



DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2026

**Centers for Disease Control
and Prevention**

***Justification of
Estimates for
Appropriation Committees***

MESSAGE FROM THE POLICY OFFICIAL

At the Centers for Disease Control and Prevention (CDC), our purpose is to protect health, save lives, and strengthen the nation's resilience against health threats. Every day, our teams work tirelessly to anticipate, detect, and respond to health challenges that impact communities across the country.

We are committed to maximizing the impact of every dollar entrusted to our agency. The FY 2026 budget proposal will enable CDC to redouble its efforts on what it does best: prevent, detect, and respond to health threats. This means investing in core capabilities that make this mission possible, including advanced data systems, robust laboratory capacity, scientific expertise, and frontline readiness.

Our FY 2026 budget request includes increased investments to:

- Improve core data and surveillance systems for health threats
- Enhance respiratory threat detection
- Support a new Biothreat Radar program to detect new and emerging threats
- Streamline preparedness and response functions to more effectively respond to threats

Protecting the health of our nation is essential to our future. The FY 2026 President's Budget reforms the CDC to focus the agency on its core mission. The CDC supports infectious disease surveillance, outbreak investigations, preparedness and response, and maintaining the Nation's public health infrastructure. For too long, CDC has grown beyond these core functions, at the detriment of being a trusted voice amongst the American people. Going forward, CDC will be focused on gold standard science and regaining the confidence of the American people. The mission of CDC is too great for continued inefficiencies and failed dangerous public health advice.

The FY 2026 Budget represents a steadfast commitment to ensuring the well-being of every American. With this support, we will strengthen our public health infrastructure, empowering communities to prevent disease, detect threats, and respond to challenges with unmatched speed and precision. This investment will ensure that we remain resilient in the face of any health challenge, securing a healthier and stronger future for all.

Sincerely,



Matthew Buzzelli
Chief of Staff, CDC/ATSDR

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INTRODUCTION AND MISSION

The Centers for Disease Control and Prevention (CDC) is part of the U.S. Department of Health and Human Services and is the Nation's public health protection agency, as well as a critical health security asset.

CDC's mission is to protect America from health, safety, and security threats, both foreign and in the United States. To accomplish our mission, CDC conducts critical science and provides health information that protects our nation against dangerous health threats and responds when these threats arise. In doing so, CDC increases the health security of our nation.

CDC works on the cutting edge of health security by detecting and confronting global disease threats through surveillance, epidemiology, and laboratory analysis of huge amounts of data and specimens to quickly find solutions and respond to public health threats. CDC continues to build the capacities to ensure America is increasingly prepared to respond to future threats, including improvements in data, communications, and the public health workforce that centers on strong, well-resourced public health leaders and capabilities at national, state, and local levels.

As the nation's health protection agency, CDC aims to build a sustainable and resilient public health system that can respond effectively to emerging threats and to ongoing public health needs to keep Americans safe and healthy.

EXECUTIVE SUMMARY

OVERVIEW OF BUDGET REQUEST

The Fiscal Year (FY) 2026 budget request to Congress for the Centers for Disease Control and Prevention (CDC) includes total funding of \$4.243 billion in discretionary budget authority and Public Health Service (PHS) Evaluation funds.

As public health threats grow in scale and complexity, investment in core capabilities is essential for protecting the Nation's health security. The FY 2026 Budget strengthens the capacities that make CDC's work possible: data modernization, laboratory capacity, scientific expertise, and frontline readiness.

It also supports critical partnerships: the majority of CDC's annual funding goes directly to state, tribal, local, and territorial health departments and laboratories.

The FY 2026 Budget supports CDC efforts to prevent, detect, and respond to health threats, including infectious diseases such as Ebola and avian flu, emerging diseases like Oropouche, vector-borne illnesses including Lyme disease, and illnesses resulting from exposure to environmental hazards.

In addition, the Budget enables CDC to prevent disease by reducing the risks that lead to serious infections, especially for those most at risk like older adults and babies. By promoting commonsense health measures and ensuring communities have what they need to stay safe, CDC works to protect Americans' lives.

CDC continuously monitors for emerging health threats using advanced tools, data systems, and global surveillance networks to detect infectious diseases and outbreaks as early as possible. This includes tracking unusual patterns, identifying new viruses, and working with partners at the local, national, and international levels to stay ahead of potential threats to the Nation's health.

When new threats emerge, CDC mobilizes quickly, deploying experts and assistance where it's needed most. Whether confronting a local outbreak or an international health emergency, CDC leads coordinated, science-driven responses that save lives and contain risks. This ability to act swiftly and effectively relies on strong partnerships across federal agencies, state, tribal, local, and territorial health departments and a resilient and well-supported public health infrastructure that ensures readiness when every second matters.

However, many serious public health emergencies involve novel or re-emerging agents for which CDC has limited or no dedicated resources. CDC's current budget structure lacks the flexibility for initiating a response that needs experts and resources from multiple accounts. The Budget includes a new transfer authority that will provide CDC with additional flexibilities during emergencies. The authority will allow the Secretary to transfer amounts within CDC accounts to address emerging diseases and public health emergencies. Similar to the existing Secretary's transfer, the proposed CDC authority will not exceed 2 percent from any discretionary CDC account and will also have a cap on increasing any CDC account by more than 5 percent. This budget flexibility will allow for greater capacity to respond to new or novel threats as soon as they are detected.

Highlights of the FY 2026 Budget:

- To support better detection, this Budget allocates resources to enhanced respiratory threat detection in the Immunization and Respiratory Diseases account and to a new Biothreat Radar program that incorporates progress made in advanced molecular detection to rapidly detect emerging threats.
- To support better response, this Budget incorporates elements of the Administration for Strategic Preparedness and Response with existing response capacity at CDC. The budget also proposes supporting non-biological health response and laboratory capabilities in the CDC-wide account to enable the agency to maintain capacity to address health crises associated with toxins, natural disasters like wildfires, and chemical, radiological, or nuclear disasters.

OVERVIEW OF PERFORMANCE

As the nation's health protection agency, the Centers for Disease Control and Prevention (CDC) works 24/7 to protect America from health, safety and security threats, both foreign and in the United States. To achieve maximum public health impact, CDC conducts research; implements strategic, evidence-based programs; and monitors results through ongoing data collection. Performance in each of these areas and in all of CDC's work is strengthened through the use of rigorous and ongoing performance metrics and program evaluation data to monitor program effectiveness and compare performance to established targets. The accomplishments described below highlight the importance of investing in high quality public health programs, preventing disease, and protecting health.

Rapidly Respond to Emerging Threats

- During the 2023-2024 respiratory season, CDC released a Health Alert Network (HAN) advisory notice on prioritizing supply of nirsevimab for prevention of RSV in infants during a national shortage. CDC increased the supply of nirsevimab over 30% of what was initially planned for the season, by maintaining control over orders and working with the manufacturer and the Food and Drug Administration (FDA). CDC experts informed planning for the 2024-2025 season by sharing CDC vaccine demand projections based on birth rates, distribution of birthweight, and other estimates.
- In March 2024, the U.S. Department of Agriculture (USDA) reported that dairy cattle in Texas had been infected with highly pathogenic avian influenza A (H5N1) which had never been reported in cattle previously. CDC quickly stood up an emergency response to support states to investigate and implement measures to protect the health and safety of people, conducting outbreak investigations in 13 states that had infected dairy cattle herds (as of August 2024).
 - Between March and August 2, 2024, more than 1,750 people with exposures to dairy cattle have been monitored for symptoms, and 70 people have been tested for H5N1.
 - CDC's robust influenza surveillance systems led to state public health laboratories testing over 36,000 specimens between March -August 2024 for Influenza A to look for any H5N1 community cases that may not be detected through direct community-level outbreak investigations.
 - CDC quickly updated guidance for workers, reaching over 7 million people between May and July 2024, through guidance and communications resources and targeted social media and radio outreach to communities with infected herds.
- In 2024, CDC made significant progress towards improving domestic preparedness to detect and contain clade I mpox should it be introduced in the United States. This type of mpox is more deadly than the type that caused a global outbreak in 2022. CDC increased U.S. readiness by: strengthening mpox surveillance, including by conducting genomic analysis of U.S. cases and wastewater testing; expanding clade-specific diagnostic testing capacity across the United States; ensuring appropriate specimen handling and waste management; emphasizing the importance of appropriate medical treatment; and communicating guidance for many prevention strategies, like contact tracing, containment, behavior modification, and vaccination strategies.
- In 2023, CDC, Wyoming (WY) Department of Health, and WY Livestock Board collaborated to investigate an outbreak of leptospirosis, a disease caused by bacteria found in contaminated water or soil, after a 40-year gap in reported human cases. Human and animal public health professionals worked to identify the origin of the outbreak, identify additional cases, and recommend control measures.
- In 2023, CDC provided expertise and field support for the largest recorded blastomycosis outbreak, linked to a Michigan (MI) paper mill. Blastomycosis, a fungal disease that can cause severe illness and death, affected 131 paper mill workers and visitors, with 16 hospitalizations and one death. An investigation involving CDC, the MI Department of Health and Human Services, and other organizations determined the sources and timing of exposure. CDC also supported education and awareness efforts and analyzed clinical features and epidemiology of hospitalized patients.

- In 2024, CDC was instrumental in responding to outbreaks of avian influenza infecting 7 people in 2024 in Vietnam and Cambodia. CDC worked closely with country officials, and in-country partners, to successfully respond to these outbreaks, including sending staff to assist with investigations on the ground, and providing laboratory and communications support from CDC headquarters. These efforts highlight the importance of our strong global partnerships that allow for rapid response and containment of these outbreaks.

Expert Public Health Workforce and Cutting Edge Laboratories

- As of January 2024, CDC's Antimicrobial Resistance (AR) Lab Network has performed more than one million different tests to rapidly detect and respond to AR threats across healthcare, the community, food supply, and the environment. This includes more than 320,000 isolate characterizations; 340,000 colonization screenings; and 480,000 whole genome sequences to identify resistance and control outbreaks as soon as they emerge.
- In 2023, CDC supported the Nebraska (NE) Rabies Laboratory to conduct genetic testing on animals thought to have rabies which uncovered the long-distance spread of a raccoon rabies strain that appeared in a stray kitten found in NE. CDC launched an Epi-Aid and partnered with USDA to support the NE Department of Health and Human Services to establish an enhanced rabies surveillance system. CDC support and rapid response for enhanced surveillance ensured that this variant was eliminated from the area. This response investment of approximately \$200,000 is estimated to have prevented \$1.9M in public health and medical sector costs over the next 5 years.
- CDC successfully characterized the pathology of the first reported fatality of Boreapox virus infection worldwide. CDC's work provided crucial insights into the pathogenesis of the disease and will aid in the development of targeted treatment strategies to mitigate multiorgan viral damage and improve patient outcomes.
- CDC is working to expand laboratory testing capacity for severe and antimicrobial-resistant ringworm infections through the AR Laboratory Network and has sequenced 323 isolates of *Trichophyton indotineae*, a type of fungal ringworm, and related species. The results indicate a recent rapid expansion of a single genetic lineage likely originating in Southeast Asia, with 64% of tested isolates showing elevated resistance to terbinafine, a common antifungal medication.
- In FY 2024, CDC's environmental health laboratory provided dried blood spot quality assurance materials for 640 newborn screening laboratories in 88 countries worldwide to ensure the early and accurate identification of babies born with life-threatening or disabling conditions. Additionally, CDC developed a method to screen for Krabbe disease, a brain disorder that can be fatal if untreated. Screening for this disease was recently added to the Recommended Uniform Screening Panel (RUSP); CDC is poised to support state programs as they incorporate screening for this disease into their newborn screening panels.
- CDC developed a test to detect new Oropouche virus infections - a vector-borne illness that may result in stillbirths and birth defects for infections during pregnancy, in response to a large outbreak of more than 10,000 laboratory-confirmed cases of Oropouche virus in the Americas in 2023-2024. CDC ran this new test on specimens from nearly 100 sick patients who returned from countries with active local transmission of Oropouche virus. The national availability of high-quality clinical diagnostics for emerging infectious diseases like Oropouche virus is important to help clinicians provide the appropriate care and to assist public health officials in preventing further spread of these diseases, as case counts began to rise in Brazil again in November 2024, further threatening the health of U.S. travelers and pregnant travelers in particular.
- In 2024, OneLab VR released two practice scenarios, allowing learners to develop key laboratory skills in a safe, controlled environment. In collaboration with the Association of Public Health Laboratories, CDC has disseminated VR training equipment to more than 40 U.S. clinical and public health laboratories.
- In FY 2023, 409 CDC fellows and trainees were assigned to positions in state, tribal, local, and territorial (STLT) health agencies and 83 unique fellows supported STLT health departments on short-term epi-, lab— or info-aid technical assistance support.

World Class Data and Analytics

- In 2023, CDC established national Immunization Information System (IIS) reporting from jurisdictions and now has 55 data use agreements with jurisdictions resulting in increased reporting on RSV, flu, and COVID vaccinations. Additionally, there are 33 jurisdictions sharing IIS data with other jurisdictions. This data exchange helps STLT health departments and partners have a better understanding of vaccine coverage and the risks for certain diseases in the communities they serve.
- In February 2024, CDC migrated its National Healthcare Safety Network (NHSN) application to the cloud as part of the national data modernization initiative. Migration reduces burden for users and increase efficiency of data use. Over 160,000 NHSN users, partners organizations, CDC staff, and reporting facilities, will have easier access to rapid reporting and analyses with less user burden.
- CDC support to the Texas Department of State Health Services (DSHS) helped successfully revolutionize the state's approach to public health surveillance by implementing electronic case reporting (eCR) which marks a significant advancement in data automation and efficiency. This transition has yielded faster detection of notifiable diseases, improved outbreak management, significant reductions in time spent on administrative tasks, reduction in costs associated with traditional data collection methods, and enhanced data accuracy.
- CDC support to Colorado, helped a local public health agency use wastewater data on influenza to guide vaccination timing in long-term care facilities (LTCFs). Vaccination timing is crucial, especially in vulnerable populations, due to the two-week period required for the vaccine to become fully effective and concerns about the duration of vaccine protection if administered too early. The wastewater data provides an indicator of increasing influenza activity in the community and has enabled local public health officials to advise the LTCF on the optimal time to begin vaccinations for their residents.
- In April 2024, CDC in collaboration with the Council of State and Territorial Epidemiologists (CSTE) made Cronobacter infections in infants less than 12 months of age a new nationally notifiable disease. Cronobacter infections are rare but are often very serious in infants who are younger than 2 months or were born prematurely; they can die. This new reporting requirement for all states, established new standardized case reporting and outbreak investigations through CDC's National Notifiable Diseases Surveillance System.
- In 2024, CDC supported 30 jurisdictions using a new tiered capacity-building approach through the Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) which facilitates high quality population-based data collection through sharing best practices broadly and providing flexibility to activate additional jurisdictions during an emergency response. The sites will be examining 1-3 exposures each, which include hepatitis C, syphilis, cytomegalovirus (cCMV), and newly added dengue.

Other CDC Accomplishments

- CDC provides easily implementable tools and educational resources aimed at increasing routine immunization coverage among children:
 - CDC's *Let's Rise* provided 61 jurisdictions school progress reports with recommendations on how to improve measurement of key data points and increase vaccination rates.
 - CDC shared National Infant Immunization Week and Back to School resources to more than 150,000 partners, including health care and education professionals.
 - CDC's *Keeps it That Way* campaign encourages parents and caregivers to talk to their child's healthcare provider. CDC has leveraged media outlets in 16 jurisdictions to educate about measles. CDC highlighted the importance of vaccination against all vaccine preventable diseases as children head back to school.
- CDC published data suggesting that the STI epidemic may have started to slow in 2023—gonorrhea dropped for a second year, declining 7% from 2022, and overall syphilis increased by only 1% after years of double-digit increases; while these data are encouraging, reportable STIs remain unacceptably high and must continue to be addressed.

- In 2024, CDC published data showing that tuberculosis (TB) programs are making improvements in activities that help identify people with TB disease and latent TB infection. Over a 5-year period (2016 to 2022) CDC found that most CDC funded TB programs (71%) had improvements in reducing overall TB incidence, and over half of TB programs (56%) increased the percentage of contacts diagnosed with latent TB infection who completed treatment.
- CDC supports 18 state and local jurisdictions to improve access to infectious disease and substance use disorder prevention, diagnosis and treatment services in settings serving people who use drugs. In 2023, funded jurisdictions:
 - Served 73,408 participants, an estimated 66% (48,734) of whom were persons who inject drugs.
 - Collaborated with community partners to increase health care access for the hardest-to-reach populations (i.e., carceral settings to facilitate testing and linkage to care for recently released individuals; mobile health units to provide onsite vaccinations).
 - Distributed 50,000,000 sterile syringes to reduce transmission of hepatitis C, HIV, and other bloodborne infectious diseases.
- As of June 2024, nationally accredited health departments serve 90% of the U.S. population. The CDC-supported Public Health Accreditation Board (PHAB) accredits public health departments to strengthen public health infrastructure and transform governmental public health. There are currently 441 accredited health departments—42 state, 6 tribal, and 393 local health departments.
- CDC established a process for institutions to submit applications for access to investigational drugs, reducing time required for institutions to apply from 14 days to 6 hours. This was utilized with tecovirimat (TPOXX) for Mpox and allowed clinicians at over 220 facilities/institutions to provide TPOXX treatment more rapidly to nearly 4,900 patients.

