efforts to build capacity to detect and respond to domestic and global threats while improving and supporting core public health capabilities, including assessment, policy, preparedness and response, community partnership, communications, equity, accountability, and performance management. Moreover, funding will support agencies in their efforts to invest in and retain a highly trained workforce ready to support emerging public health threats. It is imperative that this funding is disease-agnostic, flexible, and sustainable to support the rapid responses needed during public health emergencies.

Role of the state health agency: State and territorial health departments are best equipped to understand the unique needs of their respective communities. In addition to addressing, revitalizing, and modernizing agencies’ core functionalities, public health infrastructure resources will also address fundamental and ongoing public health challenges, as well as preparing for the next pandemic, public health emergency, or natural disaster.

Fast Facts:

- Between 2008 and 2018, federal funding for state public health decreased from an average of \$282 million to \$254 million, with a simultaneous 15% decrease in state and local contributions to public health funding.
- Between 2012 and 2019, the public health workforce decreased by 10,079 full-time employees.
- Over the past decade, public health agencies’ average expenditures and per capita expenditures have fluctuated. Despite sizeable increases in spending in FY2021 in response to the COVID-19 pandemic, when COVID-19 represented approximately one third of 2021 state public health agency expenditures, many other public health expenditures decreased during that time.

This includes:

- Building capacity to identify community risks and strengthen partnerships.
- Recruiting, retaining, training, and supporting public health workers, such as highly skilled epidemiologists, biostatisticians, and other specialists.
- Strengthening systems, processes, and policies across the agency to improve human resource data management, agency communications, and other necessary work.
- Assessing and addressing current capacity, gaps, and opportunities to modernize public health data collection and infrastructure.
- Improving protocols and processes for disease detection and containment.

How funds are allocated or used: Funds are targeted to support state and territorial actions to lead and evaluate activities and, in turn, grant funds to local health agencies and nonprofit partner organizations. The Preventive Health and Health Services Block Grant allows grantees to address emerging health issues and gaps by focusing on their specific needs at the state level. States and territories use this funding to reduce premature deaths and disabilities by focusing on the leading preventable risk factors in their specific populations. This flexibility allows grantees to address the social determinants of health with the aim of achieving health equity in the long term.

Background information: Through the American Rescue Plan Act and annual discretionary appropriations, CDC awarded \$4.01 billion over five years to public health jurisdictions to support public health infrastructure, aiming to enhance the public health workforce and health departments' systems and processes. At the end of the five-year period, recipients are expected to achieve specific outcomes related to workforce capacity, foundational capabilities, and data modernization. With the grant program expiring in November 2027, recipients face a funding cliff that will make increases in discretionary appropriation critical to maintaining the people, services, and systems essential to agency functioning and public health efforts to improve community health and wellbeing.

For more information: [CDC's website](#).

Contact information:

- Jeffrey Ekoma, *Senior Director of Government Affairs*, ASTHO
jekoma@astho.org, (443) 754-0393
- Catherine Jones, *Senior Analyst, Government Affairs*, ASTHO
cgjones@astho.org, (301) 283-8703
- Catherine Murphy, *Analyst, Government Affairs*, ASTHO
cmurphy@astho.org, (540) 855-4661

See updates to this paper at: <https://www.astho.org/advocacy/federal-government-affairs>

Last revised: March 25, 2024



Organization name: Association of State and Territorial Health Officials

Topic area: Social Determinants of Health

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: Chronic Disease Prevention and Health Promotion

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Social Determinants of Health	\$8,000,000	\$6,000,000	\$8,000,000	\$153,000,000

Funding recommendation: Appropriate \$153 million for social determinants of health (SDOH) funding at CDC, a \$147 million increase over FY24 enacted levels.

Justification: SDOH—the conditions in the environments where people are born, live, learn, work, play, worship, and age—are critical drivers of health outcomes and healthcare costs. Community-level assessments and long-term planning can change policies, programs, systems, and environments to improve SDOH in communities with the poorest health outcomes. An increase in funding will help expand such activities and help implement stronger accelerator plans and build the evidence base to better understand the factors that affect health.

Role of the state health agency: State and territorial health agencies play a significant role in leading, developing, and coordinating interventions that seek to bring economic and community sectors together to create conditions that foster vibrant health for all. They are uniquely positioned to support community-driven SDOH work by providing actionable data, identifying and promoting evidence-based practices and policy interventions, and aligning community efforts across the jurisdiction to ensure a shared mission and collective impact.

How funds are allocated or used: CDC’s Division of Nutrition, Physical Activity, and Obesity awards SDOH funds to approximately 20 state, local, and tribal and territorial jurisdictions, with no more than three state and local applicants per HHS region eligible to receive awards. At least one territory and one tribe will be funded each year. The award ceiling for grants is \$125,000 per grantee. Jurisdictions use their funds to develop action plans that assess community needs and identify ways to improve health outcomes related to chronic health conditions among population groups experiencing health disparities.

Fast Facts:

- Chronic diseases are leading causes of death and illness in the United States and leading drivers of the nation's annual \$4.1 trillion in healthcare costs.
- Some populations, including those with low socioeconomic status and individuals in certain racial and ethnic groups—including African American, Hispanic, and Native American people—have a disproportionate burden of chronic disease and long COVID diagnosis, hospitalization, and mortality.

Background information: Conditions are less than optimal for many Americans, especially for individuals living in poverty, individuals in racial and ethnic minority communities, and other marginalized groups that experience profound inequities in health and well-being. These inequities are not only the result of differential access to quality healthcare. Much of our health is influenced by non-medical, non-clinical factors, including our living, working, and learning environments, the quality of our housing, our access to meaningful employment, education, healthy foods, and recreational areas.

For more information: See CDC's web page [Supporting Communities to Address Social Determinants of Health](#).

Contact information:

- Jeffrey Ekoma, *Senior Director of Government Affairs*, ASTHO
jekoma@astho.org, (443) 754-0393
- Catherine Jones, *Senior Analyst, Government Affairs*, ASTHO
cgjones@astho.org, (301) 283-8703
- Catherine Murphy, *Analyst, Government Affairs*, ASTHO
cmurphy@astho.org, (540) 855-4661

See updates to this paper at: [ASTHO's website](#).

Last revised: March 25, 2024



Organization name: Association of Public Health Laboratories, Council of State and Territorial Epidemiologists, and Naphsis

Topic area: Data Modernization

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: Public Health Data Modernization

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Data Modernization Initiative	\$175,000,000	\$175,000,000	\$224,600,000	\$340,000,000

Funding recommendation: Appropriate \$340 million, which is a \$165 million increase over FY23, for the Data Modernization Initiative (DMI).

Bill or report language: Public Health Data Modernization—The committee is pleased to see progress toward the implementation of CDC’s DMI and encourages the agency to continue to invest in the five key pillars of data modernization: electronic case reporting, laboratory information management systems, syndromic surveillance, electronic vital records systems, and the national notifiable disease surveillance system. The committee recommends CDC create an advisory council to formalize its engagement with representatives from state, territorial, local, and tribal (STLT) public health departments, healthcare providers, and the private sector towards the development and implementation of enterprise-level public health data systems.

Justification: CDC’s DMI is a commitment to building a world-class data workforce and systems that meet the nation’s ongoing need to safeguard health. DMI is not just an emergency response need; it is necessary for rapidly identifying, tracking, and responding to daily public health threats of all types—acute, chronic, and emerging. As technology evolves, our public health data systems will continue to need updates and staff will need ongoing training. Public health workers and agencies are essential for protecting and improving the health of communities, but they cannot do their work without adequate funding. DMI funding helps to build and sustain the work of public health officials.

Providing adequate yearly funding through DMI to STLT health departments is a key investment for the continuous improvement of our public health data infrastructure, which we estimate will cost [\\$7.8 billion over five years](#) at the STLT levels with additional funded needed for supporting critical federal data efforts. By supporting CDC, Congress directly impacts every state and local public health jurisdiction's ability to keep their communities safe. So far, Congress has provided more than \$1 billion for DMI through annual and supplemental appropriations. Lack of consistent funding will halt progress and cause health departments to move backward.

Funding for DMI will also make possible the work of the Center for Forecasting and Outbreak Analytics (CFA). A \$100 million appropriation for CFA in FY25 will fund the center to facilitate the use of data, modeling, and analytics to improve pandemic preparedness and response. CFA is already transforming our disease modeling capabilities with the initial funds received. CDC is also using the Response Ready Enterprise Data Integration platform (RREDI) to integrate multiple data streams that can be used to act on a public health response regardless of the emergency and this requires investment as well. DMI, CFA, and RREDI are each needed components of CDC’s data strategy, and each must be funded separately and robustly to help communities stay safe and thrive. Base funding for DMI must be retained and grow with additional funds added for CFA and RREDI.

Role of the state health agency: The responsibility for gathering, reporting, analyzing, and safeguarding data, which healthcare providers share through automated pathways from health records, vital records, and laboratory samples, lies with state public health departments. The data are then rapidly shared with CDC by the states. The transmission of data from state health agencies to the federal government is essential for many reasons, including to ensure data has been de-identified to safeguard patient privacy. While this information must be accessible at the federal level, state and local health agencies are ultimately responsible for the immediate health response.