Agency Performance Planning and Management

CDC conducts continuous program improvement through program strategic planning, performance monitoring and accountability, and program evaluation. CDC collects information on program priorities, measurable outcomes, strategies, and progress through annual updates. Additionally, CDC has developed a Performance Improvement Framework to advance a culture of performance improvement and build performance improvement capacity at all levels of the agency. The CDC awards the majority of its budget through grants, cooperative agreements, and contracts to help accomplish its mission. CDC cooperative agreement funding announcements require applicants to specify how they are measuring, monitoring, and evaluating the activities they are implementing and progress toward achieving the intended outcomes.

Agency Use of Evaluation and Evidence

CDC is a data-driven agency and incorporates use of data for decision making and to continuously improve our programs. CDC continues to focus on the development and use of evidence to enhance all aspects of the Agency's mission. CDC is leveraging the Foundations for Evidence-Based Policymaking Act to strengthen program evaluation activities and data use for decision making across the agency. CDC uses a prospective evidence-building approach to innovate, test, evaluate and model strategies to identify those that are most impactful, cost-effective, and feasible for achieving our public health goals. As additional evidence is generated, some of these questions and approaches may shift. By continuously building and assessing the evidence, CDC is better positioned to optimize our impact and strategically drive informed decisions. This prospective generation of key evidence and ongoing data evaluation is critical for data-driven policymaking.

Alignment to Administration Priorities and Initiatives

CDC is committed to supporting the national priorities set by the Administration. CDC leads key activities for 2 measures in the FY 2026 HHS performance plan. These include:

- strengthening public health surveillance, epidemiology, and laboratory capacity
- mitigating and preventing infectious diseases

ALL PURPOSE TABLE

(dollars in thousands)	FY 2024 Final ¹	FY 2025 Enacted ¹	FY 2026 President's Budget ^{2,3}	FY 2026 +/- FY 2025
Immunization and Respiratory Diseases³	<u>\$919,291</u>	<u>\$919,291</u>	<u>\$963,291</u>	<u>\$44,000</u>
Budget Authority	\$237,358	\$237,358	\$963,291	\$725,933
ACA/PPHF	\$681,933	\$681,933	\$0	-\$681,933
Viral Hepatitis, STI and TB Prevention	<u>\$377,344</u>	<u>*</u>	<u>\$300,000</u>	<u>*</u>
Emerging and Zoonotic Infectious Diseases^{3,4}	<u>\$812,272</u>	<u>\$812,272</u>	<u>\$870,486</u>	<u>\$58,214</u>
Budget Authority	\$760,272	\$760,272	\$870,486	\$110,214
ACA/PPHF	\$52,000	\$52,000	\$0	-\$52,000
Public Health Scientific Services	<u>\$567,100</u>	<u>\$567,100</u>	<u>\$596,600</u>	<u>\$29,500</u>
Budget Authority	\$567,100	\$567,100	\$496,600	-\$70,500
PHS Eval	\$0	\$0	\$100,000	\$100,000
Global Health^{4,5}	<u>\$370,643</u>	<u>*</u>	<u>\$0</u>	<u>*</u>
Public Health Preparedness and Response	<u>\$1,292,399</u>	<u>\$1,292,399</u>	<u>\$587,678</u>	<u>-\$704,721</u>
Cross-Cutting Activities and Program Support^{3,5,6}	<u>\$1,099,520</u>	<u>\$1,099,520</u>	<u>\$884,520</u>	<u>-\$215,000</u>
Budget Authority	\$939,520	\$939,520	\$779,520	-\$160,000
ACA/PPHF	\$160,000	\$160,000	\$0	-\$160,000
PHS Eval	\$0	\$0	\$105,000	\$105,000
Buildings and Facilities	<u>\$40,000</u>	<u>\$40,000</u>	<u>\$40,000</u>	<u>\$0</u>
Total CDC - Budget Authority	<u>\$4,584,636</u>	<u>\$4,584,636</u>	<u>\$4,037,575</u>	<u>-\$547,061</u>
Total CDC - BA & PHS Evaluation Transfer	<u>\$4,584,636</u>	<u>\$4,584,636</u>	<u>\$4,242,575</u>	<u>-\$342,061</u>
CDC Program Level - BA, PPHF, & PHS Eval¹	<u>\$5,478,569</u>	<u>\$5,478,569</u>	<u>\$4,242,575</u>	<u>-\$1,235,994</u>
Agency for Toxic Substances and Disease Registry	\$81,619	\$81,619	\$78,000	-\$3,619
Prevention and Public Health Fund (PPHF)	\$893,933	\$893,933	\$0	-\$893,933
Transfer ³	\$0	\$0	\$205,000	\$205,000
PHS Evaluation Transfer	\$0	\$0	\$205,000	\$205,000
Total CDC/ATSDR	<u>\$5,560,188</u>	<u>\$5,560,188</u>	<u>\$4,320,575</u>	<u>-\$1,239,613</u>

¹ In alignment with the proposed HHS reorganization, FY 2024 and FY 2025 totals are comparably adjusted.

² In alignment with the proposed HHS reorganization, the FY 2026 Budget reorganizes all or some of the funding to the Administration for a Healthy America (AHA) from the following CDC Accounts: 1) HIV/AIDS, Viral Hepatitis, STI and TB Prevention; 2) Birth Defects, Developmental Disabilities, Disability and Health; 3) Environmental Health, 4) Injury Prevention and Control and 5) Occupational Safety and Health. The FY 2026 Budget is displayed comparably.

³ The 2026 Budget eliminates funding from the Prevention and Public Health Fund (PPHF).

⁴ FY 2024 Final and FY 2025 Enacted are comparably adjusted to reflect the proposed realignment of the following lines into *Emerging Infectious Diseases: Surveillance for Emerging Threats to Mothers and Babies* and *Parasitic Diseases and Malaria*.

⁵ FY 2024 Final and FY 2025 Enacted are comparably adjusted to reflect the proposed realignment of *Global Public Health Protection* from the Global account to the Cross-Cutting Activities and Program Support account.

⁶ FY 2024 Final and FY 2025 Enacted Account totals are comparably adjusted to reflect the proposed realignment of *Environmental Health Laboratory* and *Environmental Health Activities* to the Cross-Cutting Activities and Program Support Account.

BUDGET EXHIBITS

SUMMARY OF CHANGES

		Dollars	FTEs ¹
FY 2025 Enacted (Program Level) ²		\$5,478,569	9,754
FY 2026 President's Budget (Program Level) ^{3,4}		\$4,242,575	7,249
Net Change		(\$1,235,994)	(2,506)

(dollars in thousands)	FY 2025 FTE	FY 2025 Enacted	FTE Change	FY 2026 +/- FY 2025
Increases:				
Immunization and Respiratory Diseases				
Account Level	---	\$919,291	---	\$44,000
Emerging and Zoonotic Infectious Diseases⁵				
Account Level	---	\$812,272	---	\$58,214
Public Health Scientific Services				
Account Level	---	\$567,100	---	\$29,500
All Other Increases		\$0		\$0
Total Increases	N/A	\$2,298,663	N/A	\$131,714
Decreases:				
Public Health Preparedness				
Account Level	---	\$1,292,399	---	(\$704,721)
Cross-Cutting Activities and Program Support⁶				
Account Level	---	\$1,099,520	---	(\$215,000)
All Other Decreases		\$0		\$0
Total Decreases	N/A	\$2,391,919		(\$919,721)
Transfers				
	---	\$0	---	\$0
Built-In:				
1. Annualization of 2025 Pay Raise	---	---	---	\$0
2. FY 2026 Pay Increases	---	---	---	\$0
3. Infrastructure	---	---	---	\$0
Total Built-In		\$0	---	\$0
Absorption of Current Services				\$0
Total				\$0
Total Increases (Program Level)		\$2,298,663		\$131,714
Total Decreases (Program Level)		\$2,391,919		(\$919,721)
NET CHANGE - L/HHS/ED Program Level	9,754	\$5,478,569	(2,506)	(\$788,007)
Other Program Level Changes				
	---	\$0	---	\$0
Total - Other Program Level Net Increase	9,754	\$0	(2,506)	\$0
NET CHANGE: CDC BUDGET AUTHORITY & PROGRAM LEVEL	9,754	\$5,478,569	(2,506)	(\$788,007)

¹ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.² In alignment with the proposed HHS reorganization, FY 2025 Enacted is comparably adjusted.³ In alignment with the proposed HHS reorganization, the FY 2026 Budget reorganizes all or some of the funding to the Administration for a Healthy America (AHA) from the following CDC Accounts: 1) HIV/AIDS, Viral Hepatitis, STI and TB Prevention; 2) Birth Defects, Developmental Disabilities, Disability and Health; 3) Environmental Health; 4) Injury Prevention and Control and 5) Occupational Safety and Health. The FY 2026 Budget is displayed comparably.⁴ The 2026 Budget eliminates funding from the Prevention and Public Health Fund (PPHF).⁵ FY 2025 Enacted is comparably adjusted to reflect the proposed realignment of *Surveillance for Emerging Threats to Mothers and Babies* and *Parasitic Diseases and Malaria* into *Emerging Infectious Diseases* within the Emerging and Zoonotic Infectious Diseases account.⁶ FY 2025 Enacted reflects two proposed budget structure realignments to the Cross-Cutting Activities and Program Support Account – 1) *Global Public Health Protection* from the Global Health account and 2) *Environmental Health Laboratory* and *Environmental Health Threats Prevention* from the Environmental Health account.

APPROPRIATIONS HISTORY TABLE^{1,2}

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2016 Budget Authority	6,095,803,000	6,095,803,000	5,747,306,000	6,270,745,000
2016 Public Health Prevention Fund	914,300,000	914,300,000	892,950,000	892,300,000
2017 Budget Authority ³	5,967,376,000	6,875,144,000	6,153,448,000	6,293,503,000
2017 Public Health Prevention Fund	944,470,000	908,300,000	891,300,000	891,300,000
2018 Budget Authority	4,991,675,000	6,010,153,000	6,318,953,000	--
2018 Public Health Prevention Fund	840,600,000	840,600,000	800,900,000	--
2018 Disaster Relief Supplement (PL 115-123)	--	--	--	200,000,000
2019 Budget Authority	5,524,935,000	6,781,908,000	7,004,483,000	6,477,883,000
2019 Public Health Prevention Fund	--	848,000,000	808,300,000	804,500,000
2019 Disaster Relief Supplement (PL 116-20)	--	--	--	20,000,000
2020 Budget Authority	5,214,882,000	7,177,725,000	6,608,665,000	6,839,946,000
2020 Public Health Prevention Fund	891,100,000	854,250,000	854,250,000	854,250,000
2021 Budget Authority	5,565,318,000	7,100,396,000	6,908,446,000	6,963,296,000
2021 Public Health Prevention Fund	893,950,000	856,150,000	856,150,000	856,150,000
2022 Budget Authority	8,454,861,000	9,625,761,000	8,636,611,000	7,498,546,000
2022 Public Health Prevention Fund	903,300,000	903,300,000	903,300,000	903,300,000
2023 Budget Authority	9,620,961,000	9,540,696,000	9,542,171,000	8,258,932,000
2023 Public Health Prevention Fund	903,300,000	903,300,000	903,300,000	903,300,000
2023 Disaster Relief Supplement (PL 117-328)	--	--	--	86,000,000
2024 Budget Authority ⁴	10,217,311,000	6,350,008,000	7,711,702,000	7,980,532,000
2024 Public Health Prevention Fund	1,186,200,000	1,186,200,000	1,186,200,000	1,186,200,000
2025 Budget Authority ⁴	8,397,132,000	6,204,500,000	8,043,499,000	7,980,532,000
2025 Public Health Prevention Fund	1,186,200,000	1,186,200,000	1,186,200,000	1,186,200,000
2026 Budget Authority	4,037,575,000	--	--	--
2026 Public Health Prevention Fund ⁵	0	--	--	--

¹ Does not include funding for ATSDR. Reflects totals as enacted, does not reflect comparability adjustments to reflect proposed HHS reorganization.

² The Prevention and Public Health Fund (PPHF) amounts reflect CDC's request and final amount allotted from the PPHF to CDC from HHS.

³ FY 2017 Appropriation includes funding for Flint, Michigan response, which includes \$15 million for Lead Poisoning Prevention and \$20 million for a Lead Exposure Registry and Advisory Council.

⁴ FY 2024 and FY 2025 Appropriation includes \$43 million in funding from PHS Evaluation Transfer.

⁵ The 2026 Budget eliminates funding from the Prevention and Public Health Fund (PPHF).

NARRATIVE BY ACTIVITY

IMMUNIZATION AND RESPIRATORY DISEASES

(dollars in millions)	FY 2024 Final	FY 2025 Enacted ¹	FY 2026 President's Budget	FY 2026 +/- FY 2025
Budget Authority	\$237.358	\$237.358	\$963.291	+\$725.933
Prevention and Public Health Fund (PPHF) Transfer ²	\$681.933	\$681.933	\$0.000	-\$681.933
Total Request	\$919.291	\$919.291	\$963.291	+\$44.000
FTEs ³	1,125	1,073	1,072	-1
-- Immunization and Other Respiratory Diseases	<u>\$681.933</u>	<u>\$681.933</u>	<u>\$731.933</u>	<u>+\$50.000</u>
-- Immunization Program	\$0.000	\$0.000	\$731.933	+\$731.933
-- <i>Immunization Program (PPHF)</i>	<i>\$681.933</i>	<i>\$681.933</i>	<i>\$0.000</i>	<i>-\$681.933</i>
-- Acute Flaccid Myelitis	\$6.000	*	\$0.000	*
-- Influenza Planning and Response	\$231.358	*	\$231.358	*

¹ Consistent with the FY 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for FY 2025 and is rolled up within the account.

² The FY 2026 Budget eliminates funding from the Prevention and Public Health Fund (PPHF).

³ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Allocation Methods: Direct Federal/Intramural; Competitive Cooperative Agreements/Grants, including Formula Grants; Contracts; and Other

CDC's FY 2026 budget request of **\$963,291,000** for Immunization and Respiratory Diseases is **\$44,000,000** above the FY 2025 enacted level. This increase is necessary to keep the nation prepared for the next public health threat and will enhance cross-CDC investments in the proposed Biothreat Radar Detection System.

The increase will strengthen the nation's early warning detection and response system for routine respiratory and other vaccine preventable disease threats which can easily overwhelm our healthcare systems, including influenza, Respiratory Syncytial Virus (RSV), or novel respiratory viruses. This includes scaling up our public health workforce, strengthening our disease data collection systems, and enhancing our laboratory networks, such as supporting the use of advanced technologies to detect new or emerging biothreats like H5N1, polio, and Middle East respiratory syndrome (MERS). This investment will allow CDC to: (1) support the use of advanced technologies and data analytics to track and detect changes in circulating pathogens, (2) characterize pathogens to know what is driving epidemics of disease, and (3) develop and monitor disease prevention and mitigation strategies including, vaccines, therapeutics, non-pharmaceutical interventions, and behavioral mitigation strategies, as part of comprehensive control approaches. This increase will be implemented in partnership with key public health partners, including state, local, and non-governmental partners.

IMMUNIZATION AND RESPIRATORY DISEASES

BY THE NUMBERS

- **16** – Diseases prevented by vaccination during the first 24 months of life. **99%** of children received some vaccinations by age 24 months.
- CDC estimates that vaccination of children born between 1994 and 2023:
 - Prevented 508 million illnesses.
 - Prevented 31.9 million hospitalizations.
 - Prevented 1,129,000 deaths from infectious disease.
 - Saved \$540 billion in direct costs and \$2.7 trillion in total societal costs.
- CDC estimates that for the 2023-2024 influenza season, influenza vaccination:
 - Prevented more than 9 million influenza illnesses.
 - Prevented 4.7 million influenza-associated medical visits.
 - Prevented 118,786 influenza-associated hospitalizations.
 - Prevented 7,905 deaths.