How funds are allocated or used: STLT health departments and vital records offices apply for DMI funding through a competitive grant process. Awarded initiatives focus on the implementation of or upgrade to electronic, interoperable public health data and vital records systems, strengthening the underlying infrastructure and policy framework to facilitate the optimal use of these systems, and workforce development and training activities to build and retain a technically competent public health workforce. The five key pillars of data modernization are: the National Notifiable Disease Surveillance System; electronic case reporting; syndromic surveillance; electronic vital records systems; and laboratory systems, which encompasses laboratory information management systems, electronic test ordering and reporting, and electronic laboratory reporting.

Public health impacts: Continuous investment in these crucial activities is essential to ensure the strength and resilience of the nationwide public health system. Public health action by STLT public health authorities and CDC facilitates interventions to prevent the spread of infections, reduce morbidity and mortality due to infectious and other diseases, and improve health across the entire population. Further, it has led to improvements in clinical practice, medical procedures, and detection and control of public health threats. Modernizing public health laboratories and systems is a strategic investment to facilitate automated reporting between healthcare organizations and public health entities. In September 2023, CFA released the first-ever respiratory season outlook for fall and winter. The outlook emphasized two potential scenarios, anticipating increased peak hospitalizations attributed to the additional impact and burden of COVID-19, RSV, and influenza. This quick dissemination of information to decision-makers, made possible by advancements through DMI, enabled public health leaders to make informed decisions for the protection of communities in these seasons.

Supporting organizations: In addition to the organizations listed above, the Data: Elemental to Health Campaign includes the Association of State and Territorial Health Officials, Big Cities Health Coalition, the National Association of County and City Health Officials, and the Healthcare Information and Management Systems Society. More than [100 organizations](#) in total support DMI.

For more information: For more information visit [the Council of State and Territorial Epidemiologists' DMI web page](#).

Contact information:

- Meghan Riley, *Senior Vice President*, CRD Associates
amriley@dc-crd.com

Last revised: March 25, 2024



Organization name: Association of Public Health Laboratories and Council of State and Territorial Epidemiologists

Topic area: Epidemiology and Laboratory Capacity

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: Epidemiology and Laboratory Capacity Program and the National Center for Emerging and Zoonotic Infectious Diseases

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Epidemiology and Laboratory Capacity	\$40,000,000	\$40,500,000	\$40,000,000	\$120,000,000

Funding recommendation: Appropriate at least \$120 million for Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) base funding, an \$80 million increase over FY24 enacted levels. In addition to this essential base funding dedicated to the ELC program, more resources are needed for ELC grants and activities through the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) to fund requests of up to \$500 million across public health departments. Commensurate with these increases, additional funding is required for NCEZID to cover these and other vital public health activities NCEZID manages.

Bill or report language: The Committee recognizes the need to increase resources to the base funding for the ELC program, which provides essential flexibility to state, territorial, and large local (STL) health departments to address gaps that are not funded by the disease specific sections of the ELC cooperative agreement. The ELC program provides critical foundational support for STL health departments to fund epidemiology, surveillance, laboratory, and data science staff positions that provide the backbone for STL public health programs. This increase will allow STL health departments to build the foundational public health workforce and infrastructure that will allow them to be better prepared to respond to emerging infectious disease threats more quickly.

- For FY22, public health departments requested \$650 million through the ELC program but CDC was only able to award \$197 million. This gap must be addressed.
- A minimum of an additional 2,196 epidemiologists are needed to deliver public health services in state and territorial health departments based on current operations, which would represent a 53% increase in staffing.
- An additional 500 laboratory staff will improve testing capacity.

Justification: Funding across CDC’s NCEZID is essential to combat new and emerging infectious disease threats and must be increased. Disease-specific NCEZID funding bolsters the ELC program by directly supporting capacity within the specific program areas (e.g., vector-borne disease, foodborne disease, antibiotic resistance, and healthcare-acquired infections); however, this funding is tied to a specific disease category and can restrict or even prevent rapid response to emerging threats. Increased funding for the foundational ELC program line—which has not increased from \$40 million since 2011—is critical and must be coupled with an increase in overall funding across NCEZID programs.

The ELC program uniquely supports a core epidemiology, informatics, and laboratory workforce that can work across disease/condition disciplines. This is critical to meeting outbreak needs and ensuring optimal and flexible capacity and coordination.

Increased funding will enhance core epidemiological response by supporting flexible, prepared epidemiologists who can immediately report to and support outbreaks for disease threats of any type. Foundational ELC funding is critical to state and local health departments' ability to combat infectious diseases, as it is the principal funding source for emerging infectious disease prevention and control, which strengthens detection and response for infectious diseases, early detection of newly emerging disease threats, and identification of and response to outbreaks.

As recent years have demonstrated via concurrent outbreaks of COVID-19, pediatric hepatitis, mpox, Ebola Sudan virus, and Marburg virus, and a surge in pediatric hospitalizations due to respiratory syncytial virus (RSV) and other threats, the U.S. remains at high risk for new and emerging diseases. STL health departments require epidemiology, laboratory, and data science staff to address a wide range of disease threats. The ELC program is unique to CDC, as it is the only source of support for core epidemiology and laboratory workforce and infrastructure specifically intended to respond to any infectious disease outbreak.

With increased funds, CDC can provide foundational support to reinforce everyday infectious disease programs and ensure they are able to adequately respond to future infectious disease outbreaks. Increased funding will also help to build the epidemiology workforce, allowing STL health departments to begin to establish a minimum epidemiology, laboratory, and informatics workforce. Expanding the foundational ELC program line will also allow the ELC program to coordinate with states to expand the ability to combat new and emerging infectious disease threats to local health departments.

Role of the state health agency: State and local health departments and laboratories are critical partners in these activities, serving on the front lines and conducting surveillance and epidemiologic investigations. Data are shared with CDC, and CDC is thus heavily reliant upon the strength of state and local epidemiology and laboratory capacity. Funding provided to support communicable disease monitoring and response bolsters the overall epidemiology and informatics infrastructure needed to fight non-communicable diseases, which represent our nation's leading causes of death.

How funds are allocated or used: The core ELC program is funded directly from the ELC program line and supports flexible, response ready positions to sustain broad infectious disease epidemiology and surveillance, laboratory, informatics, and data science staff. This section of the ELC program is intentionally broad and allows STLs to address their gaps in areas that are not funded by the disease-specific sections of the cooperative agreement grant (e.g., zoonotic diseases).

Public health impacts: Supported by funding from ELC, 50 states, six local health departments, and eight territories monitor and respond to public health threats as they surge across the country and regularly respond to infectious disease outbreaks nationwide.

For more information: [CDC's ELC web page](#).

Contact information:

- Meghan Riley, *Senior Vice President*, CRD Associates
mriley@dc-crd.com

Last revised: March 25, 2024

Organization name: Safe States Alliance

Topic area: Injury and Violence Prevention

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: Core State Injury Prevention Program

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Core State Injury Prevention Program	\$7,700,000	\$7,700,000	\$7,700,000	\$12,700,000

Funding recommendation: Appropriate \$12.7 million in FY25, a \$5 million increase from FY23, for the Core State Injury Prevention program (Core SIPP).

Bill or report language: Core State Injury Prevention Program (Core SIPP)—

The agreement includes an increase of \$5,000,000 to enhance efforts to identify and respond to injury threats with data-driven public health actions.

Justification: Administered by CDC’s National Center for Injury Prevention and Control, Core SIPP is a unique program that helps states implement, evaluate, and disseminate strategies that address the most pressing injury and violence prevention issues.

The program provides funds to support states’ “core,” or baseline, capacity.

- Core SIPP supports health departments to identify and respond to existing and emerging injury threats.
- More than 240,000 people die each year due to a sustained injury.
- Each year, 27 million people suffer non-fatal injuries requiring an ER visit.

Building core capacity is an important and necessary goal—a true foundation for injury and violence prevention in every state and territory. However, this goal has never been adequately realized.

With a \$1 million FY23 increase in funding from Congress, Core SIPP now supports 26 states. While these states have achieved important accomplishments, the program is not nearly large enough to meet its goal of impacting injury and violence at the population level.

Base funding levels have been capped at \$250,000 per state for more than a decade. Six of the 26 states receive additional funds of approximately \$150,000 under an enhanced component. Core SIPP also includes a requirement that funded states address three topic areas that were prioritized by the National Center for Injury Prevention and Control in 2021, which include traumatic brain injury, adverse childhood experiences (ACEs), and transportation-related injury. Despite its limitations, Core SIPP is the best foundation for building a true national injury and violence prevention program in every state and territory.

Role of the state health agency: State public health departments use Core SIPP funding to build the public health infrastructure needed to support violence and injury prevention programs. Funds are used to collect and analyze relevant data; design, implement, and evaluate program and policy strategies; and provide technical support, training, and education.

How funds are allocated or used: Grants are competitively awarded to state health departments. Grantees receive only \$250,000 due to limited availability of federal funds and support basic program funding for coordinated and comprehensive state injury and violence prevention programs.

Public health impacts: Core SIPP states are making significant strides toward reducing injuries and violence in their communities, including:

- North Carolina’s Core SIPP developed the program named Adverse Childhood Experiences and Suicide Prevention in a Remote Environment (ASPIRE), which included a six-month [Collaborative Learning Institute](#) training program on using [systems thinking](#) approaches for ACEs and suicide prevention planning and two toolkits designed to improve learning and demonstrate best practices for ACEs and suicide prevention.
- New York adopted new concussion management guidelines for children returning to physical education following a concussion. New York Core SIPP funded the [Brain Injury Association of New York State](#) to develop a return to physical education training program that explains the struggles a student may face after having a concussion. The program reached over 2,000 educators in New York State.
- New Mexico Core SIPP developed an introductory training for the [New Mexico Injury Prevention Coalition](#) and partners on shared risk and protective factors, injury prevention, and the [social ecological model](#). The [University of New Mexico Prevention Research Center](#), New Mexico Injury Prevention Coalition, and the [New Mexico Department of Health](#) staff helped develop the training, which aimed to raise awareness and improved knowledge of how the shared risk and protective factors approach can apply to injury prevention. Objectives included describing risk factors and general causes of ACEs, traumatic brain injuries, and motor vehicle crashes.
- Virginia’s Core SIPP funding provided support for [Every Ride, Safe Ride](#), an outreach project based on existing evidence in safe transportation of children principles. The initiative’s goal is to equip pediatric and obstetric healthcare providers with the knowledge and resources to assess, screen for, provide resources for, and address safe transportation through pregnancy to a child’s transition to the seat belt.

For more information: [Core State Injury Prevention Program web page.](#)

Contact information:

- Brandon Neath, *Government Relations Manager*, Safe States Alliance
brandon.neath@safestates.org, (470) 617-7882

Last revised: March 25, 2024

Organization name: Safe States Alliance

Topic area: Injury and Violence Prevention

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: Firearm Injury and Mortality Prevention Research Program

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Firearm Injury and Mortality Prevention Research	\$12,500,000	\$12,500,000	\$35,000,000	\$35,000,000

Funding recommendation: Appropriate \$35 million in FY25, a \$22.5 million increase from FY24, for the Firearm Injury and Mortality Prevention Research program at CDC.

Justification: Firearm violence is a serious public health problem in the United States that strongly impacts the health and safety of Americans. Despite initial funding in FY21 to address firearm violence, significant gaps remain in our knowledge about the problem and ways to prevent it. Addressing these gaps is a crucial step toward keeping individuals, families, schools, and communities safe from firearm violence and its consequences.

Today there are bipartisan calls for research to better understand the root causes of gun violence to inform evidence-based gun violence prevention programs. Additional funding is needed to inform policies that address topics such as youth access to firearms, risk factors for firearm violence, and the risks and benefits of firearm ownership.

Role of the state health agency: State public health departments play an important role in coordinating the broader public health system’s efforts to address the causes of injury and violence. These state agencies are well suited to unite community partners to address the root causes of gun violence through policy, environment, and system change. The public health approach to gun violence prevention includes working to define the problem, identify risk and protective factors, develop and test prevention strategies, and assure widespread adoption of focused programs.

How funds are allocated or used: Funds will be used to support grants that examine the root causes and prevention of gun violence, focusing on those questions with the greatest potential for public health impact.

Public health impacts: The National Center for Injury Prevention and Control funding opportunities are intended to support research that addresses:

- The characteristics of firearm violence.
- The risk factors and protective factors for interpersonal and self-directed firearm violence.
- The effectiveness of interventions to prevent firearm violence.

Gun violence accounts for many injuries and deaths in the United States:

- In 2020, over 45,000 people died from gun-related injuries.
- More than 90,000 non-fatal firearm injuries are treated in emergency departments each year.
- Firearm injuries cost \$229 billion in medical and loss-of-productivity annually.

The goal of this research is to stem the continued rise of firearm violence in communities across the country and decrease the occurrence of mass shootings.

Research Grants to Prevent Firearm-Related Violence and Injuries

The National Center for Injury Prevention and Control's Division for Violence Prevention is currently supporting over 30 research awards to improve understanding of firearm injury, inform the development of innovative and promising prevention strategies, and rigorously evaluate the effectiveness of strategies to keep individuals, families, schools, and communities safe from firearm-related injuries, deaths, and crime.

CDC's Division of Violence Prevention currently funds 12 recipients for the Advancing Violence Epidemiology in Real-Time program. These recipients work to improve the timeliness of surveillance data on emergency department visits for firearm injuries, other violence-related injuries, and mental health conditions. Recipients include:

- Arizona Department of Health Services
- District of Columbia Department of Health
- Georgia Department of Public Health
- Illinois Department of Public Health
- Kansas Department of Health and Environment
- University of Kentucky Research Foundation
- Michigan Department Health and Human Services

For more information: [CDC's Firearm Violence Prevention web page](#)

Contact information:

- Brandon Neath, *Government Relations Manager*, Safe States Alliance
brandon.neath@safestates.org, (470) 617-7882

Last revised: March 25, 2024



Organization name: NASTAD

Topic area: HIV and Hepatitis Programs

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: Division of HIV Prevention

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Domestic HIV Prevention and Research	\$1,013,712,000	\$1,013,712,000	\$1,013,712,000	\$1,417,000,000

Funding recommendation: Appropriate \$1,417,000,000, which is a \$404 million increase, for the Division of HIV Prevention. Of this division's funding, \$495 million is for the implementation of the Ending the HIV Epidemic Initiative, including funding to establish a national pre-exposure prophylaxis (PrEP) program.

Justification: With the confluence of advances in science and policy, the United States has an unprecedented opportunity to achieve large-scale, measurable impact in a relatively short timeframe, drastically reduce health disparities, and end the HIV epidemic. To achieve this goal, the domestic HIV prevention and research program must see increased funding. Sixty health departments currently receive this funding (all 50 states, Washington, D.C., Puerto Rico, U.S. Virgin Islands, Baltimore, Chicago, Houston, Los Angeles County, Philadelphia, New York City, and San Francisco).

- PrEP (pre-exposure prophylaxis) can reduce your chance of getting HIV from sex or injection drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.
- The number of PrEP users in the U.S. increased by 23% from 2020 to 2021.

HIV prevention programs were severely impacted by the COVID-19 pandemic and mpox. HIV prevention programs experienced challenges in maintaining access to services, reporting significant decreases in testing and other prevention services. There was success, as HIV prevention programs shifted and implemented at-home testing programs to ensure people were still being tested for HIV and linked to care. Many of these services have continued post-COVID. To scale up these innovative programs and reach a broader audience, investments must be made in the public health system to ensure continuity of services during public health emergencies.

Launched in 2019, Ending the HIV Epidemic: A Plan for America (EHE) intends to reduce new HIV transmissions by 75% in 2025, and by 90% in 2030 by supporting 48 counties, Washington, D.C., San Juan, Puerto Rico, and seven states with high rates of HIV in rural geographic regions. EHE will supplement existing resources and focus on HIV testing, linkage to care, and access to prevention modalities.

The number of new HIV diagnoses must decrease to see meaningful improvements in individual and community level health outcomes, particularly among disproportionately impacted populations. It is clear that early detection, linkage to and retention in care, and adherence to treatment will suppress individual and community viral loads and reduce the incidence of HIV. Unfortunately, only 66% percent of people diagnosed with HIV have an undetectable viral load.

Role of the state health agency: Health departments are the cornerstone implementers of HIV prevention, coordinating federal, state, and local public health programs and policy efforts. These efforts are essential in meeting high-impact prevention and the nation's established goals to combat the HIV epidemic: reducing the annual number of new HIV diagnoses and reducing HIV-related health disparities, particularly among communities of color and gay, bisexual, and other men who have sex with men of all races and ethnicities. Providing funding to health departments is CDC's single largest investment in HIV prevention, with \$397 million going to health department prevention and surveillance activities. Fortunately, we have the tools and strategies to prevent HIV transmission, but continued funding for CDC's Division of HIV Prevention is critical to continue the progress we have made.

PrEP is a course of medications used to prevent the transmission of HIV in people who have not yet been diagnosed with HIV. The use of non-occupational post-exposure prophylaxis in a safe and timely manner is an intervention for individuals recently exposed to HIV. Unfortunately, PrEP utilization goals, particularly among vulnerable communities, have not been achieved due to a lack of investment. In 2021, only 30% of the 1.2 million people in the U.S. who could benefit from PrEP were prescribed the medication. Health departments require additional funding for these interventions to ensure their success.

How funds are allocated or used: Category A Funds are awarded to state and eligible local health departments by formula, and states and eligible local health departments may apply for Category B funds for demonstration projects through competitive awards. Health departments can provide sub-grant awards to local health departments and/or community-based organizations. Health departments that are eligible for EHE funds receive them based on formula.

Public health impacts: More than 1.2 million people are living with HIV in the U.S. The implementation of high-impact prevention has correlated with many successes in preventing new HIV transmissions, but since 2013, new HIV diagnoses have plateaued at around 38,000 per year. From 2017 to 2021, new HIV diagnoses decreased by 7%, yet unevenly. New diagnoses among women decreased 11%. During this time, the percentage of people who were aware of their HIV status increased from 86% to 87%. However, further progress in preventing new HIV transmissions is imperative. An overwhelming percentage of new HIV diagnoses are among gay, bisexual, and other men who have sex with men.

Supporting organizations: The AIDS Budget and Appropriations Coalition supports this ask.

For more information: [NASTAD website](#)

Contact information:

- Emily Schreiber, *Senior Director*, Policy & Legislative Affairs
eschreiber@NASTAD.org, (202) 897-0078

See updates to this paper at: [NASTAD's Policy & Legislative Affairs web page](#)

Last revised: March 24, 2024



Organization name: Naphsis

Topic area: Electronic Vital Records Systems

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: National Center for Health Statistics

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
National Center for Health Statistics	\$187,397,000	\$187,397,000	\$187,397,000	\$220,000,000

Funding recommendation: Appropriate \$220 million, which is a \$32.6 million increase over FY24, for the National Center for Health Statistics (NCHS).