Approximately 107,000 hospital stays and nearly 7,000 deaths prevented with the 2023-2024 COVID-19 vaccine

- **Over 180,000** – Influenza specimens tested nationally at U.S. public health laboratories in one year as part of the U.S. avian influenza A(H5) outbreak response.
- **329,000** – Hours of continuing education credits completed by healthcare professionals nationwide related to CDC immunization programming.
- **3,500** – Questions for CDC from clinicians and the public concerning vaccines, almost all of which were responded to within 24 hours.
- **80 to 90 percent**—The estimated real-world effectiveness of nirsevimab in preventing babies from being hospitalized for RSV.
- **80 percent** – The reduction in hospitalization risk for adults aged 60 and older who got the RSV vaccine.
- **8**— Number of seconds that CDC machine learning takes to identify cooling towers during Legionnaires' disease outbreaks in a 0.25-mile area.
- **\$11,600,000,000** – Estimated net societal savings after 10 years of using a pneumococcal conjugate vaccine for children that protects against more types of *Streptococcus pneumoniae* bacteria - which can cause pneumonia - compared to a similar vaccine that protected against fewer types of *S. pneumoniae* bacteria.

NOTE: Unless otherwise noted, all information and calculations are from CDC program data.

Immunization and Respiratory Diseases Funding History¹	
Fiscal Year	Dollars (in Millions)
FY 2022 Final (BA)	\$448.805
FY 2022 Final (PPHF)	\$419.350
FY 2023 Final (BA)	\$499.941
FY 2023 Final (PPHF)	\$419.350
FY 2024 Final (BA)	\$237.358
FY 2024 Final (PPHF)	\$681.933
FY 2025 Enacted (BA)	\$237.358
FY 2025 Enacted (PPHF)	\$681.933
FY 2026 President's Budget (BA)	\$963.291
FY 2026 President's Budget (PPHF)	\$0.000

¹ The 2026 Budget eliminates funding from the Prevention and Public Health Fund (PPHF).

Immunization Program Ten-Year Funding History¹	
Fiscal Year	Dollars (in millions)
FY 2017 Final (BA)	\$281.771
FY 2017 Final (PPHF)	\$324.350
FY 2018 Final (BA)	\$285.529
FY 2018 Final (PPHF)	\$324.350
FY 2019 Final (BA)	\$287.106
FY 2019 Final (PPHF)	\$320.550
FY 2020 Final (BA)	\$419.705
FY 2020 Final (PPHF)	\$370.300
FY 2021 Final (BA)	\$240.706
FY 2021 Final (PPHF)	\$372.200
FY 2022 Final (BA)	\$231.447
FY 2022 Final (PPHF)	\$419.350
FY 2023 Final (BA)	\$262.583
FY 2023 Final (PPHF)	\$419.350
FY 2024 Final (BA)	\$0.000
FY 2024 Final (PPHF)	\$681.933
FY 2025 Enacted (BA)	\$0.000
FY 2025 Enacted (PPHF)	\$681.933
FY 2026 President's Budget (BA)	\$731.33
FY 2026 President's Budget (PPHF)	\$0.000

¹ The 2026 Budget eliminates funding from the Prevention and Public Health Fund (PPHF).

Immunization and Other Respiratory Diseases

Program Description

The Immunization and Respiratory Diseases program supports CDC's 317 Discretionary Immunization Program, which provides infrastructure for U.S. immunization activities, including state immunization programs. CDC's Discretionary Immunization Program has been providing vaccines to prevent infectious diseases for more than 60 years. In FY 2026, CDC will support 66 U.S. immunization programs to prevent infectious diseases including measles, H5N1, perinatal hepatitis B, and other respiratory and vaccine-preventable disease outbreaks.

CDC supports staff in U.S. localities and the Indian Health Service who assist with daily operations and outbreak responses. In FY 2024, 20 jurisdictions requested additional funds to purchase vaccines to respond to active outbreaks including hepatitis A, varicella, and measles. Ten of those jurisdictions requested funding to support efforts to vaccinate farmworkers against seasonal flu in the context of the H5N1 outbreak; CDC also provided 105,000 seasonal flu vaccine doses to 12 states to help support this effort.

Additionally, CDC partners with healthcare systems, health departments, public and private labs, and other domestic and global partners to gather data on pathogens. State and local health departments receive funding to support critical disease monitoring, pathogen strain characterization, and outbreak investigation.

Budget Request

CDC's FY 2026 budget request of **\$731,933,000** for Immunization and Other Respiratory Diseases program is **\$50,000,000** above the FY 2025 enacted level and moves funding into CDC's discretionary budget authority. This funding is critical to the support of essential activities that ensure the nation is ready and rapidly responsive to respiratory viruses and bacteria. Funding will also improve respiratory virus and bacteria surveillance and ensure the agency can nimbly respond and defend the American public from emerging pandemic threats. Collectively, the surveillance systems supported will provide a robust approach to addressing respiratory viruses and bacteria across the federal government and will provide foundational data to state/local public health partners and healthcare providers. Specifically, CDC will enhance work across several major areas:

- **Disease surveillance and pandemic preparedness** for early identification of respiratory threats. CDC shares timely knowledge of how respiratory pathogens are evolving throughout the country. Through a network of sentinel sites and platforms like RESP-Net, the only public-facing system monitoring severe respiratory illness outcomes, CDC tracks and analyzes how respiratory viruses and bacteria affect Americans. These systems allow the agency to quickly detect changes in infectivity, severity, and transmission trends.
- **Characterizing pathogens** is critical to improving diagnostics, therapeutics, and vaccines. CDC's leadership in pathogen genomics and characterization enables the nation to understand how viruses and bacteria are evolving, at local, state, and national levels. Platforms like Nowcast give healthcare professionals and public health officials timely data on emerging variants and novel pathogens, allowing them to anticipate impacts and implement mitigation strategies with speed and precision.
- **Informing the development and evaluating the effectiveness of vaccines and other prevention measures.** CDC will support core vaccine effectiveness platforms such as the Virtual SARS-CoV-2, Influenza, and Other respiratory viruses Network (VISION) and the New Vaccine Surveillance Network (NVSN), a critical resource for evaluating the effectiveness of pediatric vaccines and monitoring the epidemiology of common childhood viral and bacterial illnesses. These resources enable evidence-based

decision-making, assisting healthcare providers and public health decisionmakers to take action to prevent severe health outcomes and protect American families.

Program Accomplishments

CDC's Immunization and Respiratory Disease program provides the resources and technical support for state, tribal, local and territorial public health programs to protect children, their families, and their communities against respiratory and vaccine-preventable diseases.

RSV: In 2023, new immunization products for RSV became available in the United States, including RSV vaccines, along with nirsevimab, to prevent severe RSV disease in infants. Before these products became available, RSV caused approximately 2 million medical encounters, between 58,000-80,000 hospitalizations, and 100-300 deaths among children under 5 years of age annually. Preliminary analyses from two CDC surveillance systems show that RSV hospitalization rates in babies under 8 months were 28-43% lower and hospitalizations for the youngest babies (under 3 months old) were reduced by approximately half compared to seasons before RSV prevention products were available. Immunizing 50% of infants could prevent an estimated 107,000 outpatient visits, 15,000 hospitalizations, and 10 deaths in a year.

Measles: CDC responds to measles outbreaks in the United States when they occur. In 2024, CDC assisted the Chicago Department of Health and the State of Illinois with a large outbreak of measles. Another large measles outbreak is ongoing in Texas, New Mexico, Kansas, and Oklahoma. CDC is supporting state and local health departments during this outbreak through technical assistance for epidemiology and laboratory testing; conducting lab testing and genomic sequencing; and providing information to the public and healthcare professionals. CDC is gathering data on confirmed measles cases and evaluating and monitoring these data. Funding for additional MMR vaccine doses has been made available to states. To date, four CDC Epi-Aid teams have deployed to provide support at the request of jurisdictions. Additionally, CDC has issued a Health Alert Network Advisory to notify clinicians, public health officials, and potential travelers about the risks and signs of measles infections; released the *Be Ready for Measles* toolkit that public health workers can use to communicate with different audiences; released an MMWR which includes important guidance for health departments and clinicians on how to prepare for and respond to cases; and holds bi-weekly National Measles Readiness Calls for STLT partners.

Meningococcal disease: CDC worked with partners to develop and implement new recommendations for prevention of meningococcal disease cases caused by antibiotic-resistant strains of *Neisseria meningitidis*. These bacteria cause meningococcal disease which can be deadly in a matter of hours. Over 10 jurisdictions within the United States have since implemented these new recommendations to protect their communities from this emerging threat.

Legionnaires' disease (LD): To respond to LD outbreaks more quickly, CDC provided leadership to create TowerScout, a machine learning tool, that automatically identifies water cooling towers (CTs) from aerial imagery. Large LD outbreaks are often caused by improperly maintained CTs, often used in large buildings, such as hotels, office buildings, and hospitals which produces infectious aerosols that travel for miles. Since its inception in April 2021, CDC's Legionella Team has used TowerScout in more than 35 outbreak investigations, drastically improving the efficiency and effectiveness of CDC in protecting these communities.

CDC will continue to build a sustainable and effective immunization program to support the nation's readiness to detect and respond to respiratory diseases capable of causing a public health emergency and vaccine-preventable diseases across the lifespan and by sustaining high vaccination coverage rates for routine immunizations.

Immunization Cooperative Agreements

(dollars in millions)	FY 2024	FY 2025	FY 2026
	Final	Enacted level	President's Budget
Number of Awards	64	64	64
- New Awards	0	0	0
- Continuing Awards	64	64	64
Average Award	\$4.323M	\$4.208M	\$4.208M
Range of Awards	\$0.115–\$25.778 M	\$0.112–\$25.092 M	\$0.113–\$25.092M
Total Awards	\$276.717	\$269.358	\$269.358

*These funds are awarded by formula.

Influenza Planning and Response Budget Request

CDC's influenza program works to detect, control, and prevent influenza disease, including seasonal influenza, which causes annual epidemics, and novel influenza, which occurs when a new flu virus from animals emerges that can infect people and has pandemic potential. Because influenza viruses are always changing, CDC supports robust influenza surveillance systems that allow CDC and state, tribal, local and territorial (STLT) health departments to identify when and where influenza is circulating and help guide decisions for prevention and treatment. CDC's laboratories characterize and sequence influenza viruses, which is critical to detecting changes in both seasonal and novel influenza viruses, such as avian influenza A(H5N1). To reduce the burden of seasonal influenza in the United States, CDC recommends an annual influenza vaccine for everyone six months and older. The vaccine must be produced and administered annually to account for changes in seasonal viruses and requires annual recommendations for vaccine composition that are based on up-to-date CDC surveillance data and laboratory analyses to optimal protection against currently circulating viruses that have a higher likelihood of causing illness.

Budget Request

CDC's FY 2026 budget request for Influenza Planning and Response is **\$231,358,000**.

Influenza surveillance: CDC will monitor influenza viruses, maintain U.S. influenza surveillance systems, collect and transmit data, and assure timely reporting from public health laboratories, emergency department syndromic surveillance systems, electronic health record-based hospital surveillance, long-term care facilities, commercial testing laboratories, and other clinical providers. These activities inform public health decision-making to prevent and treat flu.

Laboratory analysis: CDC will characterize and sequence influenza viruses to detect emerging threats and potential changes that may make viruses less susceptible to vaccines or antiviral medications, or more difficult to detect with current diagnostic tests. Assuring that the U.S. has effective medical countermeasures is essential to protect American's health from seasonal and pandemic flu.

Vaccine effectiveness: CDC conducts studies through a network of U.S. hospitals each flu season to help determine how well vaccines are working. This work helps to regularly assess the value of flu vaccination as a public health intervention. These activities directly contribute to the U.S. Government's [National Influenza Vaccine Modernization Strategy](#).

STLT support and H5N1 outbreak response: As part of the current U.S. bird flu outbreak response, CDC supports STLT health departments to prepare for and respond to human cases of avian influenza A(H5N1). CDC will support flu surveillance coordinators in U.S. health departments, and state public health laboratories as designated National Influenza Reference Centers (NIRCs) and Influenza Sequencing Centers (ISCs). NIRCs and ISC assure sequencing capacity across the United States and assure increased capacity should a pandemic of novel

influenza occur. CDC will also work with health departments and clinicians to investigate reports of pediatric influenza-associated encephalopathy and encephalitis (IAE), including acute necrotizing encephalopathy (ANE). In the 2024-2025 influenza season, CDC received reports of pediatric influenza positive patients presenting with ANE, including two pediatric deaths. CDC rapidly responded to identify the scope of disease spread and provide support and guidance to public health and clinical partners. CDC is also working with partners to plan for continued IAE public health surveillance during the 2025-2026 influenza season.

Program Accomplishments

CDC's seasonal influenza efforts, which occur each year, are the foundation of the agency's influenza pandemic preparedness activities. CDC characterizes viruses to assess the effectiveness of medical countermeasures and identifies emerging threats to allow for more rapid vaccine development in the event of a pandemic. In 2024, CDC influenza laboratories sequenced over 8,000 virus specimens. Additionally, CDC developed six new candidate vaccine viruses against emerging and novel influenza threats/viruses with the potential to cause epidemics and pandemics.

In March 2024, the U.S. Department of Agriculture (USDA) reported that dairy cattle herds in two states had been infected with avian influenza A(H5N1). CDC along with ASPR, USDA, NIH, and FDA, formed a joint outbreak response structure in early 2024 and CDC's preparedness investments immediately helped states protect human health and safety through monitoring and testing of exposed workers; supporting field studies in dairies to gain real-time understanding of human risk; and outreach and education to farmworkers and rural communities. Between March 2024 and May 2025, more than 16,600 people have been monitored for potential symptoms following exposure to infected animals, and more than 880 people who developed influenza-like symptoms were tested for influenza A(H5N1). Additionally, CDC's long-standing influenza surveillance systems have been essential to look for any potential community infections. Since February 2024, more than 186,000 specimens have been tested. CDC provided intensive support to states to implement seroprevalence studies to understand if people with previous exposure to sick dairy cattle also had undetected avian influenza A(H5N1) virus infections. These studies contributed to a better understanding of what activities and behaviors may contribute to a higher risk of acquiring influenza A(H5N1) infections while working on dairy farms.

VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS, AND TUBERCULOSIS

(dollars in millions)	FY 2024 Final	FY 2025 Enacted ¹	FY 2026 President's Budget	FY 2026 +/- FY 2025
Budget Authority	\$377.344	*	\$300.000	*
Total Request²	\$377.344	*	\$300.000	*
FTEs ³	1,114	*	149	*
-- Consolidated Hepatitis, STD, and Tuberculosis Prevention Grant ⁴	N/A	N/A	\$300.000	N/A

¹ Consistent with the FY 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for FY 2025 and is rolled up within the account.

² FY 2024 Final and FY 2025 Enacted do not reflect funding for Domestic HIV/AIDS Prevention and Research. CDC's Domestic HIV programs will be realigned to AHA under the planned HHS reorganization; FY24 and FY25 domestic HIV funding is reflected in the AHA CJ.

³ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

⁴ The FY 2026 PB proposes to realign the following lines into the new proposed line, Consolidated Hepatitis, STD and Tuberculosis Prevention Grant: Consolidated Viral Hepatitis, STD and Tuberculosis Prevention Grant, Viral Hepatitis, Sexually Transmitted Infections (STIs), Domestic TB, and Infectious Diseases and the Opioid Epidemic.

Allocation Methods: Direct Federal/Intramural, Competitive Grants/Cooperative Agreements, Formula Grants/Cooperative Agreements, Contracts, and Other

CDC envisions a future free of viral hepatitis, sexually transmitted infections (STIs), and tuberculosis (TB). In working toward that future, CDC prioritizes cost-effective, scalable programs, policies, and research to achieve the greatest reduction in the incidence and disparities of these conditions—all of which have substantial individual, societal, and economic costs for all Americans, and an even greater cost for certain populations. From 2017 to 2020, over 2.4 million—and up to 4 million-- people had hepatitis C virus infection in the United States and an estimated 660,000 were living with hepatitis B, but about one in three people with hepatitis C and about one in two people with hepatitis B are unaware of their infection. Viral hepatitis is a serious public health threat and a leading cause of liver cancer.

Sexually transmitted infections (STIs) continue as a national public health problem – spanning various communities and groups and all regions of the United States. In 2021, more than 2.5 million cases of chlamydia, gonorrhea, and syphilis were reported. Beyond individual and community health impacts, STIs are costly. There are more than 26 million estimated new STI cases annually, costing the healthcare system \$17.2 billion in lifetime direct medical costs.

CDC is the lead agency for eliminating tuberculosis (TB) in the United States and a global expert in programmatic TB research, laboratory science, TB surveillance, epidemiology, education, and training. CDC data show that TB incidence increased for a third year in a row in the United States. Although TB incidence in the United States is among the lowest in the world and most U.S. residents are at minimal risk, TB continues to cause substantial global morbidity and mortality. During 2023, 9,615 TB cases were reported in the United States, compared with 8,320 cases reported in 2022. Overall, the U.S. TB rate increased by 15 percent from 2.5 per 100,000 persons in 2022 to 2.9 per 100,000 persons in 2023.

VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS, AND TUBERCULOSIS

BY THE NUMBERS

- **Preventing STIs:** Over the past 15 years, state and local STI programs funded by CDC have prevented 6.4 million cases of syphilis, gonorrhea, and chlamydia saving the U.S. healthcare system \$2.7 billion in lifetime medical costs.
- **Preventing TB Cases and Cutting Costs:** Between 1995 and 2023, U.S. tuberculosis (TB) control efforts helped prevent up to 549,000 TB cases, saving the country up to \$26 billion in medical and societal costs.
- **Preventing Viral Hepatitis:** 59 state and local health departments received CDC support since 2021 to improve viral hepatitis response, prevention and service integration; by 2024, 83% of recipients improved data quality and completeness, and more than 4,000 providers were trained to diagnose and treat viral hepatitis.

*References: Unless otherwise noted, all information and calculations are from CDC program data.

Viral Hepatitis, STI and TB Prevention Funding History ¹	
Fiscal Year	Dollars (in Millions)
FY 2022 Final	\$358.344
FY 2023 Final	\$377.344
FY 2024 Final	\$377.344
FY 2025 Enacted	*
FY 2026 President's Budget	\$300.000

¹ FY 2022 Final through FY 2025 Enacted amounts for the Viral Hepatitis, STI and TB Prevention account do not reflect funding for Domestic HIV/AIDS Prevention and Research. CDC's Domestic HIV programs will be realigned to AHA under the planned HHS reorganization and are reflected in the AHA CJ.

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

Program Description

Viral hepatitis, STIs, and TB are serious public health threats which have substantial individual and economic costs. Through the consolidated grant, CDC will offer recipients strategic direction, technical support, and laboratory and programmatic expertise. The grant program provides an opportunity to integrate delivery of services to the public to address related infections, develop capacities across programs, improve efficiencies and cost effectiveness, and achieve optimal health outcomes.

Budget Request

The FY 2026 budget request for the Consolidated Hepatitis, STD and Tuberculosis Prevention Grant is **\$300,000,000**. The budget request reflects the proposal to realign the Viral Hepatitis, Sexually Transmitted Infections (STIs), Domestic TB, and Infectious Diseases and the Opioid Epidemic funding lines into the new proposed Consolidated Viral Hepatitis, STD and Tuberculosis Prevention Grant. The FY 2026 budget gives states flexibility to address local needs in addressing state specific challenges by consolidating funding for Infectious Disease and Opioids, Viral Hepatitis, STIs, and TB programs into one newly established grant program.

CDC prioritizes cost-effective, burden based, and scalable programs to efficiently and effectively reduce incidence of these infectious diseases. In FY 2026, CDC will support state, local, and territorial health departments to implement proven public health interventions, conduct infectious disease surveillance to track and respond to outbreaks, and address the dynamic consequences these diseases present. CDC will provide

resources allocated through a burden-based formula to ensure funds are distributed efficiently and achieve maximum impact.

Viral Hepatitis, STI and TB Prevention

(dollars Thousands)			
	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	62	*	*
Average Award	\$3,309.376	*	*
Range of Awards	\$315.376 - \$17,544.392	*	*

*Grant award estimates under development

EMERGING AND ZOONOTIC INFECTIOUS DISEASES

(dollars in millions)	FY 2024 Final	FY 2025 Enacted ¹	FY 2026 President's Budget	FY 2026 +/- FY 2025
Budget Authority	\$760.272	\$760.272	\$870.486	+\$110.214
Prevention and Public Health Fund (PPHF) Transfer ²	\$52.000	\$52.000	\$0.000	-\$52.000
Total Request	\$812.272	\$812.272	\$870.486	+\$58.214
FTEs ³	1,679	1,586	1,720	+134
-- Antimicrobial Resistance Initiative	\$197.000	*	\$197.000	*
-- Vector-borne Diseases	\$90.603	*	\$87.817	*
-- Prion Disease	\$8.000	*	\$0.000	*
-- Chronic Fatigue Syndrome	\$5.400	*	\$0.000	*
-- Emerging Infectious Diseases ⁴	\$265.997	*	\$303.897	*
-- Food Safety	\$72.000	*	\$72.000	*
-- National Health Care Safety Network	\$24.000	*	\$24.000	*
-- Travel and Port Health Protection ⁵	\$53.772	*	\$79.772	*
-- Advanced Molecular Detection (AMD)	\$40.000	*	\$66.000	*
-- Harmful Algal Blooms	\$3.500	*	\$0.000	*
-- Epi and Lab Capacity Program	<u>\$40.000</u>	<u>\$40.000</u>	<u>\$40.000</u>	<u>\$0.000</u>
-- Epi and Lab Capacity program (BA)	N/A	N/A	\$40.000	+\$40.000
-- <i>Epi and Lab Capacity program (PPHF)</i>	<i>\$40.000</i>	<i>\$40.000</i>	<i>\$0.000</i>	<i>-\$40.000</i>
-- <i>Healthcare-Associated Infections (PPHF)</i>	<i>\$12.000</i>	<i>\$12.000</i>	<i>\$0.000</i>	<i>-\$12.000</i>

¹ Consistent with the FY 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for FY 2025 and is rolled up within the account.

² The FY 2026 Budget eliminates funding from the Prevention and Public Health Fund (PPHF).

³ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

⁴ FY 2024 Final and FY 2025 Enacted are comparably adjusted to reflect the proposed realignment of the following activities into Emerging Infectious Diseases: Surveillance for Emerging Threats to Mothers and Babies and Parasitic Diseases and Malaria.

⁵ Formerly reflected as "Quarantine" PPA name.

Allocation Methods: Direct Federal/Intramural, Contracts, and Competitive Grants/Cooperative Agreements

CDC defends the country against public health threats by preventing and controlling a wide range of infectious diseases, including outbreaks caused by bacteria, viruses, fungi, parasites, Select Agents, high-consequence pathogens, and other zoonotic pathogens that threaten national security. CDC's world-class scientists, researchers, laboratorians, and outbreak responders reduce illness and deaths associated with infectious diseases through several core functions, including:

- **Public health surveillance:** CDC's disease surveillance systems, which serve as early warning systems, are critical to enabling CDC experts to quickly identify and rapidly respond to emerging threats, control outbreaks, and save lives.
- **Outbreak preparedness and response:** CDC has unique scientific expertise on over 880 pathogens and works closely with partners to rapidly detect and contain outbreaks at the source, protecting Americans.
- **Laboratory expertise:** CDC laboratories advance disease detection, identification, and prevention and serve as world-renowned reference laboratories for the United States and abroad. These laboratories develop state-of-the-art diagnostic tools, support essential confirmatory testing activities to identify pathogens, and research new targets for drug and vaccine development - capabilities that do not exist elsewhere in the United States. CDC's virtual reference laboratories (e.g., MicrobeNet, DPDx, and CDC's National Rabies Reference Laboratory) provides tools to identify rare and complex pathogens quickly and accurately, leading to early diagnosis, tailored approaches to treatment, and prevention of new infections.
- **Improving healthcare quality, health systems resilience, and patient safety:** CDC uses science, data, and expertise to protect patients, keep healthcare workers safe, and strengthen healthcare delivery systems both internationally and domestically through surveillance and tracking, medical product safety,

infection prevention and control training and capacity, strengthening health systems, and improving health systems resilience.

- **Support to state and local health departments:** The Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) program works to reduce illness and deaths associated with a wide range of infectious diseases. It provides direct financial support to 65 jurisdictions, including all 50 states, seven localities, and U.S. territories and affiliates for surveillance, detection, outbreak response, and prevention of infectious diseases while offering recipients strategic direction and technical assistance.
- **Protecting public health through CDC Port Health Protection System:** CDC plays a vital role limiting the introduction and spread of contagious diseases into the U.S., including those with the potential to cause widespread epidemics. CDC's Port Health Protection doctors, veterinarians, and staff respond to reports of sick travelers who arrive in the United States at ports of entry, alert travelers to health threats, and restrict the importation of animals and products that may carry disease. These layers of protection work in concert to proactively identify and mitigate health risks at our borders and points of entry, preventing the spread of infectious diseases into and within the U.S.

CDC's FY 2026 budget request of **\$870,486,000** for Emerging and Zoonotic Infectious Diseases is **\$58,214,000** above the FY 2025 enacted level. This request includes funding to prioritize emerging and re-emerging infectious disease threats and to expand innovative outbreak detection through implementation of a new Biothreat Radar program at CDC. In coordination with the White House, CDC and the Department of Defense (DoD) will work to establish a new biodetection system that can rapidly detect novel pathogens with 24-hour turnaround times. Unlike many of the USG's current biosurveillance systems, the proposed biodetection system would be pathogen agnostic. The new surveillance system consists of four components across DoD and HHS/CDC. Of the four components, three are in CDC: Advanced Molecular Detection (AMD), Traveler Genomic Surveillance (TGS), and RREDI. The request also reflects a proposed budget structure realignment of Parasitic Diseases and Malaria from the Global Health account and Surveillance for Emerging Threats to Mothers and Babies from the Birth Defects, Developmental Disabilities, Disability and Health account to the Emerging and Zoonotic Infectious Diseases account.

EMERGING AND ZONOTIC INFECTIOUS DISEASES

By the Numbers¹

- **>200,000**—Tests conducted from January to December 2024 by the Antimicrobial Resistance Laboratory Network to rapidly detect and respond to AR threats across healthcare, the community, food supply, and environment.
- **>\$364 million**— Critical infectious disease program funding awarded to state, local, and territorial health departments through the ELC cooperative agreement in FY 2024 to strengthen jurisdictions' core and cross-cutting epidemiology, laboratory, and health information systems and to fund more than **500** highly skilled staff to address infectious diseases.
- **>200** healthcare-related outbreaks across **49** state and local health jurisdictions and **3** non-U.S. locations were contained using CDC experts.
- **620,000 Department of Defense personnel** safeguarded by CDC's state-of-the-art insectary laboratory critical mosquito research, developing field-friendly tests to detect insecticide levels on military uniforms, ensuring timely re-treatment.
- **>1,500** clinical consultations on cases involving biothreat agents that cause anthrax and melioidosis and other rare but deadly pathogens including viral hemorrhagic fevers and poxviruses.
- **>15,000 port health protection activities** (e.g. ill traveler or death, animal/animal products importation) requiring CDC Port Health Station staff response at U.S. land, air, and seaports of entry in 2024.
- **~270,000 illnesses prevented** and at least **\$500 million saved** in medical costs and lost productivity through CDC's PulseNet laboratory network, which uses whole genome sequencing to stop foodborne outbreaks, delivering a \$70 return for every \$1 invested.

¹ All statistics are from CDC program data unless otherwise stated.

Emerging and Zoonotic Infectious Diseases Funding History ¹	
Fiscal Year	Dollars (in Millions)
FY 2022 Final (BA)	\$641.272
FY 2022 Final (PPHF)	\$52.000
FY 2023 Final (BA)	\$698.772
FY 2023 Final (PPHF)	\$52.000
FY 2024 Final (BA)	\$760.272
FY 2024 Final (PPHF)	\$52.000
FY 2025 Enacted (BA)	\$760.272
FY 2025 Enacted (PPHF)	\$52.000
FY 2026 President's Budget (BA)	\$870.486
FY 2026 President's Budget (PPHF)	\$0.000

¹ FY 2024 and FY 2025 levels reflect the proposed realignment of the following activities into Emerging Infectious Diseases: Surveillance for Emerging Threats to Mothers and Babies and Parasitic Diseases and Malaria.

Antimicrobial Resistance Initiative Budget Request

Antimicrobial resistance (AR) – when bacteria or fungi do not respond to the drugs designed to kill them—is a threat to lives, modern medicine and healthcare, and veterinary and agriculture industries in the United States. Antimicrobial-resistant infections are difficult to treat and add considerable burden to patients and the U.S. healthcare system. CDC works to quickly prevent, detect, contain, and respond to outbreaks of antimicrobial-resistant infections. Through CDC’s Antimicrobial Resistance Initiative (*AR Initiative*), CDC leads the U.S. public health response to combat AR. Through the *AR Initiative*, CDC supports a comprehensive response against AR and ensures resilient public health infrastructure is in place to fight AR when and where it emerges, helping to maintain our ability to successfully care for patients.

Budget Request

CDC’s FY 2026 budget request for the Antimicrobial Resistance Initiative is **\$197,000,000**.

CDC’s FY 2026 request will support core public health capacities and innovative approaches to combat AR and prevent infections. CDC will continue investing in state, territorial, and local capacity to detect and prevent emerging and existing threats through strengthened infection prevention and control, antibiotic stewardship, and healthcare quality improvement efforts. CDC will continue to support:

- Critical AR testing capacity through the Antimicrobial Resistance Laboratory Network, which supports laboratories nationwide for rapid AR detection in healthcare, food, and communities.
- Working with key public health and healthcare partners to improve patient safety by ensuring appropriate use of antibiotics across inpatient and outpatient healthcare settings.
- Providing critical scientific resources to support development of new antibiotics, antifungals, prevention products, and diagnostics to support the health of Americans.
- Slowing the spread of AR threats before they reach the United States through the Global Antimicrobial Resistance Laboratory and Response Network.

Program Accomplishments

State, Local, and Territorial Investments: In FY 2024, CDC invested more than \$68 million to sustain core AR laboratory and epidemiological capacity in all states, as well as several large cities and territories. Since 2019, health departments’ Healthcare-associated Infections (HAIs)/AR Programs have responded to more than 180,000 confirmed and potential outbreaks and conducted more than 37,000 prevention-based infection control assessments. As of December 2024, CDC’s AR Lab Network has performed more than 1.25 million tests, including over 370,000 isolate characterizations; over 430,000 colonization screenings; and over 480,000 whole genome sequences to rapidly identify AR resistance and control outbreaks.

Supporting treatment and prevention options in fighting AR: In FY 2024, CDC invested approximately \$50 million in innovative approaches to prevent infections and combat AR. CDC works to identify pathways for novel pharmaceutical agents – such as pathogen reduction products – to better prevent the spread of resistant infections and protect patients. In FY 2024, CDC Prevention Epicenter partners published two studies demonstrating the impact of existing pathogen reduction approaches to prevent infections and stop pathogen transmission. Through the CDC and FDA AR Isolate Bank, more than 1,000 unique AR isolates are available to diagnostic device and drug manufacturers, researchers, and clinical laboratories to develop new lab tests to improve patient care, conduct research and development for new products, and help labs detect new AR threats that require swift intervention.

Travel and Port Health Protection (formerly Quarantine) Budget Request

CDC's travel and port health protection activities create a multi-layered system of public health defenses that mitigate the risk of communicable diseases spreading into and within the United States and protect U.S. travelers going abroad. This comprehensive system ensures that there are medical and veterinary experts at U.S. ports of entry available 24/7 to respond to travelers, animals, or animal products at risk of transmitting dangerous pathogens so the flow of travel is not interrupted. Despite the increasing number and complexity of public health emergencies and higher volumes of travelers over the past decade, resources for national border health security activities have historically seen little growth.

The budget request includes renaming the Quarantine appropriations line to Travel and Port Health Protection to better align with programmatic work, including the newly renamed Port Health Stations and the Traveler-Based Genomic Surveillance program. The new name will better reflect the breadth of work that CDC does beyond the use of quarantine to protect the United States from communicable disease threats. CDC is using innovative surveillance technology to detect pathogens entering the United States and relies on multiple tools and systems to prevent the introduction of communicable disease into and within the United States.

Budget Request

CDC's FY 2026 budget request for the Travel and Port Health Protection is **\$79,772,000**. CDC will use these funds to maintain national public health security at key ports of entry throughout the United States, implement a new Biothreat Radar capability established through the Traveler-Based Genomic Surveillance program, and maintain public health programs that mitigate the spread of any potential international outbreaks or epidemics that threaten the public health of Americans. CDC will continue to leverage its expertise, surveillance systems, and global partnerships to develop public health alerts, recommendations, and education for American travelers and healthcare providers, further equipping Americans with the information they need to safely travel abroad. Work funded through the Travel and Port Health Protection line contributes to a safer, stronger, and more prosperous America.

CDC's travel health surveillance activities are vital to understanding the risk of a high-consequence disease coming to the United States to prepare and respond quickly to incoming threats. Funding at \$26,000,000 for traveler metagenomic surveillance would allow CDC to build on travel and port health protection surveillance that supports early warning systems for emerging pathogens. This funding would enhance CDC's ability to understand potential infectious disease threats by, for example, increasing the number of sites for the collection of voluntary anonymous swabs from international travelers via a public-private partnership. An increase in funding also could allow CDC to test for additional pathogens and expedite the development timeline for onboarding pathogen-agnostic approaches (i.e., metagenomics) to detect a large number of pathogens, including new and emerging threats. These activities are critical for U.S. biosecurity efforts to fill gaps in global biosurveillance and speed up detection to stop incoming threats from crossing our borders.