Bill or report language: Modernizing Vital Statistics Collection—Electronic birth and death registration systems are essential tools to monitor public health and fight waste, fraud, and abuse in federal programs. Vital records are a key component of the Data Modernization Initiative (DMI). The Committee recommends that funding from DMI be allocated to jurisdictions through the National Center for Health Statistics to support necessary upgrades to its vital statistics systems to enable more, better, and faster vital records data. The Committee requests a briefing within 90 days of enactment of this act on the progress and plans for programs and activities supported by DMI funding.

- Vital records systems capture data from approximately 6 million births and deaths annually and can signal trends and help monitor public health events.
- CDC’s Data Modernization Initiative is working across CDC and states to improve electronic vital records systems.

Justification: NCHS data have long been the gold standard for measuring health status and changes in health outcomes for the most vulnerable populations and identifying emerging health issues for the nation. Increased investment is required to support a fully modernized vital statistics system capable of tracking critical mortality trends. NCHS faces the challenge of continuing to provide essential data while also making necessary upgrades. An increased investment of \$220 million will support NCHS to improve vital records sharing with jurisdictions and advance the timeliness of data through research, staffing, and systems development.

Role of the state health agency: NCHS is the nation’s principal health statistics agency, and its mission is to provide information that will guide actions and policies to improve the health of the American people. Of particular importance, NCHS collects vital records information. Vital records are permanent legal records of life events, including live births, deaths, fetal deaths, marriages, and divorces. Consistent with the constitutional framework set forth by our founding fathers in 1785, states were assigned certain powers. The 57 vital records jurisdictions, not the federal government, have legal authority for the registration of these records, which are thus governed under state laws. The laws governing what information may be shared, with whom, and under what circumstances vary by jurisdiction. In an example of effective federalism, the vital records jurisdictions provide the federal government with data collected through birth and death records to compile national health statistics, facilitate secure Social Security number issuance to newborns through the Enumeration at Birth Program, and report individual deaths.

How funds are allocated or used: NCHS provides more than \$20 million per year to the states for the use of their birth, death, and fetal death records. Funding is not equal, however, and is based on the number of births and deaths within each jurisdiction, not on the extensive and expensive electronic systems required in every jurisdiction to support this essential data set. This is not nearly enough to run a state vital records program, let alone the growing technologically skilled workforce required to administer it. This decades-old pricing structure leaves state vital records agencies universally financially challenged, and the majority are “fee funded,” which means they rely on sales of birth and death certificates, which can cost as little as \$5, to get by.

Public health impacts: Vital records are essential for public health and civil registration; these data are used to monitor disease prevalence and trends and our nation’s overall health status, develop programs to improve public health, and evaluate the effectiveness of those interventions. For example, the mechanisms to report deaths—whether by a state medical examiner, coroner, hospital, physician, or other provider—are not interconnected with a patient’s medical record or electronic health record and require reporters to enter data twice into two different systems or worse, still rely on fax machines. The National Vital Statistics System has been modernized thanks to the enduring support and leadership of Congress, but ongoing improvements are required. NCHS has funded states and territories to speed the release of birth and death statistics, including infant mortality and prescription drug overdose deaths. In fact, the percentage of mortality records reported within 10 days has increased from less than 10% in 2010 to 68% in 2022. Congress must provide increased funding to support continued progress.

Supporting organizations: [Friends of NCHS](#)

For more information: [National Center for Health Statistics web page](#)

Contact information:

- Meghan Riley, *Senior Vice President*, CRD Associates
mriley@dc-crd.com, (202) 484-2024

Last revised: March 25, 2024

Organization name: National Association of Chronic Disease Directors

Topic area: Chronic Disease

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Division of Nutrition, Physical Activity, and Obesity	\$58,420,000	\$58,420,000	\$58,420,000	\$125,000,000

Funding recommendation: The National Association of Chronic Disease Directors (NACDD) strongly recommends an appropriation of \$125 million, which is a \$66.58 million increase over FY24 enacted levels, for the Division of Nutrition, Physical Activity, and Obesity (DNPAO).

Justification: An increase in funding in FY25 for DNPAO will continue efforts to improve nutrition and increase physical activity across the lifespan, with a special focus on children ages 0-5. Currently, only 17 states receive funding to support physical activity and healthy eating through state-based public health programs. Public health programming per capita expenditure is approximately \$0.25, far below the estimated \$1,429 per capita cost of obesity-related medical care.

- Obesity costs the U.S. healthcare system \$147 billion a year.
- Despite the proven health benefits of physical activity, 50% of U.S. adults are not active enough to protect their health.
- Every state should have a grant for DNPAO efforts.

A sustained and sufficient level of investment in nutrition and physical activity interventions through state-based public health programs can improve health outcomes and quality of life and help individuals maintain optimal health at every age. CDC directs funding to evidence-based interventions that promote nutrition and physical activity and obesity prevention, including increasing access to healthy food and beverages, increasing physical activity access and outreach, designing communities that support safe and easy places for people to walk, improving nutrition and increasing physical activity in early care and education settings, and improving support for mothers who choose to breastfeed.

Role of the state health agency: State health agencies have a unique role in efforts to coordinate activity and steer resources to communities most in need, creating linkages across systems with healthcare providers, insurers, educators, community organizations, and others. State participation is needed to maximize federal actions and assure the most efficient mobilization of local organizations.

How funds are allocated or used: Funds are targeted to support state action to lead activities and evaluation and, in turn, grant funds to local health agencies and nonprofit partner organizations.

Public health impacts: At \$125 million, DNPAO and states will:

- Reduce the age-adjusted proportion of adults (age 18 and older) who are obese.
- Reduce the proportion of children and adolescents (ages 2 through 19) who are obese.
- Increase the contribution of vegetables to the diets of the population ages 2 years and older (cup equivalents per 1,000 calories).
- Increase the proportion of adults (age 18 and older) who engage in physical activity.
- Increase in the number of states with nutrition standards for foods and beverages provided in early care and education centers.
- Increase the number of states with physical education standards that require children in early care and education centers to engage in vigorous- or moderate-intensity physical activity.
- Increase the proportion of infants who are breastfed at 6 months.

Background information: Despite the proven health benefits of physical activity, only half of American adults and about a quarter of adolescents get enough aerobic physical activity to maintain good health and avoid disease. Physical activity saves lives, saves money, and protects health. If Americans met the recommended physical activity levels, one in ten premature deaths could be prevented. In addition, meeting physical activity recommendations could prevent:

- \$117 billion in annual healthcare expenditures.
- 1 in 8 cases of breast and colorectal cancers.
- 1 in 15 cases of heart disease.

Obesity rates are still too high. Nationally, 42% of adults and 19% of all children and adolescents (ages 2 to 19 years) have obesity. Over the last two decades, obesity rates for adults over 60 have been steadily increasing, from 24% in 1988-1994 to almost 43% in 2017-2018.

Obesity costs the U.S. healthcare system \$147 billion a year. Obesity and related chronic diseases cost employers up to \$93 billion per year in health insurance claims. Persons with obesity are at higher risk for hypertension, high cholesterol, type 2 diabetes, heart disease, certain cancers, and early death. Obesity also negatively impacts our nation's businesses, economy, and military readiness. Nearly 1 in 4 young adults is too heavy to serve in our military.

Supporting organizations: NACDD works closely with many national partners to assure high quality and consistent approaches to address public health challenges. These include the American Diabetes Association, American Heart Association, YMCA of the USA, and many others.

For more information: [National Association of Chronic Disease Directors website](#)

Contact information:

- Amy Souders, *Principal and Director*, Cornerstone Government Affairs
asouders@cgagroup.com, (202) 488-9500

See updates at: [National Association of Chronic Disease Directors Appropriations Fact Sheets web page.](#)

Last revised: March 25, 2024



Organization name: Association of State and Territorial Dental Directors

Topic area: Oral Health

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Oral Health	\$20,250,000	\$20,250,000	\$20,250,000	\$36,250,000

Funding recommendation: The Division of Oral Health (DOH), located in CDC’s National Center for Chronic Disease Prevention and Health Promotion, currently receives \$20.25 million from Congress to support states and territories to reduce cavities and oral disease rates among different populations. The Association of State and Territorial Dental Directors (ASTDD) strongly recommends an appropriation of \$36.25 million for DOH, a \$16 million increase over the FY24 appropriation. With this increase, \$10 million would be directed to evaluating and enhancing the nation’s surveillance data collection efforts to better identify oral health burden at national, state, and local levels and make data available more quickly. Currently, the main tool for tracking state-level oral disease burden is the Basic Screening Survey, which focuses on children. Some states have completed dental screenings in Head Start programs and elder care settings, but this school-administered instrument primarily provides a snapshot of third graders, and occasionally of younger schoolchildren. DOH is exploring more cost-effective and valid methods to collect data. Current assessments conducted at the state level need enhancement through demonstration projects. The COVID-19 pandemic greatly impacted the ability to use school settings; therefore, exploring other approaches is warranted to facilitate state level data collection.

Similarly, at the national level, data collection efforts have stopped and will not resume until 2025. Data collection at the state and national levels is critical for strengthening the ability to monitor state oral health conditions and promising preventive dental interventions as well as monitoring the burden of disease across the lifespan in the U.S. and tracking Healthy People 2030 objectives. An additional \$2 million will enable exploration and evaluation of methods to track adherence to infection prevention and control guidelines for dental settings. In addition, \$4 million of the increase would support educational efforts focusing on medical-dental integration, a deliberate effort to increase coordination of care that is patient-centered and considers a person’s oral health as part of their whole-body system. DOH would launch a national initiative promoting a range of strategies and collaboration across diverse partners to advance medical-dental integration at state and local levels. These strategies would be centered around four pillars: 1) awareness, 2) workforce development and operations, 3) information exchange, and 4) payment. Initial partnerships would be focused on improving care coordination among patients with diabetes and creating a national campaign and resources to reduce the incidence of non-ventilator healthcare-associated pneumonia.

Justification: Oral health has a direct effect on one’s body, mind, and emotional, social, and career wellness. Oral diseases, including cavities, gum diseases, and oral cancers, progress and become more complex over time, affecting people at every stage of life. This creates a significant personal and financial burden on individuals, public health systems, and dental care systems. Oral diseases are chronic, just like diabetes and high blood pressure. They cause people to lose time from work, affect school performance, and impact some people’s ability to get a job or enlist in the military. While CDC provides funding to every state health department to reduce rates of cancer, diabetes, and cardiovascular diseases and to support tobacco control programs, it funds less than half of states for oral disease prevention programs. These proposed efforts would allow CDC and states to identify areas with the greatest oral health needs, improve access to effective interventions, and improve care coordination for chronic diseases associated with oral health.

Role of the state health agency: State health agencies are responsible for assessing and tracking oral disease in the state’s population, developing and implementing policies and programs to prevent or minimize oral disease, and assuring that laws and regulations are in place to keep the public safe and healthy. To translate proven health promotion and disease prevention approaches into policy development, healthcare practice, and personal behaviors, state oral health programs must have adequate capacity and infrastructure. Stronger surveillance data collection efforts and resources to accelerate medical-dental integration throughout the state are paramount and would directly support state-based initiatives.

How funds are allocated or used: CDC grants are competitively awarded to state health departments and territories to implement effective core activities. State oral health programs assist in efforts to decrease cavities, oral health disparities, and other chronic diseases associated with oral health.

Public health impacts:

- Cavities are the most common chronic disease in the United States.
- Over half (52%) of children aged 6 to 8 years have had a cavity in their primary (baby) teeth.
- Almost 1 in 5 (17%) adolescents aged 12 to 19 years have at least one untreated cavity.
- Children aged 5 to 19 years from low-income families are twice as likely to have cavities as children from higher-income households (25% versus 11%).
- More than 1 in 4 (27%) adults in the United States have untreated cavities.
- Nearly half (46%) of all adults aged 30 years or older show signs of gum disease, and severe gum disease affects about 9% of adults.
- On average, over 34 million school hours and 92 million work hours are lost yearly because of unplanned (emergency) dental care.
- Over \$45 billion is lost in productivity in the U.S. each year because of untreated oral disease.
- The U.S. healthcare system could save up to \$100 million a year if dental offices screened patients for diabetes, high blood pressure, and high cholesterol and referred them for treatment.
- Nearly 18% of working-age adults report that the appearance of their mouth and teeth affects their ability to interview for a job. For those with low incomes, the percentage increases to 29%.
- Oral health has been linked with other chronic diseases, like diabetes and heart disease. Oral disease is also associated with risk behaviors like using tobacco and consuming sugary foods and beverages.

For more information: [Association of State and Territorial Dental Directors website](#)

Contact information:

- Christine Wood, *Executive Director*, Association of State and Territorial Dental Directors
cwood@astdd.org, (775) 626–5008

Last revised: March 25, 2024



National Coalition of STD Directors

Organization name: National Coalition of STD Directors

Topic area: Sexually Transmitted Infections

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: National Center for HIV, Viral Hepatitis, STD and TB Prevention’s Division of STD Prevention

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
National Center for HIV, Viral Hepatitis, STD and TB Prevention’s Division of STD Preventions Prevention	\$174,310,000	\$174,310,000	\$174,310,000	\$322,500,000

Funding recommendation: Appropriate \$322,500,000, which is a \$148.2 million increase from the FY24 enacted level, for CDC’s Division of STD Prevention (DSTDP).

Report language: Sexually Transmitted Infections (STIs)—The Committee has included \$322,500,000 to address the high incidence of STIs. The Committee recommends that CDC provide state and local entities a larger percentage of STI prevention funding to address the increasing rates of STIs and plan for future outbreaks. Within the funds provided, the Committee directs that a portion of these funds be used to ensure that none of the grantees receives less than the amount received in fiscal year 2024. In addition, the Committee directs CDC to continue to move the grant year forward by one month to provide for a more efficient expenditure of funds and improve grantee activities, with the intention that the grant year will be moved forward by one month each year for the next three years, contingent on the availability of funds.

- Congenital syphilis rates have increased 937% in the last decade, leading to 282 stillbirths in 2022.
- In 2022, the U.S. reported more than 2.5 million cases of syphilis, gonorrhea, and chlamydia.
- In the last 20 years, STI prevention’s purchasing power has decreased by 40% due to inflation and funding stagnation.

Justification: After 20 years of funding declines, in 2023 federal funding finally returned to 2003 levels, still far below current need. Adjusted for inflation, departments have lost 40% of their purchasing power in that time. The STI prevention workforce lost an additional \$400 million in federal dollars in 2023 due to the rescission of unobligated COVID-19 funds in the Fiscal Responsibility Act, which threatens the future of disease intervention specialists hired with these funds. Increased funding at DSTDP would enable state and local health departments to preserve full-time employee positions jeopardized by the rescission.

Building on the direction from Congress in FY23, which instructed DSTDP to hold harmless health departments’ STI prevention and control funding levels and move the grant year forward one month to alleviate administrative burdens, the funding request for FY25 includes a \$4,000,000 set aside to hold harmless funding levels for awardees that may otherwise see a reduction in funding due to the nuances of the funding formula and includes another one-time investment of \$20,000,000 to move the grant year forward another month in FY25, with the ultimate goal of moving the grant year to July. This language is crucial to enable awardees to build on existing programs and not lose ground in the fight against STIs.

Role of the state health agency: DSTDP partners with all 50 state health departments and seven large urban areas to support STI prevention and surveillance through this funding.

How funds are allocated or used: Funds are awarded to state and city health agencies through an STI morbidity-based formula, and in FY23, due to Congress's inclusion of language in appropriations to hold harmless grantees' funding, no jurisdiction received less than it did in FY22. This funding is used by health agencies to support STI monitoring, outbreak response, assurance of appropriate screening and treatment by healthcare providers, contact tracing, linkage to care, and providing STI prevention information to the general public. In most jurisdictions, the state health agency is the sole entity doing this essential work.

Public health impacts: STIs are a growing threat to our nation's health. Chlamydia, gonorrhea, and syphilis infections breached 2.5 million reported cases in 2022. STIs can have life-changing and life-threatening consequences, including infertility, cancer, ectopic pregnancy, pelvic inflammatory disease, and death. Increasing cases of syphilis in newborns (congenital syphilis) are particularly worrisome; cases of congenital syphilis have increased 937% in the last decade.

Supporting organizations: The Hepatitis Appropriations Partnership and the AIDS Budget and Appropriations Coalition support this ask.

For more information: [National Coalition of STD Directors website](#)

Contact information:

- Rachel Deitch, *Director of Federal Policy*, National Coalition of STD Directors
rdeitch@ncsddc.org, (202) 990-5838

See updates to this paper at: <https://www.ncsddc.org/wp-content/uploads/2024/02/FY25-STIRequest.pdf>

Last revised: March 25, 2024



Organization name: Association of Immunization Managers

Topic area: Immunization Funding

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: Section 317 Immunization Funding

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Section 317 Immunization Program	\$681,933,000	\$681,933,000	\$731,933,000	\$1,130,000,000

Funding recommendation: Appropriate \$1.13 billion, which is a \$448 million increase for the Section 317 Immunization Program over FY24 enacted levels. This is critical to maintain emergency preparedness improvements made during the pandemic and to support urgent routine vaccination catch-up efforts, implement new vaccines, sustain and update immunization information systems (IIS), and respond to current and potential outbreaks of measles, varicella, RSV, influenza, hepatitis and other illnesses.

Committee Report Language: “The Committee recognizes that the pandemic exposed critical gaps in our nation’s immunization infrastructure resulting from years of stagnant funding. The agreement includes an increase to help sustain improvements made with one-time emergency funding and purchase critical vaccines. It will enhance immunization efforts by increasing annual funding to jurisdictions to promote routine vaccines, improve data collection and public data presentation, and expand and sustain a network of and private and public providers to ensure access to vaccines in all communities. CDC is expected to use this funding to increase base awards to jurisdictions, promote enhanced access to protection from vaccine preventable diseases, and address vaccine hesitancy.”

Justification: The need to establish and maintain a robust public health immunization infrastructure has never been greater. Jurisdictions need significant new resources to sustain improvements made with one-time emergency funding and avoid a funding cliff when emergency funds expire in June 2025. They also need resources to investigate and respond to predictable outbreaks of vaccine-preventable diseases due to reduced vaccine coverage. Additional resources are also needed to implement recent recommendations from CDC’s Advisory Committee on Immunization Practices for expanded adult vaccination against hepatitis B, pneumococcal disease, and shingles, as well as breakthrough products to prevent RSV in both infants and older adults.