Program Accomplishments

Preparedness and Response: In 2024, CDC Port Health Station staff took action on more than 15,000 port health protection activities, which included responding to almost 2,000 reports of ill travelers or deaths at U.S. land, air, and sea ports of entry. These activities also included CDC Port Health Station staff distributing life-saving drugs, on 155 occasions. For example, on June 25, 2024, the San Francisco Port Health Station received a call about a possible botulism outbreak related to a family gathering. Since botulism antitoxin is only available from CDC, staff at the Los Angeles and San Francisco Port Health Stations quickly mobilized the emergency drug release process.

Travelers' Health: CDC's Travelers' Health website had over 26 million views in 2024. The website includes the digital version of the CDC Yellow Book, an authoritative resource in travel medicine authored by more than 200

leading experts. Travel Health Notices and destination pages on the website are updated regularly to ensure that American travelers have the latest disease information, including outbreak locations, to keep them safe and healthy before, during, and after travel.

Emerging Infectious Diseases Budget Request

CDC scientists play a critical role in protecting the United States from dangerous viruses, bacteria, and organisms that emerge as new threats. Emerging Infectious Diseases (EI) funding provides pathogen-agnostic flexible resources that sustain and strengthen the critical foundation for many of CDC's world-renowned programs, applied research, laboratories, and outbreak responses. These flexible resources are particularly important because they support cross-cutting public health activities that may not have dedicated resources but warrant ongoing CDC engagement.

CDC has seen rapid growth in newly emerging pathogens and increasing complexity of outbreaks in the U.S. and overseas. As outbreaks and emerging infectious diseases increase, CDC must be ready to respond and contain them at the source. Resources for critical response efforts support core programmatic work, including the development and evaluation of medical countermeasures; tracking and identification of newly emerging threats; and examining how people are exposed to these diseases and how to prevent them. The EI funding line ensures CDC is prepared for and able to nimbly respond to future public health threats by providing cross-cutting, flexible, and pathogen-agnostic infectious disease surge support during outbreaks. These response-ready funds allow CDC to lead and conduct response activities early in an emergency until the outbreak is contained or is escalated to a higher-level agency response. CDC also provides fundamental infectious disease support to state and local public health agencies and partners who rely on CDC to identify new pathogens, confirm unusual pathogens, diagnose mystery illnesses, and rapidly coordinate multi-jurisdictional investigations and responses when they are needed to protect the public.

Budget Request

CDC's FY 2026 budget request for Emerging Infectious Diseases is **\$303,897,000**. The request reflects a proposed budget structure realignment of the following lines into Emerging Infectious Diseases: Surveillance for Emerging Threats to Mothers and Babies and Parasitic Diseases and Malaria.

This funding will enable CDC to maintain existing foundational infectious disease activities and build the capacity needed to respond to an increasing number of high-consequence outbreaks in the U.S. and overseas. Prevention of high-consequence infectious diseases is essential for protecting people, saving lives and money, preparing for future public health threats and improving national security. This funding will support:

- Outbreak investigations in healthcare settings and in blood, organ, and tissue donations.
- Food and water-borne infectious disease investigations nationwide, utilizing novel disease detection tools, identifying risk factors, and responding to diseases caused by contaminated food and water.
- Fungal disease outbreak investigation, emerging fungal threat identification, laboratory services and support to state and local health departments, and national surveillance efforts to monitor for diseases and AR.
- Efforts to detect, understand, and prevent or reduce threats to mothers and babies and reduce the impact of infectious diseases, such as Dengue, during pregnancy in addition to exploring the potential relationships between emerging threats and stillbirth, one of the most devastating pregnancy outcomes.
- National parasitic disease reference laboratories and expertise on over 80 parasitic disease pathogens-providing 24/7 support to clinicians, hospitals, and health departments across the United States to ensure timely care to prevent serious illness and death.
- Implementation of CDC's Hospital Sepsis Program Core Elements to optimize institutional sepsis programs and sepsis outcomes. CDC will also continue to expand data collection related to sepsis and

the sepsis core elements by working with the CMS and other relevant partners to develop three healthcare quality measures to dramatically increase sepsis detection, as well as improve sepsis outcomes in the U.S.

- Diagnostic, vaccine, and therapeutic development in CDC’s BSL3 and BSL4 High Containment Laboratories, the laboratories used to work on the world’s deadliest diseases like Ebola and anthrax.
- CDC’s poxvirus work which ensures clinicians and patients have reliable, validated assays to test for poxviruses and a better vaccine with fewer side effects.
- CDC’s National Rabies Reference Laboratory is the only reference center for diagnosing rabies in the United States. Through this lab, CDC provides financial and technical support to over 130 US-based laboratories. This lab is one of only three in the United States that can test human organ or tissues samples for rabies virus.

This proposed funding increase would strengthen CDC’s readiness for and response to **high-consequence pathogens** with pandemic potential. These threats, including viral hemorrhagic fevers such as Marburg virus, poxviruses, and other emerging threats, often lack treatments or vaccines to protect people against them. Novel viruses and bacteria are emerging and pose threats to human health with increasing frequency and in new geographic locations – and pose a threat to national security, given the frequency of global travel and trade. This additional funding will accelerate scientific and programmatic advances to effectively prevent, detect, and respond to these deadly threats, improving CDC’s ability to rapidly identify and contain outbreaks at their source. Funding will advance innovations in vaccines, therapeutics, and diagnostic testing technologies. It will also support CDC’s infectious disease pathology program allowing CDC and state and local health departments to more rapidly identify new or previously unrecognized diseases. Finally, these funds will continue to ensure medical countermeasures in the Strategic National Stockpile are safe and ready for rapid use, and that guidance for how and when to use them is readily available to protect the American people from catastrophic biothreats.

The proposed funding increase would also support the use of community-level tools to detect, monitor, and respond to infectious diseases. This will incorporate novel approaches that complement clinical surveillance to detect and prevent the spread of new or emerging infectious diseases. This will support nationwide early warning capabilities to detect infectious diseases and better understand patterns of disease transmission in ways that will inform more efficient and impactful response actions.

Surveillance for Emerging Threats to Mothers and Babies (SET-NET): SET-NET is a multi-faceted program to detect, understand, and prevent or reduce threats to mothers and babies. This effort identifies and addresses the impact of infectious diseases and other health threats to pregnant women and their babies and families. CDC currently funds health departments and clinics that are distributed geographically to collect and link population-based, high-quality mother-infant data. SET-NET data inform clinical and public health guidance for protecting women and babies from infectious diseases. For example, as a result of findings from SET-NET, the American College of Obstetrician and Gynecology now recommends that obstetrician- gynecologists screen women for syphilis three times during pregnancy.

Parasitic diseases and Malaria: Parasitic diseases lead to devastating health effects for hundreds of millions of people around the world and in the United States. They can be transmitted directly from other people, by insects or animals, from blood or tissue donation, congenitally, or through contaminated food or water. CDC reduces parasitic disease related death, illness, and disability in the United States, reduces the global burden of malaria, and controls and eliminates targeted neglected tropical diseases.

CDC maintains the national parasitic disease reference laboratories and coordinates national surveillance for notifiable parasitic diseases, including malaria. The diagnostic laboratory conducts 129 CLIA-approved tests for parasitic diseases, seven of which are exclusively available at CDC. To address the emerging threat of an invasive

mosquito, *Anopheles stephensi*, which threatens malaria control in Africa, CDC is monitoring malaria epidemiological trends and enhancing vector detection and rapid response.

Program Accomplishments

High consequence viral pathogen outbreaks: Over the past 14 months, CDC has responded to **18** viral hemorrhagic fever (VHF) or Nipah virus outbreaks, including Lassa fever in Iowa, Sudan ebolavirus in Uganda, Marburg virus in Tanzania, and Chapare virus in Bolivia. CDC rapidly deployed epidemiology and laboratory teams for on-the-ground support or provided technical assistance to contain these outbreaks. CDC subject matter experts provided **143** clinical consultations on VHFs and other high-consequence pathogens related to outbreaks and suspected domestic importations of deadly pathogens. Additionally, CDC supported epidemiological investigations and partnerships to scale-up diagnostic testing—helping to reduce transmission, prevent spread, and protect national security. CDC also took steps to rapidly contain and prevent ongoing spread of four clade I cases in the United States in the past six months. Clade I mpox historically has been deadlier than the type of mpox called clade II seen in the United States since 2003. CDC helped protect the nation by strengthening mpox surveillance through genetic characterization of mpox samples, expanding clade-specific diagnostic testing capacity across the United States, ensuring appropriate specimen handling and waste management for this high-consequence pathogen, and providing extensive guidance on mpox prevention and vaccination.

Identification of emerging bacterial infections: In 2024, CDC subject matter experts provided **725** clinical consultations on cases involving biothreat agents that cause anthrax, melioidosis, brucellosis, and other rare but deadly bacterial pathogens. During these consults, CDC scientists provided insight for U.S. health departments and clinicians on patient management, exposure monitoring, and outbreak investigations on these diseases. Additionally, CDC supported epidemiological investigations, provided laboratory support, continued to refine and develop new diagnostic tools to detect these bacteria and any antimicrobial resistance in them, and ensured access to therapeutics, when available, to rapidly respond to these deadly diseases and protect the American public.

Rabies detection and prevention: As the National Rabies Reference Laboratory, CDC provided financial and technical support to the Nebraska Rabies Laboratory to conduct genetic testing that identified the spread of a raccoon rabies strain in a stray kitten. CDC participated in an Epi-Aid and partnered with USDA to support the Nebraska Department of Health and Human Services in establishing an enhanced rabies surveillance system to better understand if this variant was spreading. Rapid response was critical to ensure this variant did not spread to local wildlife. If the virus had gone undetected, this strain of rabies would easily spread to neighboring states, putting an estimated 7 million people at increased risk of exposure in just five years. CDC support for enhanced surveillance ensured that this variant was eliminated from the area. This investment of approximately \$200,000 is estimated to have prevented \$1.9 million in public health and medical sector costs over the next five years.

Vector-Borne Diseases Budget Request

The United States is increasingly vulnerable to deadly diseases transmitted by ticks, mosquitoes, fleas, and other insects, as vectors expand into new areas and put more Americans at risk. CDC leverages state-of-the-art techniques and unique expertise to prevent, detect and respond to cases and outbreaks of vector-borne disease such as Oropouche, dengue, chikungunya and yellow fever. CDC is also leading activities to protect Americans from Lyme disease, the most common vector-borne disease in the United States.

Budget Request

CDC's FY 2026 budget request for Vector-Borne Diseases is **\$87,817,000**. This request consolidates CDC's Lyme Disease and Related Tick-borne Illnesses and Vector-Borne Diseases into a single Vector-Borne Diseases line. In FY 2026, CDC will:

- Respond to emerging and re-emerging infectious disease threats, like dengue and Oropouche viruses as well as expanding vector-borne disease threats, like Lyme disease.
- Increase national and jurisdictional preparedness and response capacity for vector-borne diseases through the vector-borne disease Centers of Excellence (COEs); Training, and Evaluation Centers (TECs); and the ELC cooperative agreements.
- Improve and develop diagnostic tests, including diagnostic tests for new and emerging diseases and existing ones like Lyme, for which reliable diagnosis at early and late stages of illness is not yet possible.
- Develop, expand, and refine vector surveillance to better understand the risk factors for vector-borne diseases, including the factors driving the expansion and emergence diseases transmitted by mosquitoes, ticks, and biting midges.
- Prioritize prevention by developing better vector control tools, vaccines, and other prevention tools; working with partners to evaluate and implement these strategies through public health programs; and educating the public and healthcare providers on best practices.

Program Accomplishments

Responding to emerging and re-emerging vector-borne disease threats:

In April 2024, CDC established an emergency response structure to support the U.S. and territories in their response to the ongoing dengue outbreak in Puerto Rico and the U.S. Virgin Islands. This outbreak is part of a record surge in dengue cases globally, with more than 13 million reported dengue cases in the Americas in 2024. In the continental United States in 2024, locally acquired cases were reported in Florida, California, and Texas. A record number of dengue cases were identified among U.S. travelers (3,483 cases), an 84% increase from the previous year. This trend is expected to continue with increased dengue activity in endemic areas in 2025. In response to this spreading public health threat, CDC has worked to prevent, detect, and respond to dengue through dengue surveillance, vector control, and laboratory testing to promote prevention strategies and best practices.

Concurrent to the dengue outbreaks, large outbreaks of Oropouche virus (OROV) occurred in South America and in new areas such as Cuba and Panama. During this outbreak, deaths have been reported in otherwise healthy people and infection during pregnancy has now been associated with fetal death and possible birth defects. CDC added Oropouche to its existing emergency response structure in August 2024, has identified more than 100 returning travelers with OROV, and is working to better understand the risk of severe disease, adverse birth outcomes, and spread for people and communities in the United States.

Progress toward eliminating Rocky Mountain spotted fever in Arizona Tribal Communities

More than 580 cases of Rocky Mountain spotted fever (RMSF), a bacterial disease spread by the bite of infected ticks, have been reported in Arizona tribal communities since 2002, leading to 28 deaths. Half were children. Through partnerships with Arizona tribal communities, public health officials, and companies interested in companion animal health, CDC has led efforts to eliminate deaths from RMSF in impacted communities. This targeted outcome in the National Public Health Strategy to Prevent and Control Vector-Borne Diseases in People has been achieved, as collaborative effort culminated in no deaths from RMSF reported in tribal communities since 2019.

National Healthcare Safety Network (NHSN) Budget Request

NHSN is the nation's most comprehensive and widely used system to identify emerging and enduring threats across healthcare, including those caused by AR pathogens, emerging infectious diseases, and infections leading to sepsis.

Almost 39,000 U.S. healthcare facilities, including nearly every hospital, ambulatory surgery center, dialysis facility, and CMS-certified nursing home participate in NHSN. The number of participating healthcare facilities has doubled since 2015 and there are now more than 160,000 users from healthcare providers to health departments sending data to inform action. NHSN data and analytics help drive real-time patient safety and healthcare quality improvement by enabling healthcare facilities to track, report, assess gaps, and take actions related to a range of urgent health threats.

Budget Request

CDC's FY 2026 budget request for NHSN is **\$24,000,000**. With this funding, CDC will continue collecting and sharing data and analytical tools with healthcare facilities, states, and other federal partners to help them better identify, prepare for, and respond to a wide range of infectious disease threats. NHSN will also continue working to automate and further integrate the data systems necessary to track hospital admissions for respiratory diseases and monitor hospital bed capacity to provide situational awareness for health departments, state and federal agencies, and healthcare facilities to better assess hospital capacity during emergencies. NHSN will continue working closely with healthcare facilities and state, local, and federal government agencies to meet Centers for Medicare and Medicaid Services (CMS) and other regulatory requirements.

Program Accomplishments

Real-time hospital capacity data: In 2024 CDC launched NHSN's hospital bed capacity module, which provides real-time data that allow health departments, other state and federal agencies, and healthcare facilities and health systems to understand hospital capabilities. Patient surges and other stressors (i.e., limited staffing and bed capacity) can negatively impact patient safety in healthcare facilities. Real time bed capacity data help facilities, jurisdictions, and federal partners plan for these events, helping to increase patient safety and lower staff burnout. Accurate, timely hospitalization data improves national, state, and local efforts to optimize and mitigate resource constraints, including during emergencies.

Advanced Molecular Detection (AMD) Budget Request

The AMD program is a cross-cutting, collaborative program that has transformed public health surveillance and response at CDC and across the U.S. public health system through the use of genomic sequencing. The AMD program is a key component of our national biosecurity, providing a flexible, cross-cutting, and multi-pathogen set of tools for sequencing and bioinformatics that allow us to rapidly detect and respond to emerging infectious disease threats.

Budget Request

CDC's FY 2026 budget request for AMD is **\$66,000,000**. This proposed increase will implement a new Biothreat Radar capacity to conduct metagenomic surveillance for multiple pathogens in the U.S. and inform clinical and public health action. CDC's AMD program will work across the interagency, and with public and private sector partners, to create a secure approach that supports implementation of next generation surveillance, ensuring privacy and consistency across laboratories and a platform to efficiently share timely data for action.

In FY 2026, CDC will maintain critical support for federal, state, and local sequencing capacity, sequencing analytics, cloud-based computing, and training for an expert workforce in state and local public health agencies. It will continue to support Pathogen Genomic Centers of Excellence to drive innovation, advance the use of cutting-edge technology, and enhance response readiness and capabilities for pathogen genomics. The AMD program will continue to grow and focus investments in four key areas:

- **Fostering innovation in advanced genomic technologies** to improve how we detect, track, and respond to infectious diseases.
- **Advancing powerful data tools and next-generation analytics** to unlock insights from complex pathogen sequencing data.
- **Strengthening pathogen genomic capacity in state and local health departments** to turn data into action and protect communities from infectious disease threats.
- **Enhancing quality and standardization for pathogen sequencing tests** to ensure they are accurate, reliable, and ready for use in public health.