- The COVID vaccination campaign illustrates the power of vaccines—saving 3.2 million lives, preventing over 18 million hospitalizations, and avoiding over \$1 trillion in healthcare costs.
- Millions of children and adults are still behind on routine vaccinations.
- Other infectious disease threats remain; 1,282 measles cases were confirmed in 2019—the greatest number of cases reported in the U.S. since 1992— and the high number of preventable flu, RSV, and COVID hospitalizations in winter 2023-2024 stressed already stretched healthcare systems.
- Millions of people get flu every year, hundreds of thousands of people are hospitalized due to flu, and thousands to tens of thousands of people die from flu-related causes.
- The U.S. spends nearly \$27 billion annually to treat four vaccine-preventable illnesses (flu, pertussis, pneumococcal disease, and shingles).

New program requirements from CDC for all jurisdictions to report all vaccine doses to CDC in real time cannot happen without new investments. Increased and sustained investment is needed to modernize IIS, establish state-to-state IIS data sharing, provide aggregate doses administered data from IIS to CDC in real time, increase and sustain a network of adult immunization providers reporting data into IIS, and engage with community-based organizations to build vaccine confidence and reduce disparities.

In 2019, the World Health Organization declared vaccine hesitancy one of the top ten global threats. This threat is not going away and must be aggressively addressed in every state and local community. Congress can assert leadership now to assure that our nation's public health system does not repeat past cycles of panic and neglect. Now is the time to sustain improvements made through one-time emergency supplemental funding. This will ensure that both routine immunization is restored, and future preparedness is assured.

Role of the state health agency: The Section 317 program provides cooperative agreements to state, local, and territorial health agencies to purchase vaccine for uninsured adults; conduct outbreak responses; enroll, educate, and provide vaccines to over 40,000 private physicians in the Vaccines for Children Program (vaccinating millions of children annually); track vaccination rates and vaccine inventory; and identify disease incidence and stop transmission of deadly, preventable disease.

How funds are allocated or used: Funds are awarded to 64 state, local, and territorial health agencies by formula based largely on population.

Public health impacts: For each dollar invested in the U.S. childhood immunization program, there are over ten dollars of societal savings and three dollars in direct medical savings. Moreover, CDC estimates that vaccination of children born between 1994 and 2021 will prevent 472 million illnesses and 29.8 million hospitalizations and help avoid 1,052,000 deaths, saving nearly \$2.2 trillion in total societal costs. Inadequate vaccination will result in preventable illness, suffering, and death.

Supporting organizations: Association of State and Territorial Health Officials (ASTHO), National Association of City and County Health Officials (NACCHO), American Immunization Registry Association (AIRA), Vaccinate Your Family (VYF), American Academy of Pediatrics (AAP), 317 Coalition, Adult Vaccine Access Coalition (AVAC), Immunization Action Coalition (IAC), Families Fighting Flu, Meningitis Angels, National Meningitis Association, and Meningitis B Action Project.

For more information: [Association of Immunization Managers website](#), [Vaccinate Your Family website](#), [American Academy of Pediatrics immunizations recommendations](#), [317 Coalition Website](#), [Adult Vaccine Access Coalition website](#), [Immunize.org website](#).

Contact information:

- Brent Ewig, *Chief of Policy and Government Relations*, Association of Immunization Managers
bewig@immunizationmanagers.org, (301) 424-6080

Last revised: March 25, 2024. Data citations available upon request.



Organization name: Association of Maternal & Child Health Programs

Topic area: Maternal and Child Health

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: Chronic Disease Prevention and Health Promotion, Safe Motherhood

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Safe Motherhood and Infant Health	\$108,000,000	\$110,500,000	\$118,000,000	\$164,000,000

Funding recommendation: Appropriate \$164,000,000 which is a \$53,500,000 increase for CDC’s Safe Motherhood program line over FY24 levels.

Justification: \$164M for the Safe Motherhood and Infant Health line in FY25 would enable CDC’s Division of Reproductive Health to strengthen and expand the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program and the National Network of Perinatal Quality Collaboratives from geographically limited programs to national programs. Additionally, increased funding would enable CDC’s Division of Reproductive Health to expand the Hear Her Campaign—a communication campaign to increase awareness of warnings signs that could lead to pregnancy-related death or delivery complications and strengthen patient and provider communication—by funding community-based organizations to implement multi-level maternal mortality prevention efforts built on the data.

Role of the state health agency: ERASE MM funding directly supports state health departments to coordinate and manage their Maternal Mortality Review Committees to identify, review, and characterize pregnancy-related deaths and identify prevention opportunities.

Further, Perinatal Quality Collaboratives (PQCs) are state or multi-state networks of teams working to improve the quality of care for mothers and babies.

State health departments partner with hospitals, providers, nurses, patients, public health, and other stakeholders to identify healthcare processes that need to be improved and provide opportunities for collaborative learning, rapid response data, and quality improvement science support to achieve systems-level change.

How funds are allocated or used: This portfolio of programs at CDC supports a broad range of activities that seek to improve the health of moms and babies and reduce disparities in maternal and infant health outcomes. This includes the ERASE MM program to provide funding, technical assistance, and guidance to state maternal mortality review committees as well as support for PQCs. The Safe Motherhood program also supports CDC’s Hear Her campaign.

Safe Motherhood Highlights:

- Maternal Mortality Review Committees develop comprehensive, data-driven recommendations for the state health department, PQCs, and other healthcare and public health entities to actualize.
- PQCs identify processes within the local healthcare and public health systems that need improvement and find solutions that can be implemented swiftly.
- The Hear Her Campaign increases awareness of warning signs that could lead to pregnancy-related death or delivery complications and strengthens patient and provider communication.

Public health impacts: CDC has made 46 awards, supporting 44 states and two U.S. territories, for the ERASE MM Program.

This work will:

- Facilitate an understanding of the drivers of maternal mortality and complications of pregnancy and help stakeholders better understand the associated disparities.
- Determine which interventions at the patient, provider, facility, system, and community levels will have the most effect.
- Inform the implementation of initiatives in the right places for families and communities who need them most.

Currently, there are 36 states with CDC-funded PQCs out of 50 total programs. PQCs have contributed to the following changes:

- Reduced preterm births.
- Reduced severe pregnancy complications associated with high blood pressure and hemorrhage.
- Reduced cesarean births among low-risk pregnant women.
- Improved screening and treatment for mothers with substance use disorder (including opioids) and affected newborns.
- Improved outcomes by implementing initiatives to address birth equity and improve respectful care.
- Improved connections between clinical and community settings to address nonmedical factors that influence health outcomes.

For more information: [CDC's PQC web page](#) and [CDC's ERASE MM web page](#).

Contact information:

- Sherie Lou Santos, *Chief of Policy and Government Affairs*, Association of Maternal & Child Health Programs
ssantos@amchp.org, (202) 964-2411

Last revised: March 25, 2024

Organization name: Association of Maternal & Child Health Programs

Topic area: Maternal and Child Health

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: National Center on Birth Defects and Developmental Disabilities, Surveillance for Emerging Threats to Mothers and Babies Network

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Safe Motherhood and Infant Health	\$108,000,000	\$110,500,000	\$118,000,000	\$164,000,000

Funding recommendation: Appropriate \$100,000,000—a \$77,000,000 increase over FY23 enacted levels—for the Surveillance for Emerging Threats to Moms and Babies Network (SET-NET) program.

Justification: With \$100 million in FY25, the Surveillance for Emerging Threats to Moms and Babies Network (SET-NET) could expand to support up to 64 state, local, and territorial health departments as they collect, analyze, and report data on additional existing and emerging infectious disease threats to pregnant individuals and their babies and broaden the scope of the program. A truly national SET-NET would increase the racial, ethnic, geographic, and socioeconomic diversity of data available regarding how exposures during pregnancy impact to women, infants, and children. With additional resources, SET-NET could also support academic institutions and clinical networks to conduct mother-baby longitudinal cohort studies to examine the risks, benefits, and adoption of prevention and treatment strategies for specific health threats. Investing in this sustainable framework for rapid, evidence-based data collection will ensure that the United States is prepared to monitor and address the unique health impacts on pregnant individuals and infants during public health emergencies.

Role of the state health agency: The success of SET-NET depends on the collaboration of state, tribal, local, and territorial health departments. These health departments participate in the following ways:

- Identifying pregnant people with an infection during pregnancy and their babies.
- Collecting, analyzing, and reporting information about pregnant people and infants.
- Working with CDC to determine the best methods for collecting and sharing data.

SET-NET Highlights:

- Findings from SET-NET help families, healthcare providers, public health professionals, and policymakers take action to save lives, reduce risk, and improve the health of pregnant individuals and infants.
- A national SET-NET would increase the racial, ethnic, geographic, and socioeconomic diversity of data available regarding how exposures during pregnancy impact women, infants, and children.
- Investing in this sustainable framework for rapid, evidence-based data collection will ensure that the United States is prepared to monitor and address the unique health impacts on pregnant individuals and infants during public health emergencies.

Currently, SET-NET provides support to 29 state, local, and territorial health departments to monitor how pregnant individuals and their babies are impacted by exposure to Zika, syphilis, hepatitis C, COVID-19, mpox, and congenital cytomegalovirus.

How funds are allocated or used: SET-NET collects health information for people exposed to a health threat during pregnancy and their infants over time to understand the effects of emerging and reemerging threats on mother-baby dyads. These data are then used to inform clinical decision-making and public health action.

Public health impacts: SET-NET data is used to:

- Monitor and improve the health of pregnant people and infants.
- Link families to medical and social services to get recommended care.
- Strengthen laboratory and clinical testing to find emerging health threats quickly.
- Ensure public health is ready and prepared to meet the needs of pregnant people and infants during emergencies.