Program Accomplishments

Pathogen Genomics Centers of Excellence (PGCoE): The PGCoE network fosters innovation and technical capacity in pathogen genomics at state health departments, academic institutions, and private partners to harness advances in genomic and bioinformatic technologies for public health response needs. For example, Massachusetts dairy farmers participated in a Highly Pathogenic Avian Influenza (HPAI) virus monitoring program with the New England PGCoE. The state achieved 100% participation, and confirmed the farms were virus-free at no cost to farmers.

AMD Platform for federal, state, and local data analysis: AMD has developed and is deploying a comprehensive, cloud-based AMD platform for high-volume biological data exchange, management, transformation, and analysis by CDC and state and local jurisdictions. The AMD platform will allow better, more secure sharing of pathogen genomic data on a common infrastructure for data analysis, with access to data visualization tools that help public health partners interpret the large and complex volume of data – helping to enhance outbreak detection, and pathogen surveillance and control.

Food Safety Budget Request

CDC has a unique role in detecting and investigating foodborne illnesses and outbreaks and attributing them to specific foods and settings. CDC collaborates with FDA, USDA, state and local health departments, and food industries to protect Americans from food contaminated with dangerous pathogens.

CDC's network of food safety surveillance is the only source of enteric disease human illness data in all of the U.S. government. CDC's goals for reducing foodborne illness include reducing the size, scope, and severity of foodborne outbreaks, including rapid detection of outbreaks caused by priority pathogens; improving molecular surveillance systems that rapidly detect and characterize foodborne pathogens; and work with our partners in preventing and responding to them.

Budget Request

CDC's FY 2026 budget request for Food Safety is **\$72,000,000**. CDC will continue supporting the nation's food safety system, focusing on disease detection, outbreak response, and prevention efforts. In FY 2026 CDC will continue to:

- Use whole genome sequencing (WGS) in the PulseNet USA network to identify outbreaks rapidly and better define the reservoirs of bacteria that make foods unsafe. CDC will also support expanded adoption of WGS methods in other countries through PulseNet International to improve detection and control spread before pathogens reach the United States.
- Assess trends in foodborne illness and associated disparities, identify high-risk foods, and evaluate the effectiveness of prevention strategies.
- Coordinate with FDA, USDA, and NIH for the application of laboratory technology including genomics, metagenomics, and bioinformatics for outbreak detection and characterization of foodborne bacteria.

Program Accomplishments

Rapid outbreak detection: Every year, PulseNet prevents approximately 270,000 illnesses and saves at least \$500 million in medical costs and lost productivity. For every \$1 invested into PulseNet, an estimated \$70 is saved. The use of WGS has improved CDC's ability to detect and investigate widespread problems in the food supply. In 2024, CDC worked with state, local, territorial, and federal regulatory partners to investigate *Salmonella* illnesses linked to cantaloupes imported from Mexico. CDC quickly identified the source of the outbreak and used WGS to link this outbreak to an outbreak in Canada, which helped identify additional cases. This investigation led to expanded recalls, limiting the number of illnesses in both countries, and demonstrating the value of lab surveillance networks.

Training to improve capacity for laboratory partners: In FY 2024, CDC trained over 461 public health laboratory personnel in best practices for foodborne disease detection, surveillance, laboratory/whole genome sequencing, pathogen identification, and outbreak investigation and control. CDC also expanded a pilot of next generation metagenomic sequencing methods, providing training and technical support to nine domestic PulseNet member laboratories. Metagenomic sequencing is critically important to continuing PulseNet surveillance to protect the food supply because of reduced public health access to the samples currently used for WGS. The investment in laboratory capacity building for food safety is key to preparedness and allows the CDC to better protect people and reduce foodborne illnesses.

Epidemiological and Laboratory Capacity Program Budget Request

The Epidemiology and Laboratory Capacity Program and cooperative agreement (ELC) provides support to all 50 states, seven large localities, and eight U.S. territories to address the growing threats posed by infectious diseases. This program affords recipients the flexibility to meet program goals and milestones while allowing them to find approaches that incorporate unique community-specific needs.

The ELC program awards more than \$200 million each year (\$364 million in 2024) from across a variety of CDC programs and serves as the primary mechanism to support emerging infectious disease epidemiology and laboratory capacity in the United States. These funds support more than 3,000 infectious disease staff across the nation, providing state and local jurisdictions with a critical workforce and leadership.

Budget Request

CDC's FY 2026 request for the ELC Program is **\$40,000,000** and moves funding into CDC's discretionary budget authority. This funding will strengthen emerging infectious disease epidemiology, laboratory, and information system capacity in communities across the United States. This includes support for a skilled public health workforce and systems that can maintain critical flexibility to address emergent infectious disease threats and outbreaks including those most critical for states. These investments support approximately 500 highly skilled and cross-trained public health professionals at the state and local level. This funding ensures that the frontlines of our national health security – our state and local health departments – can maintain their ability to detect and respond to new or unexpected pathogens and address the most urgent needs.

Program Accomplishments

Histoplasmosis in Louisiana: ELC funding supported a disease investigation following the hospitalization of young and previously healthy boy scouts in Louisiana. Disease investigators from the health department found that 15 out of 23 scouts who participated in a geocaching exercise at camp reported experiencing illness; nine sought medical care; five visited the emergency room; and, unfortunately, 3 were hospitalized. ELC funding allowed the health department staff to mobilize immediately to investigate and identify the disease—histoplasmosis, a fungal infection—and its source. Being able to act this quickly allowed our health department staff to alert healthcare providers, immediately halting further transmission.

Ohio Responds to Infectious Disease Threats: Ohio has harnessed ELC funding to build a highly-trained, responsive workforce for public health crises. By creating a streamlined monitoring system in collaboration with local health departments, Ohio effectively tracked potential cases and enhanced its response for mpox and other infectious diseases. This proactive approach has accelerated information sharing across local, state, and federal levels, enabling swift action on hundreds of potential cases.

Epidemiology and Laboratory Capacity Program			
	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	65	*	*
Average Award	\$5,606,781	*	*
	\$349,339 -	*	*
Range of Awards	\$19,887,400		

* Grant award estimates are under development.

PUBLIC HEALTH SCIENTIFIC SERVICES

(dollars in millions)	FY 2024 Final	FY 2025 Enacted ¹	FY 2026 President's Budget	FY 2026 +/- FY 2025
Budget Authority	\$567.100	\$567.100	\$496.600	-\$70.500
PHS Evaluation Transfer	\$0.000	\$0.000	\$100.000	+\$100.000
Total Request²	\$567.100	\$567.100	\$596.600	\$29.500
FTEs ³	1,647	1,560	1,132	-428
-- Surveillance, Epidemiology, and Informatics	\$298.100	*	\$327.600	*
-- Advancing Laboratory Science	\$23.000	*	\$23.000	*
-- Public Health Data Modernization	\$175.000	*	\$175.000	*
-- Public Health Data Modernization	\$175.000	*	\$75.000	*
-- <i>Public Health Data Modernization (PHS Eval)</i>	<i>N/A</i>	<i>N/A</i>	<i>\$100.000</i>	<i>+\$100.000</i>
-- Public Health Workforce	\$71.000	*	\$71.000	*

¹ Consistent with the FY 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for FY 2025 and is rolled up within the account.

² In alignment with the proposed HHS reorganization, FY 2024 Final and FY 2025 Enacted amounts do not reflect funding for Health Statistics, which will be realigned to the planned HHS Office of the Secretary Office of Strategy (OS) in the FY 2026 Budget.

³ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Allocation Methods: Direct Federal/Intramural, Competitive Grants/Cooperative Agreements, Contracts

Program Description

CDC's Public Health Scientific Services (PHSS) budget supports the agency's activities to lead, promote, and facilitate scientific standards and policies to protect the health of Americans here and abroad:

- Providing leadership and training for a diverse, competent, and sustainable public health workforce
- Modernizing public health surveillance systems and infrastructure
- Advancing laboratory science and safety; and
- Improving access to information needed by public health professionals who monitor and respond to disease outbreaks and other threats.

Budget Request

CDC's FY 2026 budget request of **\$596,600,000** for Public Health Scientific Services is **\$29,500,000** above the FY 2025 enacted level.

Program Accomplishments

CDC collects, analyzes, and reports scientific data to inform policies and practices to protect the health of all Americans through the Public Health Scientific Services (PHSS) activities. CDC has made substantial progress in modernizing the data ecosystem used for gathering, analyzing, and sharing data across public and private health care systems. Making data available for more rapid decision-making is a monumental effort requiring upgrades to hundreds of individual systems that were operating independently. CDC's leadership in laboratory response and safety results in millions of laboratory tests being completed accurately and safely, providing data for decision-makers regarding patient care or public health response. U.S. investment is aligning systems to seamlessly share data across public and private sector health systems, while also ensuring that an individual's privacy and confidentiality is maintained.

Key activities include:

- Modernizing CDC and state, territorial, local, and tribal data, surveillance, and analytics capabilities
- Expanding data linkages between CDC health data and datasets from other federal agencies
- Increasing laboratory data exchange

- Ensuring the safety of laboratory personnel and compliance with laboratory protocols and regulatory requirements
- Collaborating with clinical and public health laboratories and federal partners to ensure timely and actionable data is available to protect public health; and
- Strengthening and supporting the public health workforce.

PUBLIC HEALTH SCIENTIFIC SERVICES

BY THE NUMBERS

- **6,908**—Number of healthcare facilities across the 50 states, Washington, D.C., and Guam that contribute data to the National Syndromic Surveillance Program's BioSense Platform.
- **72**—Number of state, tribal, local, and territorial public health jurisdictions using electronic case reporting to receive patient case reports from more than 38,500 healthcare facilities, including hospitals, clinics, urgent care centers, nursing homes, schools, occupational health clinics, and more.
- **15.3 million**—Case notifications received by the National Notifiable Diseases Surveillance System for response, surveillance, analysis, and research purposes.
- **2,202**—CDC laboratory spaces receiving onsite, in-person safety inspections from CDC laboratory safety officials each year.
- **285,000**—Laboratory systems training course registrations by CDC and non-CDC learners as of June 2024.
- **1.83 million** —Number of downloads of CDC publications from CDC Stacks, which houses over 160,000 CDC document releases
- **500**—Technology transfer agreements to help move scientific research and discovery forward and 14 Influenza A(H5) assay technology agreements that were executed

Public Health Scientific Services Funding History ¹	
Fiscal Year	Dollars (in Millions)
FY 2022 Final (BA)	\$471.600
FY 2023 Final (BA)	\$567.100
FY 2024 Final (BA)	\$567.100
FY 2025 Enacted (BA)	\$567.100
FY 2026 President's Budget (BA)	\$496.600
FY 2026 President's Budget (PHS Eval)	\$100.000

¹ In alignment with the proposed HHS reorganization, FY 2022 through FY 2025 levels do not reflect funding for Health Statistics, which will be realigned to the planned HHS Office of the Secretary Office of Strategy (OS) in the FY 2026 Budget.

Surveillance, Epidemiology, and Informatics Budget Request

Surveillance, Epidemiology, and Informatics are the foundation for the nation's ability to identify and respond to health threats. CDC supports state and local capacity that alerts people to health threats, how they are affecting their communities, and what can be done to keep people health and safe.

CDC supports public health surveillance systems, laboratory exchange between public health and clinical laboratories, and high-quality scientific publications that give vital information about the nation's health—from case reporting to emergency department visits to laboratory result data. Continued investment is needed to support and maintain platforms for syndromic data and case reporting while modernizing systems at the federal, state, and local level to ensure that data can move faster than the spread of disease.

National Syndromic Surveillance Program (NSSP)

CDC's NSSP provides local, state, and federal health officials with near-real time situational awareness for detecting and monitoring health events. NSSP tracks symptoms and diagnoses of patients across secure electronic health data sources to detect unusual levels or changing patterns of infectious diseases. More than 2,000 users across local, state, and federal government search data to inform decision-making and action.

Electronic Case Reporting Program (eCR)

eCR enables secure transfer of data to public health authorities for use with disease tracking, case management, and contact tracing. Derived data, with patient identifiers removed, that meet nationally notifiable disease criteria are shared by public health departments with the CDC through the National Notifiable Diseases Surveillance System (NNDSS). Public health departments rely on eCR to receive patient case data in less than one minute from healthcare providers in their jurisdictions. Increasing eCR coverage provides health departments with expanded access to healthcare facility data from hospitals, clinics, urgent care centers, nursing homes, schools, and occupational health clinics while reducing the clinical and administrative burden.

National Notifiable Diseases Surveillance System (NNDSS)

Across the United States, more than 3,000 state, tribal, local, and territorial health departments collect data on 120 diseases and conditions that threaten health. CDC supports health departments in receiving and analyzing data to identify outbreaks and prevent disease spread. CDC continues to make progress on modernizing NNDSS functionality, especially by improving data validation, processing, and provisioning pipelines. These improvements include utilizing additional cloud functionality, providing alternative methods for receiving data, and implementing tools to assist jurisdictions with data reconciliation. The NNDSS program leads efforts to implement a CDC-wide system for receiving Minimal Data Necessary for case data during a response.

Budget Request

CDC's FY 2026 budget request for Surveillance, Epidemiology, and Informatics is **\$327,600,000**. In FY 2026, the Budget will continue to support the agency's scientific integrity and quality infrastructure; clinical and public health laboratory activities; long-standing surveillance systems such as the National Syndromic Surveillance Program and the National Notifiable Disease Surveillance System for specific diseases and conditions; and the Disease Risk Factor Surveillance System to collect data on health-related conditions that threaten communities' resilience to infectious diseases.

NSSP Awards^{1,2}

	FY 2024	FY 2025	FY 2026
(Dollars in millions)	Final	Enacted	President's Budget
Number of Awards	51	*	*
- New Awards	0	*	*
- Continuing Awards	51	*	*
Total Awards	\$6.000	*	*

¹ Table includes core funding from the Surveillance, Epidemiology, and Public Health Informatics budget activity and other CDC programs.

² These funds are not awarded by formula.

* Grant award estimates are under development.

NNDSS Awards¹

	FY 2024	FY 2025	FY 2026
(Dollars in millions)	Final	Enacted	President's Budget
Number of Awards	64	*	*
- New Awards	0	*	*
- Continuing Awards	64	*	*
Average Award	\$0.172	*	*
Range of Awards	\$0.003 - \$0.342	*	*
Total Awards	\$11.035	*	*

¹ These funds are not awarded by formula.

* Grant award estimates are under development.

Disease Risk Factor Surveillance

CDC will support broad, state-based surveys used across health conditions and risk factors, for both ongoing programs and CDC emergency responses. State-based surveillance systems for risk factors for disease are critical for proactively addressing public health challenges. These systems continuously monitor a wide range of risk factors, providing health authorities with real-time data to identify emerging threats and track trends over time. Early detection of these risk factors enables timely interventions, which can prevent diseases from spreading or becoming more severe. By capturing these data, surveillance systems allow public health officials to make informed decisions and implement strategies that reduce the impact of these risks on the population, helping to prevent widespread illness and improve overall health outcomes. In addition to early detection, these surveillance systems enhance the efficient allocation of resources. With a clear understanding of where risk factors are most prevalent, public health efforts can be directed to areas that need them most.

Program Accomplishments

Examples of Surveillance, Epidemiology, and Informatics accomplishments include the following:

- CDC used NSSP data to provide more in-depth insight into infectious diseases and to coordinate surveillance efforts across public health jurisdictions and federal agencies, such as the H5N1 avian influenza response.
- The number of reportable conditions within the eCR infrastructure and the engagement and coordination with electronic health record industry partners has increased from 6 in 2020 to over 200 in 2024.

- CDC developed a detailed NNDSS Technical Roadmap for transformational improvements and further modernization of its case notification systems. The roadmap aims at improving adoption of automation, better response readiness capabilities for case data, and reduced burden for jurisdictions.

Scientific Integrity and Quality

CDC ensures the highest standards of scientific integrity, relevance, credibility, and transparency for data, publications, research, and communication materials. CDC scientific services include training, guidance, consultations, library resources, science dissemination, extramural research coordination, and technology transfer facilitation for scientists across the agency and funded partners.

CDC's investments ensure the timely dissemination of scientific information by promoting data sharing, public access, and aligning with federal data initiatives and privacy, ethics, and confidentiality principles. CDC executes technology transfer agreements, in which CDC partners with industry, academia, non-profits, and other government agencies to transfer CDC's research portfolio, including diagnostics assays, early therapeutics, vaccine candidates, and software, into products and services to improve public health. These agreements foster dissemination and application of CDC science and technology innovations, enabling rapid prevention, detection, and treatment of public health threats.