Background information: SET-NET is an innovative data collection system that links maternal exposures during pregnancy to health outcomes for babies. Building on a mom-baby linked data collection approach developed in response to the Zika outbreak, SET-NET leverages existing data sources to enable CDC and health departments to detect the impact of new and emerging health threats on pregnant individuals and their babies.

Supporting organizations: A total of 81 organizations signed onto [this letter](#) in support of the Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) at CDC.

For more information: [Association of Maternal & Child Health Programs website](#) and [CDC's SET-NET web page](#).

Contact information:

- Sherie Lou Santos, *Chief of Policy and Government Affairs*, Association of Maternal & Child Health Programs
ssantos@amchp.org, (202) 964–2411

Last revised: March 25, 2024



Organization name: NASTAD

Topic area: HIV and Hepatitis Programs

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Centers for Disease Control and Prevention

Program, office, or center: Viral Hepatitis Programs

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Viral Hepatitis Prevention	\$43,000,000	\$43,000,000	\$43,000,000	\$150,000,000

Funding recommendation: Appropriate \$150 million, which is a \$107 million increase, for the Viral Hepatitis Prevention program in CDC’s Division of Viral Hepatitis.

Justification: Currently, 59 jurisdictions receive funding for hepatitis prevention and surveillance. The nation is committed to eliminating the public health threat of viral hepatitis by 2030, as laid out in the HHS Viral Hepatitis National Strategic Plan.

Despite these commitments, CDC’s viral hepatitis program has been underfunded for decades, and recent increases in the number of new hepatitis B (HBV) and hepatitis C (HCV) cases driven by injection drug use, as well as the workforce strains caused by the COVID-19 pandemic, place a new urgency for increasing funding to viral hepatitis prevention programs. According to CDC’s 2021 Viral Hepatitis Surveillance Report, the number of new cases of acute HCV increased by 129% from calendar years 2014 to 2021, with new cases in 2021 significantly exceeding CDC’s targeted cap to set the nation on a path to achieving viral elimination. Available data suggest that up to 70% of new HCV transmissions are attributed to injection drug use and the use of shared injection equipment. Additionally, despite the availability of preventive HBV vaccines, declining rates of HBV prevention have stagnated and are beginning to reverse.

- CDC data show that up to 70% of new HCV infections are attributable to injection drug use and the use of shared injection equipment.
- Health departments need more resources to ensure that the nation is on track to eliminate viral hepatitis by 2030.

Increasing funding would allow CDC’s hepatitis program to:

- Enhance existing, and create new, program and clinical capacity and state and territorial health departments.
- Increase provider education on updated HBV screening and vaccination recommendations.
- Increase viral hepatitis surveillance infrastructure in health departments to detect acute viral hepatitis infections and enhance ability to conduct cluster identification and investigations.
- Increase capacity of health departments to work in coalition with community-based organizations to implement effective primary infectious disease prevention programs and services tailored to impacted communities and persons who use drugs.
- Increase access to, and proper disposal of, sterile injection equipment in areas where health departments and community-based harm reduction programs are authorized to operate.

The COVID-19 pandemic severely impacted hepatitis programs. People living with liver disease are at increased risk for COVID-19 complications, so it is incredibly important that people living with hepatitis are tested and linked to care. Unfortunately, hepatitis programs were strained by the pandemic and saw a significant decrease in their ability to do outreach, education, testing, and linkage services. Hepatitis programs implemented innovative ways to continue hepatitis testing, including integrating hepatitis testing with COVID-19 testing. To scale up these innovations, increased investments must be made at CDC's Division of Viral Hepatitis.

Role of the state health agency: The state health department is the only government funded entity in most states that is focused on hepatitis prevention and elimination and provides the public health infrastructure to fight this epidemic. The state health agency provides education, works to prevent mother to child transmission, addresses hepatitis A outbreaks, coordinates surveillance efforts, and coordinates testing and linkage to care for people living with HBV or HCV.

How funds are allocated or used: Currently, 58 jurisdictions receive funding for hepatitis prevention to increase the number of persons living with undiagnosed hepatitis A, HBV, and/or HCV who are tested for these infections, made aware of their infection, and linked to recommended care and treatment services.

Public health impacts: CDC estimates that up to 5.8 million people live with HBV and/or HCV in the U.S. As many as 75% are unaware of their infection. CDC also estimates that there are more HCV-related deaths annually than deaths from all other nationally notifiable infectious diseases combined. Hepatitis disproportionately impacts several communities, particularly people who inject drugs, African Americans, Asian Americans, Latinos, Native Americans, gay, bisexual, and other men who have sex with men, residents of rural and remote areas, and people living with HIV. While people born between 1945 and 1965 represent the group with the highest HCV-related morbidity and mortality, there has been a rise in HCV transmission among young people throughout the country. Some jurisdictions have noted that the number of people ages 15 to 29 being diagnosed with HCV now exceeds the number of people diagnosed in all other age groups combined, which is typically attributed to injection drug use.

Supporting organizations: The Hepatitis Appropriations Partnership and the AIDS Budget and Appropriations Coalition support this ask.

For more information: [NASTAD website](#)

Contact information:

- Emily Schreiber, *Senior Director*, Policy & Legislative Affairs
eschreiber@NASTAD.org, (202) 897-0078

See updates to this paper at: [NASTAD's Policy & Legislative Affairs web page.](#)

Last revised: March 25, 2024



National Coalition of STD Directors

Organization name: National Coalition of STD Directors

Topic area: Sexually Transmitted Infections Clinical Services

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Health Resources and Services Administration

Program, office, or center: Bureau of Primary Health Care

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Bureau of Primary Health Care	N/A	N/A	N/A	\$200,000,000

Funding recommendation: Appropriate \$200,000,000 for a new program at the Health Resources and Services Administration (HRSA) to provide the first direct federal support for sexually transmitted infection (STI) clinics.

Bill report language: STI Clinical Services—The Committee has included, within the Bureau of Primary Health Care, \$200,000,000 for demonstration projects to support grants and contracts to public and private nonprofit STI clinics. Funds are to be used to address staffing, training, and clinical services and expand capacity to address shortages in STI clinical services.

Bill Language: Provided, that \$200,000,000 to remain available until expended, shall be to carry out a program to award grants to public and private nonprofit sexually transmitted disease clinics for clinical services, pursuant to demonstration project authority under section 318(b)(2) of the Public Health Service Act (42 U.S.C. 247c(b)(2)).

- In 2022, lack of timely testing and adequate treatment contributed to almost 90% of congenital syphilis cases in the U.S.
- Congenital syphilis rates have increased 937% in the last decade.
- In 2022, the U.S. reported more than 2.5 million cases of syphilis, gonorrhea, and chlamydia.

Justification: As STI rates continue to rise, neither private nor public healthcare systems have effectively addressed these epidemics. STIs represent a growing public health concern, especially as the mpox outbreak stretched thin existing infectious disease resources and revealed the syndemic risk of STIs alongside HIV and mpox. In 2022, America’s STI clinics were simultaneously our first and last line of defense for community responses to mpox; STI clinics diverted resources to ensure people could be tested, treated, and vaccinated for mpox and saw their capacity decimated by the pressure of the outbreak. However, in the midst of a public health emergency, these clinics received no federal funding support due to the lack of an existing funding infrastructure. America needs a dedicated funding stream for public and nonprofit STI clinics so that we can take a consistent and national public health approach to the treatment of STIs and other emerging infectious diseases.

Role of the state health agency: By applying HRSA’s safety net clinical service expertise to the out-of-control STI epidemics, this program would directly complement the surveillance and prevention work being done by CDC-funded state STD programs by injecting much-needed investments into their jurisdictions via a currently under-resourced vehicle: STI clinics. Additionally, state health agencies with public clinics would be eligible to apply for funding under this new project.

How funds are allocated or used: The HRSA demonstration project would provide a dedicated federal funding stream (\$600,000,000 over three years) for STI clinical services to ensure providers are fully equipped to provide comprehensive STI testing and treatment in their communities. The project would also include a rigorous evaluation to determine outcomes.

The project would be administered by HRSA's Bureau of Primary Health Care. Funds would be distributed in accordance with a funding formula devised to advance the STI National Strategic Plan, with allocations to clinical providers based on morbidity and services, and awarded by a competitive application process. Public health clinics or private nonprofit clinics that have demonstrated the ability to provide sexual health services to target populations would be eligible to apply for funding. Clinics would need to demonstrate the ability to provide key STI clinical services or develop the capacity to do so within six months of receipt of funds. In order to sustain and expand this investment, clinics would need to have the ability to bill public and/or private insurance or develop the ability to do so also within six months of receiving funds.

Public health impacts: It is time for a new investment that treats STIs within a public health framework. STIs are a growing threat to our nation's health. Chlamydia, gonorrhea, and syphilis infections breached 2.5 million reported cases in 2022. STIs can have life-changing and life-threatening consequences, including infertility, cancer, ectopic pregnancy, and pelvic inflammatory disease. Increasing cases of syphilis in newborns (congenital syphilis) are particularly worrisome; cases of congenital syphilis have increased 937% in the last decade. Treatment is prevention for these bacterial infections, and creating a federal funding stream to support STI clinical services across the country is a crucial component of reversing these epidemics.

Background information: Our nation's safety net clinical services are funded through HRSA, the clinical service expert in HHS. This makes HRSA the obvious choice to run this first-ever dedicated federal STI clinical funding stream and provide an opportunity to further integrate STI clinical services into the activities of HRSA.

For more information: [National Coalition of STD Directors website.](#)

Contact information:

- Rachel Deitch, *Director of Federal Policy*, National Coalition of STD Directors
rdeitch@ncsddc.org, (202) 990-5838

Last revised: Feb. 9, 2024



Organization name: Association of Maternal & Child Health Programs

Topic area: Maternal and Child Health

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Health Resources Services Administration

Program, office, or center: Maternal and Child Health Bureau, Title V MCH Block Grant

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Maternal and Child Health Services Block Grant	\$815,700,000	\$813,700,000	\$831,714,000	\$1,000,000,000

Funding recommendation: Appropriate \$1,000,000,000, which is a \$186,300,000 increase over FY24 enacted levels for the Maternal and Child Health Block Grant.

Justification: According to CDC, approximately 700 pregnancy-related deaths occur in the U.S. each year, and more than 80% of these deaths are preventable. Further, CDC recently released provisional data indicating that the total infant mortality rate in the U.S. has increased by 3% from 2021-2022, and additional data from CDC and the National Center for Health Statistics show a marked increase in maternal deaths due to the pandemic.

The Maternal and Child Health Services Block Grant (MCH Block Grant) is the only federal program of its kind devoted solely to improving the health of all women and children. The flexible nature of the MCH Block Grant makes it an invaluable resource for states to use to address the most pressing needs of MCH populations, including addressing our rising maternal and infant mortality rates, while maintaining high levels of accountability and utilizing evidence-based strategies.

Role of the state health agency: State maternal and child health agencies, usually located within a state health department, apply annually for Title V funding. States conduct needs assessments every five years and then use those findings to implement programs aimed at addressing critical needs for the maternal and child health populations in their states, including for children and youth with special healthcare needs.

How funds are allocated or used: Title V funds are distributed to state and territorial maternal and child health agencies in 59 states and jurisdictions by formula, which considers the proportion of low-income children in each state. States and jurisdictions must match every \$4 of federal Title V money that they receive with at least \$3 of state and/or local money.

The Maternal and Child Health Services Block Grant:

- Builds local and community-based workforce capacity to address cultural awareness, racism, and implicit bias.
- Promotes access to high quality, family-centered healthcare for all children, including those with special healthcare needs.
- Broadens the inclusivity of state and local maternal and child health data collection.
- Addresses social determinants of health to improve pregnancy, birth, and infant health outcomes.
- Reduces racial and ethnic disparities in maternal, child, and infant mortality rates.

Public health impacts: In FY 2022, approximately 93% of pregnant women, 99% of infants, and 61% of children nationally benefitted from a Title V-supported service, translating to improvements in areas such as reducing infant mortality, reducing smoking during pregnancy, and increasing rates of preventive dental visits for children.

Through this program, states are working to reduce infant mortality and maternal mortality; promote preventive services; help individuals access appropriate healthcare; improve state systems of care; provide wraparound supports, medical homes, and family-centered, community-based systems of care for children and youth with special healthcare needs; and more. It is a cost-effective, accountable, and flexible funding source used to address the most critical, pressing, and unique needs of maternal and child health populations in each state, territory, and jurisdiction. In recent years, the MCH Block Grant has also proven to be an effective means of responding to maternal and child health needs during public health crises, including the COVID-19 pandemic, the opioid epidemic, and the Zika virus outbreak.

Background Information: Another key component of the MCH Block Grant is the Special Projects of Regional and National Significance (SPRANS) program. SPRANS funding complements and helps ensure the success of state Title V, Medicaid, and CHIP programs by driving innovation and building capacity to create integrated systems of care for mothers and children. Examples of innovative projects funded through SPRANS include guidelines for child health supervision from infancy through adolescence (i.e., Bright Futures), nutrition care during pregnancy and lactation, recommended standards for prenatal care, successful strategies for the prevention of childhood injuries, health safety standards for out-of-home childcare facilities, and maternal health innovation grants to reduce maternal mortality and morbidity.

Supporting organizations: A total of 98 organizations signed onto [this letter](#) in support of Title V funding, including the Association of State and Territorial Health Officials, the Association of Public Health Laboratories, NASTAD, and the Safe States Alliance.

For more information: [Association of Maternal & Child Health Programs website](#), [Title V Maternal and Child Health Services Block Grant web page](#).

Contact information:

- Sherie Lou Santos, *Chief of Policy and Government Affairs*, Association of Maternal & Child Health Programs
ssantos@amchp.org, (202) 964-2411

Last revised: March 25, 2024



Organization name: NASTAD

Topic area: HIV and Hepatitis Programs

Name of appropriations bill: Labor, Health and Human Services, Education, and Related Agencies

Agency: Health Resources and Services Administration

Program, office, or center: Ryan White Part B

Program	FY23 Enacted	FY24 Enacted	FY25 President's Request	FY25 Recommendation
Ryan White Part B	\$1,013,712,000	\$1,013,712,000	\$1,013,712,000	\$1,417,000,000

Funding recommendation: Appropriate \$1,488,300,000, which is a \$123.4 million increase for the Ryan White HIV/AIDS program Part B, inclusive of the AIDS Drug Assistance Program (ADAP).

Justification: The Ryan White HIV/AIDS Program Part B (RWHAP) funds all 50 states, Washington, D.C., Puerto Rico, Guam, the U.S. Virgin Islands, and the five other U.S. territories and freely-associated states to provide care, treatment, and support services for low-income uninsured and underinsured people living with HIV (PLWH). With these funds, states and territories provide access to HIV clinicians, lifesaving and life-extending therapies, and a full range of vital coverage completion services to ensure adherence to complex treatment regimens. The state ADAPs provide medications to low-income PLWH who have limited or no coverage from private insurance, Medicare, and/or Medicaid.

- RWHAP serves more than 562,000 people—over half of PLWH in the United States who have been diagnosed.
- In 2022, 89.6% of Ryan White Program clients had reached viral suppression. This figure exceeds the national viral suppression rate of 66% among persons with diagnosed HIV.

RWHAP was severely impacted by the COVID-19 and mpox pandemics. During this time, programs worked to quickly innovate services, including investing in telehealth provider capacity to alter service delivery procedures and performing COVID-19/mpox immunization outreach. A majority of RWHAP ADAP/Part B Programs saw an increased demand for emergency financial assistance for housing and food and saw an increased demand for RWHAP medical services.

Launched in 2019, Ending the HIV Epidemic: A Plan for America (EHE) intends to reduce new HIV transmissions by 75% by 2025, and by 90% by 2030 by focusing on increasing diagnosis, access to care, access to biomedical prevention modalities, and rapid response to clusters and outbreaks. To achieve this goal, state health agencies will need additional funding.

State health agencies provide both core medical and supportive services to PLWH. By the Health Resource and Services Administration definition, “Core medical services include outpatient and ambulatory health services, AIDS Drug Assistance Program, AIDS pharmaceutical assistance, oral healthcare, early intervention services, health insurance premium and cost-sharing assistance, home healthcare, medical nutrition therapy, hospice services, home and community-based health services, mental health services, outpatient substance abuse care, and medical case management, including treatment-adherence services. Support services must be linked to medical outcomes and may include outreach, medical transportation, linguistic services, respite care for caregivers of people with HIV/AIDS, referrals for healthcare and other support services, non-medical case management, and residential substance abuse treatment services. Grant recipients are required to spend at least 75% of their Part B grant funds on core medical services and no more than 25% on support services.”

How funds are allocated or used: All 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the other five U.S. territories and freely associated states are eligible for Part B funding. Within the Part B award there is a base grant for core medical and support services, ADAP award, the ADAP supplemental award, and the Part B supplemental award for recipients with demonstrated need.

Public health impacts: RWHAP serves more than 562,000 people—over half of the PLWH in the United States who have been diagnosed. RWHAP is crucial to meet the healthcare needs of PLWH and improve health outcomes. Part B of the Ryan White Program funds state health departments to provide care, treatment, and support services and ADAPs for low-income uninsured and underinsured individuals living with HIV. Sustained funding for RWHAP is integral to meeting the nation’s goals and to ending the HIV epidemic. There is conclusive scientific evidence that a person living with HIV who is on antiretroviral therapy and is durably virally suppressed (defined as having a consistent viral load of less than <200 copies/ml) does not sexually transmit HIV. In 2022, 89.6% of RWHAP clients had reached viral suppression. This figure exceeds the national PLWH viral suppression rate. This demonstrates the unique success of RWHAP in accelerating health outcomes for disproportionately impacted populations. Among the services necessary to improving health outcomes are linkage to, and retention in, care, as well as access to medications that suppress viral loads (and thereby reduce transmission, which leads to fewer new HIV transmissions). Underfunding RWHAP’s system of care will only serve to exacerbate existing structural challenges, such as the disproportionate impact of HIV on communities of color; those in greater poverty; and those without employment, educational opportunities, or access to vital prevention, care, and treatment services.

Supporting organizations: The AIDS Budget and Appropriations Coalition supports this ask.

For more information: [NASTAD website](#)

Contact information:

- Emily Schreiber, *Senior Director*, Policy & Legislative Affairs
eschreiber@NASTAD.org, (202) 897–0078

See updates to this paper at: [NASTAD's Policy & Legislative Affairs web page.](#)

Last revised: March 25, 2024



(202) 371-9090



www.astho.org



National Headquarters: 2231 Crystal Dr., #450, Arlington, VA 22202
Regional Office: 855 Emory Point Drive, NE, Suite C-100, Atlanta GA 30329