Morbidity and Mortality Weekly Report (MMWR)

CDC's mission is to detect and respond to health threats requires rapid dissemination of information. CDC's *MMWR*, is the agency's primary vehicle for releasing timely, reliable, and objective scientific findings as fast as pre-prints and faster than peer-reviewed journals. MMWR also includes public health recommendations for prevention and treatment, surveillance findings, and supplemental information.

Advancing Laboratory Science Budget Request

Americans receive more than 15 billion diagnostic laboratory tests in 320,000 clinical and public health laboratories each year. Laboratories are core to the U.S. public health infrastructure, providing critical test results that detect and prevent disease and harmful exposures, and inform the nation's response to public health emergencies. CDC provides scientific expertise and technical services, public health, and clinical laboratories nation-wide to advance:

- High-quality and safe laboratory science
- Reliable testing for diseases and harmful exposures
- Strong laboratory partnerships for readiness and response

Budget Request

CDC's FY 2026 budget request for Advancing Laboratory Science is **\$23,000,000**. CDC will maintain the consistency, quality, and response readiness of laboratory testing within CDC and across laboratories in the public and private sectors by:

- Providing tools, services, and resources to CDC laboratories for quality and safety, risk management and mitigation, and regulatory compliance.
- Developing comprehensive educational resources to enhance diagnostic testing quality.
- Developing, improving, and distributing diagnostic tests for CDC and public health laboratories.
- Improving technical services to CDC laboratories and increasing operational efficiency for diagnostic testing at CDC.
- Improving coordination and communication across diagnostic testing partners across the nation for a public health response to emergencies that is timely, scalable, and resilient.
- Implementing efficient, coordinated strategies for laboratory readiness and response, including strengthening the Laboratory Response Network.

Program Accomplishments

To ensure safety and accuracy of tests, laboratories are certified under Clinical Laboratory Improvement Amendments of 1988 (CLIA) requirements overseen by CMS in partnership with CDC and FDA. CDC also partners with commercial laboratories to enhance the preparedness and response capabilities and capacities of the clinical and public health testing community. For example,

- CDC trained more than 100,000 laboratory professionals via the Laboratory Outreach Communication System (LOCS) providing technical support and assistance for urgent problems, such as shortages of laboratory resources during a public health emergency.
- CDC hosted training through CDC OneLab™ a training community of practice that gives U.S. laboratory staff and testers open access to innovative tools and courses.

Public Health Data Modernization Budget Request

Modernizing public health data is critical to national security and a fundamental component of response readiness. Most critically, the detection, prevention, and response to disease threats depends on core data and surveillance systems which provide essential information to detect threats, track disease spread and severity and provide actionable information that can be used to save lives. CDC's investment in data infrastructure and data modernization at both the national and state health department levels enable core data to flow faster for earlier threat detection and informed public health response decision-making.

Budget Request

CDC's FY 2026 budget request for Public Health Data Modernization is **\$175,000,000**. This request includes **\$75,000,000** in budget authority and **\$100,000,000** million in PHS Evaluation funds.

In FY 2026, CDC will support the enhancement and expansion of core data sources for surveillance of disease threats by investing in critical infrastructure necessary to exchange data securely and in real time, across and with jurisdictional public health authorities, healthcare, and other federal agencies.

Program Accomplishments

Data Modernization investments have improved every aspect of public health data gathering and reporting so that all levels of government have faster, actionable insights for decision-making. CDC provided essential funding and support for collection and analyses, system modernization (e.g., cloud services), and capacity building at public health departments to implement new technological innovations. Because of modernization efforts, CDC has more data for decision-making, particularly across the core surveillance systems used by many CDC programs and public health partners, including the following examples:

- In as little as 8 seconds, eCR sends patient case reports to public health departments for more than 200 conditions, including biothreat agents, respiratory diseases, and infectious diseases.
- CDC built a new electronic pathway for COVID-19 laboratory-based diagnostic tests that has handled over one billion diagnostic test reports, reaching over 1.5 million per day, and is supporting reporting for mpox, allowing CDC to evaluate testing practices, assess percent positivity, and inform response.
- Advancements in interoperability of immunization information systems have improved national situational awareness. Data pipelines have allowed for aggregate reporting of over one million mpox vaccine doses.

Funding for State, Local, Tribal, and Territorial Jurisdictions

CDC will continue to provide direct funding and technical assistance to state, tribal, local, and territorial health departments to improve the timeliness and quality, of core data, to support automated integrated surveillance and analytic capabilities, and improved interoperability with healthcare and CDC.

Building U.S. Data Capabilities to Protect Health

CDC will also continue to improve access to open data, increasing data linkage, automating analytic and data processes, enhancing data visualization, and improving interagency information sharing. CDC will leverage data intermediaries, including Health Data Utilities and Health Information Exchanges, to efficiently route data between healthcare providers, health departments, and CDC.

Public Health Workforce Budget Request

CDC's workforce programs build capacity and strengthen public health department core capabilities. These CDC programs deliver measurable results for communities by boosting frontline services, enhancing emergency response, and driving continuous improvement. These essential components of the nation's public health defense require tools, resources, and a well-trained workforce to work better, faster, and smarter.

- CDC strengthens the U.S. public health workforce through world-class public health fellowships. CDC fellows provide boots-on-the-ground expertise wherever they are needed most – supporting outbreak response, disease investigation, and data systems improvement in state and local health jurisdictions across the nation.
- A highly skilled public health workforce depends on access to high-quality, affordable training. CDC leads national efforts to provide free continuing education and accredited learning opportunities to public health professionals. These trainings promote quality improvement, prepare the workforce to prevent and respond to health threats, and strengthen public health leadership nationwide.

Budget Request

CDC's FY 2026 budget request for Public Health Workforce is **\$71,000,000**. In FY 2026, CDC will support state, local, and territorial health departments through CDC fellowships and training programs to identify and address public health workforce gaps and build capacity to respond to current and future public health threats.

Program Accomplishments

In FY 2024:

- CDC deployed 582 fellows across 11 CDC programs to support 137 emergency and other priority efforts. Fifty-one percent of these fellows were stationed in state, local, or territorial health agencies.
- Provided multi-disciplinary training at no cost to state, tribal, local, and territorial health professionals to advance laboratory quality and safety practices, investigate outbreaks, and better utilize data for outbreak detection, program evaluation, and decision-making.
- Supported on-line continuing education courses that are accessed by hundreds of thousands of health care workers throughout the United States.

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

(dollars in millions)	FY 2024 Final	FY 2025 Enacted ¹	FY 2026 President's Budget	FY 2026 +/- FY 2025
Budget Authority	\$1,292.399	\$1,292.399	\$587.678	-\$704,721
Total Request²	\$1,292.399	\$1,292.399	\$587.678	-\$704,721
FTEs ³	556	563	682	+119
-- Public Health Emergency Preparedness Cooperative Agreement	\$735.000	*	\$350.000	*
-- Academic Centers for Public Health Preparedness	\$9.200	*	\$0.000	*
-- CDC Preparedness and Response	\$139.000	*	\$139.000	*
-- National Disaster Medical System ⁴	\$78.904	*	\$64.904	*
-- Health Care Readiness and Recovery ⁴	\$305.055	*	\$29.774	*
-- Pandemic and Response Innovation (PRI) ⁴	\$4.000	*	\$4.000	*
-- HCORE ⁴	\$15.000	15.000	\$0.000	-15.000
-- Medical Reserve Corps ⁴	\$6.240	*	\$0.000	*

¹ Consistent with the FY 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for FY 2025 and is rolled up within the account.

² FY 2024 Final and FY 2025 Enacted are comparably adjusted to reflect the proposed realignment of the combined Ready Response Enterprise Data Integration Platform/Forecasting and Outbreak Analytics line from the Public Health Preparedness and Response account to the Cross-Cutting Activities and Program Support account. The FY 2026 Budget displays separated, dedicated funding for these two activities within the Cross-Cutting narrative.

³ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

⁴ In alignment with the proposed HHS reorganization, FY 2024 Final and FY 2025 Enacted amounts are comparably adjusted to reflect funding from ASPR PPAs, which the FY 2026 Budget realigns to CDC.

Allocation Methods: Direct, Federal Intramural, Cooperative Agreements, including Formula Grants/Cooperative Agreements; and Contracts

The United States must be prepared to face emerging health threats in today's highly connected world; the COVID-19 pandemic underscored this fact and highlighted the essential need for sustained investment in our domestic public health preparedness and response infrastructure. Local disease outbreaks can quickly escalate into regional, national, and global emergencies. Over the last two decades, we have seen outbreaks of influenza, (H1N1, H7N9, H5N1), Ebola, Zika, SARS-CoV-1 (SARS), SARS-CoV-2 (COVID-19), and mpox. These emerging infectious diseases and localized disease outbreaks spread rapidly and affect populations around the world. CDC empowers communities to respond to any emergency that may strike, including natural disasters and terrorist attacks. CDC's preparedness efforts rely on its expertise in laboratory science, public health surveillance, epidemiology, and public health emergency management, in addition to its longstanding relationships with federal, state, tribal, local, territorial, and global partners.

Budget Request

CDC's FY 2026 budget request of **\$587,678,000** for Public Health Preparedness and Response is **\$704,721,000** below the FY 2025 enacted level. CDC will continue to support state, tribal, local, and territorial health departments to ensure their capability, flexibility, and adaptability in the face of naturally occurring or intentional events that cause public health emergencies. This request eliminates CDC's Office of Readiness and Response and establishes the Center for Preparedness and Response, which includes three programs from the Administration for Strategic Preparedness and Response to the new Center.

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

BY THE NUMBERS¹

- **5,800**—PHEP funding currently supports more than 5,800 state and local employees in health departments across the United States, including nurses, doctors, epidemiologists, laboratorians, logistics and operations staff, and other public health preparedness and response employees working on the front lines to provide critical public health expertise where emergencies begin—at the local level—enabling faster and more effective responses.
- **0**—Releases of select agents or toxins resulting in illness among the general public, death or transmission among workers, or transmission to the outside of a laboratory into the surrounding environment or community, out of over 300 incident reports involving occupational exposures in 2024.
- **~4000**—The number of CDC staff from across the agency pre-identified to respond at a moment's notice to a public health emergency of any scope and scale, and who possess a wide range of essential skills and knowledge critical to public health response.
- **24 → 1** – The number of disparate, outdated, single-function systems that were replaced by one system, CDCReady, to streamline and right-size emergency response operations and support any and all concurrent responses at a lower overall operating cost. CDCReady can be accessed by all agency staff before, during, and after an event, for a total of around \$500 a month—less than 2 cents per user per month for the 28,000 network users with access.
- **199** – Final Federal Select Agent Program (FSAP) inspection reports issued in 2024, with 100% of those reports being issued on time for the second consecutive year.
- **66** – The number of improvement actions that have been completely addressed as the result of response evaluations since COVID-19. Those improvements ensure that CDC's response capabilities, operations, and procedures are more robust ahead of the next public health emergency.
- **5** – Biological agents removed from the FSAP regulated select agents and toxin list in 2024, significantly reducing the regulatory burden on some entities and facilitating greater focus on those agents posing the highest risk to the public. This underscores FSAP's commitment to calibrating and adjusting regulatory oversight based on biorisk.

Public Health Preparedness and Response Funding History ¹	
Fiscal Year	Dollars (in Millions)
FY 2022 Final	\$862.200
FY 2023 Final	\$905.100
FY 2024 Final	\$1,292.399
FY 2025 Enacted	\$1,292.399
FY 2026 President's Budget	\$587.678

¹ In alignment with the proposed HHS reorganization and other proposed realignments, the FY 2024 and FY 2025 Levels– 1) funding from ASPR PPAs and 2) Ready Response Enterprise Data Integration Platform/Forecasting and Outbreak Analytics realigned to the Cross-Cutting Activities and Program Support account.

Public Health Emergency Preparedness Cooperative Agreement

Program Description

The Public Health Emergency Preparedness (PHEP) Cooperative Agreement is an indispensable national security asset that provides direct funding to 62 state, local, and territorial jurisdictions. PHEP supports thousands of front-line workers (nurses, doctors, epidemiologists, laboratorians, logistics, operations, and other preparedness and response employees) in health departments across the United States that do critical work to prevent, detect and respond to life-threatening events.

Budget Request

CDC's FY 2026 budget request for the Public Health Emergency Preparedness (PHEP) Cooperative Agreement is **\$350,000,000**. Funding will support federal preparedness staff positioned in SLTs and hundreds of higher risk jurisdictions that provide expertise in emergency preparedness and response, to ensure multi-hazards readiness for health threats requiring rapid distribution, dispensing, and administration of critical medical countermeasures. Also, investments will support STLT capability to respond faster and more effectively to infectious diseases, natural disasters, and other health emergencies.

Program Accomplishments

During FY 2024, CDC provided additional support for state, local, and territorial (SLT) preparedness in several areas, advancing CDC's capabilities in workforce development, laboratory preparedness, outbreak response, and overall domestic preparedness. CDC supported local health department activities through additional funding for more than 400 local planning jurisdictions that are part of the PHEP program's Cities Readiness Initiative. CDC also modernized critical preparedness infrastructure with the replacement of obsolete chemical laboratory testing equipment for 10 testing laboratories in the Laboratory Response Network for Chemical Threats (LRN-C).

In FY 2024, CDC released a new PHEP notice of funding opportunity that outlines three overarching strategies and related requirements for the next five-year period of performance, which began July 1, 2024. The three strategies are designed to:

- Prioritize a risk-based approach to all-hazards planning and improve readiness, response, and recovery capacity for existing and emerging public health threats and modernized laboratory and electronic data systems,
- Improve whole community readiness, response, and recovery through enhanced partnerships and improved communication systems for timely situational awareness and risk communication, and
- Improve capacity to meet jurisdictional administrative, budget, and public health surge management needs and to improve public health response workforce recruitment, retention, resilience, and mental health.

PHEP Awards

(whole dollars)	FY 2024	FY 2025	FY 2026
	Final¹	Enacted²	President's Budget²
Number of Awards	62	*	*
- New Awards	0	*	*
Average Award	\$10,666,000	*	*
Range of Awards	\$370,000 - \$44,882,000	*	*
Total Awards	\$653,738,609	*	*

¹ CDC awards PHEP funding using the formula established under section 319C-1of the Public Health Service Act. The formula includes a base funding amount; population funding based on risk; and dedicated funding for Cities Readiness Initiative jurisdictions and Level 1 Chemical Laboratories.

² Grant award estimates are under development.

CDC Preparedness and Response

Program Description

Preparedness readiness and response remains central to CDC's mission. The refocused preparedness and response entity at CDC will bring enhanced interagency and STLT coordination to address the full range of 21st Century threats facing U.S. communities.

Budget Request

CDC's budget request for All Other CDC Preparedness is **\$139,000,000**. Funds support the end-to-end programming and evaluation of preparedness and response at the agency, including the Emergency Operations Center (EOC), a vital focused and efficient mission-driven outbreak management hub that strengthens readiness and response capacity to protect Americans from health threats 24/7. These investments support CDC's recent consolidation of 24 outdated systems and functions into one system, CDCReady, effectively modernizing the agency's emergency response systems to drive more efficient day-to-day operations, response activities, and early warning and situational awareness.

Preparedness funding also facilitates biosafety and biosecurity oversight through the Federal Select Agent Program, Import Permit Program, and U.S. National Authority for Containment (Polio), which ensure the safe and secure handling of deadly biological agents and toxins across the nation by conducting over 200 select agent lab inspections, processing more than 2,500 permits for import of infectious biological agents, and working with facilities to prevent the accidental release of poliovirus.

The Budget moves the CDC Preparedness and Response funding to the newly established Center and moves the following three programs from the Administration for Strategic Preparedness and Response to the new Center.

Program Accomplishments

CDC uses the agency's response framework to guide the management of public health emergency responses, ensuring effective and efficient operations regardless of the event's size and scope. In FY 2024, CDC

- Responded to threats including 2023 Lead in Applesauce, 2024 Clade I Mpox, 2024 Influenza A/H5N1, and 2024 Dengue, meeting the unique needs of each event while limiting impact on other CDC activities and resources.
- Inspected nearly 250 registered laboratory facilities to ensure compliance with the select agent regulations. These inspections allow CDC to confirm appropriate biosafety and security measures are in place.

National Disaster Medical System Budget Request

Program Description

The National Disaster Medical System (NDMS) is the only federal medical resource trained and ready to support communities during and after disasters. In 2024, NDMS's most significant deployment was to support the communities affected by Hurricanes Helene and Milton. Over 500 NDMS personnel were deployed to Western North Carolina and NDMS personnel treated hundreds of patients while the two primary medical facilities – Blue Ridge and Mission – worked to bring their facilities back online. NDMS was ready to support the response because of investments made to support personnel trainings and readiness initiatives. Since its establishment in 1984, NDMS has responded to over 300 domestic incidents and two international incidents.

To provide the American public with high quality and comprehensive federal medical care, NDMS has developed four priority areas to guide the program: Readiness, Response, Mitigation and Recovery, and Steady State Coordination.

Readiness: NDMS will continue to use appropriated funds to support provider training and education. A trained workforce ensures personnel will continue to provide high quality care to communities when they are most vulnerable. NDMS will also advance engagement with other USG partners, to include the Department of Defense, to support planning and readiness for threats outside of traditional Stafford Act funded activities. This includes the renewed concerns over movement and care for military casualties resulting from large-scale combat operations (LSCO).

Response: NDMS will continue to support traditional and non-traditional operations, including hurricanes, floods, earthquakes, and other public health emergencies.

Mitigation and Recovery: Aiding a community's return to normal operations post disaster is critical in reducing longer-term health impacts and supports Making America Healthy Again. NDMS will continue to advance partnerships and provide access to federal resources to support communities impacted by disaster.

Steady State Coordination: Regional emergency coordinators (RECs) supported within the NDMS program, will continue to engage with STLT partners to enhance local preparedness and readiness strategies to meet the goals and intent of the Executive Order on Achieving Efficiency through State and Local Preparedness.

Budget Request

CDC's FY 2026 Budget request for NDMS is **\$64,904,000**. The Budget includes **\$4,000,000** for Mission Zero and **\$7,000,000** for Pediatric Disaster Care. In FY 2026, the NDMS will continue to support STLT partners when communities become overwhelmed by disaster. NDMS will also be positioned to support other federal partners when needed, including support for national security special events. NDMS will continue to align its activities to Executive Order (EO) 14239: Achieving Efficiency Through State and Local Preparedness.

National Disaster Medical System Funding History	
Fiscal Year	Dollars (in Millions)
FY 2022 Final	\$75.404
FY 2023 Final	\$96.904
FY 2024 Final	\$78.904
FY 2025 Enacted	\$78.904
FY 2026 President's Budget	\$64.904

Program Accomplishments

Celebrating 35 years of service to the nation, the National Disaster Medical System led and coordinated training for over 800 NDMS intermittents in FY 2024, that focused on developing broad essential skills for medical operations in austere environments, revisited Disaster Mortuary Response Team (DMORT) operations and capabilities, invested in NDMS's aeromedical evacuation large scale combat operation contingencies and behavioral health surge capacity.

Regional Response

NDMS conducted approximately 8,000 readiness and operational coordination activities in FY 2024, advancing preparedness and readiness at the STLT level. RECs supported routine communication, including providing over 100 notifications to jurisdictions related to HHS operations, including MPOX and H5N1.

Readiness:

NDMS successfully executed funding to restore, maintain, and improve HHS's response caches, including modernizing supporting IT systems.

NDMS enhanced HHS response capabilities by procurement of a state-of-the-art mobile veterinary vehicle; building of five additional DMAT caches; building nine aero-medical evacuation kits; and procuring updated x-ray capability and IT infrastructure for the modernization of Disaster Portable Morgue Unit.

In coordination with global partners, NDMS coordinated and facilitated the highly successful Health Security Meeting in Tokyo, Japan, bringing HHS participants together with partners in Japan, European Union/HERA, and Taiwan to discuss enhanced engagement on medical countermeasures, surveillance, and disaster operations. Also on the international front, NDMS hosted the second International Medical Response Forum at the NDMS Training Summit. This Summit included 11 countries and 7 external partners. The forum focused on disaster medical response capabilities and capacities.

Response:

In FY 2024, NDMS deployed over 1,300 personnel and 300 tons of material in support of emergency response, training, and special events.

Mitigation and Recovery

NDMS coordinated disaster recovery missions in FY 2024 in Arkansas, California, Guam, Hawaii, the Hoopa Valley Indian Tribe, Iowa, Louisiana, Mississippi, New Mexico, Ohio, and Vermont. Important advances made possible by NDMS's coordination of the Health and Social Services Recovery Support Function include restoration of child care services to Lahaina after the Maui wildfires; healthcare workforce expansion initiatives on Guam; expansion of clinical mental health services in the Hoopa Valley Tribe; keeping open the only acute-care hospital in Rolling Fork, MS following storms there; and expansion of community capacity for disaster behavioral health recovery support in Louisiana. Community Mitigation and Recovery conducted a successful FY 2024 Disaster Behavioral Health capability development sprint, significantly strengthening NDMS's ability to support states, tribes, territories, and local communities to manage the behavioral health consequences of disasters, public health emergencies, and incidents of mass violence.

In FY 2024, NDMS was able to execute the largest and longest federal disaster behavioral health mission in the Maui wildfires, with over 20,000 behavioral health encounters with survivors and responders, while concurrently supporting Maine following the Lewiston mass shooting event, and subsequently delivered behavioral health teams in response to the New Mexico wildfires.

Health Care Readiness and Recovery Budget Request

Program Description

Disasters and emergencies can cause the health care delivery system to face sudden, high demand that exceeds day-to-day capacity and strains the ability to provide quality care. Disasters rarely respect state lines, requiring coordinated national systems that eliminate siloes between different types of health care organizations while facilitating collaboration to serve the national health security mission. The Health Care Readiness and Recovery (HCRR) portfolio engages partners across states, localities, tribes, and territories, providing funding and leadership to improve the capability and capacity of the health care delivery system to efficiently and effectively prepare for and respond to disasters and emergencies. Additionally, this funding line supports health care readiness for special pathogens and strengthens health care and public health critical infrastructure resilience, including cybersecurity.

Budget Request

CDC's FY 2026 budget request for HCRR is **\$29,774,000**. The Budget continues to support the National Special Pathogen System (NSPS) and Critical Infrastructure Protection (CIP) activities.

Health Care Readiness and Recovery Funding History	
Fiscal Year	Dollars (in Millions)
FY 2022 Final	\$295.555
FY 2023 Final	\$305.055
FY 2024 Final	\$305.055
FY 2025 Enacted	\$305.055
FY 2026 President's Budget	\$29.774

Program Accomplishments

National Special Pathogen System (NSPS): National Emerging Special Pathogens Training and Education Center

The NSPS is a national, tiered System of Care – similar to the National Trauma Care System – with four facility levels that have increasing capabilities to care for patients that have suspected or confirmed High Consequence Infectious Diseases (HCIDs). National Emerging Special Pathogens Training and Education Center (NETEC) is a consortium of three academic medical centers, acts as the Coordinating Body for NSPS, and regularly serves as a special pathogen response advisor to the Secretary and the U.S. government. During recent outbreaks including H5N1, Argentine and Bolivian Hemorrhagic Fevers, Sudan Virus, and Nipah Virus, NETEC provided training materials, situational awareness, technical assistance, and recommendations on patient care to relevant health care entities, enabling high-quality, lifesaving special pathogen care for patients. NETEC directly supports state-level capabilities for special pathogen readiness, partnering with state public health departments and providing consultative services to help strengthen private and public sector health care partners. In FY 2024 alone, NETEC addressed 74 requests for consultation and provided targeted support services to entities like the South Dakota Department of Public Health, which worked with NETEC to revise their concept of operations for responding to HCID threats and facilitating cross-jurisdictional exercises with neighboring states. In collaboration with CDC, NSPS and NETEC accelerated the nationwide response to HCIDs and sustained a heightened level of healthcare preparedness for public health and medical emergencies.

NSPS: Regional Emerging Special Pathogen Treatment Centers (RESPTCs)

RESPTCs serve as regional “hubs” for special pathogen readiness in the United States, contributing to improved patient- and community-centered care for individuals suspected of or infected by a special pathogen. With 100 percent of RESPTC biocontainment units prepared to admit patients within 8 hours or less, RESPTCs have unique facility and clinical capabilities that are essential in providing timely, specialized care during regional and national special pathogen responses. RESPTCs build regional partnerships to streamline care delivery, disseminate information, and provide resources and other support to health care entities across their regions, including to less-resourced entities in rural and geographically isolated areas.

The NSPS – through RESPTCs and NETEC – streamline special pathogen preparedness and response, ultimately saving patient lives and avoiding preventable outbreaks. For example, when a patient in Iowa was diagnosed with Lassa Fever, all components of the NSPS quickly activated to prevent an outbreak in the United States. NETEC coordinated with five health care facilities including RESPTCs to manage infection control, prevent secondary transmission among 180 close contacts, and maintain situational awareness across all response partners. This rapid and coordinated response resulted in zero additional infections. CDC works with the RESPTCs, NSPS, and NETEC to ensure healthcare facilities plan, exercise, and prepare for rapid response to HCID patient care. Through these programs, CDC helps regional, state, and local partners build community-based resilience and improved readiness for HCID and other public health incidents.

Cybersecurity and Infrastructure Protection (CIP)

The Cybersecurity and Infrastructure Protection (CIP) division is the statutorily-required Sector Risk Management Agency for healthcare and public health. On behalf of HHS, CIP strengthens health care and public health partner capabilities and reduces duplicative resource-sharing across state, local, tribal, and territorial (SLTT) partners and private sector entities. For example, in 2024, CIP released a module enabling CIP to more accurately quantify the severity and impact of cyber incidents, streamlining prior manual tools and more accurately deploying mitigation tactics. CIP also developed and quantified risk to health care critical infrastructure with the Risk Identification and Site Criticality (RISC) Toolkit 2.0, and in the 2024 Sector Risk Assessment and preliminary Sector Risk Management Plan, empowering a risk-based approach to SRMA preparedness activities.

Between January 2024 and March 2025, CIP triaged 580 cybersecurity incidents, including the largest cybersecurity attack on health care in American history. In the immediate wake of the Change Healthcare cyber-attack, CIP led an incident response team that rapidly gathered lessons learned, conducted a choke-point assessment, and developed mitigation strategies that are strengthening cyber resilience across the health care and public health sector. CIP is leading similar risk assessments to identify areas to evolve guidance (i.e., streamlining the Cybersecurity Incident Response Plan and aligning guidance with the National Institute of Standards and Technology Cyber Security Framework v2.0) and increase the public health and medical disaster, including cybersecurity disaster, resilience of its SLTT partners.

In 2024, CIP launched the Risk Identification and Site Criticality (RISC) 2.0 Tool. The tool directly and analytically assesses 67 risks, including cyber, infrastructure, and personnel, which hospitals and clinics may face during steady state and response periods. Hospitals and healthcare facilities use the results to mitigate both cyber and infrastructure vulnerabilities in advance. In the four months of operation in 2024, more than 800 healthcare organizations, including hospitals and clinics, used the assessment functions within RISC 2.0 Tool; since the beginning of 2025, that number has more than doubled with more than 2,000 facility-users. This represents approximately 40 percent of the hospital infrastructure nationwide, including several states who have mandated use of the tool for hospitals in the state. Some insurance companies have begun accepting use of the RISC 2.0 Tool as a basis for reducing insurance rates, further improving community resilience by putting money back into the facilities.

In 2024, CIP developed and implemented a new module focused on cyber incident tracking and severity scoring and an objective tool for quantitatively assessing cyber incident severity. CIP uses this data to inform decision-making for response, in alignment with the HPH Sector Cyber Incident Response Plan. These advancements have enabled CIP to provide HHS leaders with enhanced visibility of HPH Sector cybersecurity incidents, speeding up response times to partners and driving down incident impact.

Preparedness and Response Innovation Budget Request

Program Description

The Preparedness and Response Innovation (PRI) program was designed to develop, prototype, and procure health security products, technologies, and innovations. The PRI program provided funds to develop technologies beyond chemical, biological, radiological, and nuclear medical countermeasures (MCMs), and made it possible to adapt practical solutions to ensure the availability of the highest standards of care.

Budget Request

CDC's FY 2026 Budget request for Preparedness and Response Innovation is **\$4,000,000** to continue supporting the development of health technologies, a clinical accelerator network, and establishing a bilateral cooperative program with Israel

Preparedness and Response Innovation Funding History	
Fiscal Year	Dollars (in Millions)
FY 2022 Final	\$2.000
FY 2023 Final	\$2.000
FY 2024 Final	\$3.080
FY 2025 Enacted	\$4.000
FY 2026 President's Budget	\$4.000

Program Accomplishments

The PRI program is developing revolutionary health security products, technologies and innovations from both U.S. and Israeli public and private sources and was established to coordinate strategic innovation and industrial base expansion efforts across HHS, federal partners, academia, and the private sector to bring novel solutions and practices for response and recovery operations to life. The program places emphasis on joint-country revolutionary advancements in health security products, technologies, and solutions, specifically to invigorate operations, response, recovery, deployment, and dispensing activities. This program has furthered developments in novel therapies, individualized medicine, AI-enhanced healthcare monitoring, AI-enhanced drug discovery, remote digital care, and synthetic tissue substitutes.

The Advanced Regenerative Manufacturing Institute (ARMI) in collaboration with the Israel-America Chamber of Commerce further expanded the searchable data base initiated early in the program to over 1,600 Israeli start-up companies sorted by technology sector (medical device, pharma, biologic, software), sub-sector (technologies utilized), phase of development, number of employees, and other categories to share with HHS and use in coordination with the Israeli Innovation Authority, to most efficiently and strategically identify new start-ups and become better connected in the Israeli start-up community.

CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

(dollars in millions)	FY 2024 Final	FY 2025 Enacted ¹	FY 2026 President's Budget	FY 2026 +/- FY 2025
Budget Authority	\$939.520	\$939.520	\$779.520	-\$160.000
Prevention and Public Health Fund ²	\$160.000	\$160.000	\$0.000	-\$160.000
PHS Evaluation Transfer	\$0.000	\$0.000	\$105.000	+\$105.000
Total Request	\$1,099.520	\$1,099.520	\$884.520	-\$215.000
FTEs ³	2,345	1,878	2,495	+617
-- Preventive Health and Health Services Block Grant (PPHF)	\$160.000	\$160.000	\$0.000	-\$160.000
-- Public Health Leadership and Support	\$128.570	*	\$113.570	*
-- Infectious Disease Rapid Response Reserve Fund	\$25.000	\$25.000	\$25.000	\$0.000
-- Public Health Infrastructure and Capacity	\$350.000	\$350.000	\$260.000	-\$90.000
-- Ready Response Enterprise Data Integration Platform/Forecasting and Outbreak Analytics ⁴	\$55.000	*	N/A	*
-- Center for Forecasting and Outbreak Analytics (PHS Eval) ⁴	N/A	N/A	\$50.000	+\$50.000
-- Ready Response Enterprise Data Integration Platform (PHS Eval) ⁴	N/A	N/A	\$55.000	+\$55.000
-- Environmental Health Laboratory ⁵	\$70.750	*	\$70.750	*
-- Environmental Health Threats Prevention ⁵	\$17.000	*	\$17.000	*
-- Global Public Health Protection ⁶	\$293.200	\$293.200	\$293.200	\$0.000

¹ Consistent with the FY 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for FY 2025 and is rolled up within the account.

² The FY 2026 Budget eliminates funding from the Prevention and Public Health Fund (PPHF).

³ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

⁴ FY 2024 Final and FY 2025 Enacted are comparably adjusted to reflect the proposed realignment of the combined Ready Response Enterprise Data Integration Platform/Forecasting and Outbreak Analytics line from the Public Health Preparedness and Response account to the Cross-Cutting Activities and Program Support account. The FY 2026 Budget displays separated, dedicated funding for these two activities.

⁵ FY 2024 Final and FY 2025 Enacted are comparably adjusted to reflect the proposed realignment of Environmental Health Laboratory and Environmental Health Threats Prevention to the Cross-Cutting Activities and Program Support account.

⁶ FY 2024 Final and FY 2025 Enacted are comparably adjusted to reflect the proposed realignment of Global Public Health Protection from the Global account to the Cross-Cutting Activities and Program Support account.

Allocation Methods: Direct Federal/Intramural, Contracts, Competitive Grants/Cooperative Agreements

Program Description

The CDC-Wide Activities and Program Support account supports cross-cutting agency functions that drive coordination, enhance foundational capacities, and support CDC's ability to deliver rapid, decisive responses to emerging public health threats.

Budget Request

CDC's FY 2026 budget request of **\$884,520,000** for CDC-Wide Activities and Program Support is **\$215,000,000** below the FY 2025 enacted level. This request includes **\$105,000,000** in PHS Evaluation Transfer funds.

The FY 2026 request also reflects two proposed budget structure realignments to the Cross-Cutting Activities and Program Support Account – 1) Global Public Health Protection from the Global Health account and 2) Environmental Health Laboratory and Environmental Health Threats Prevention from the Environmental Health account.

CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

BY THE NUMBERS

- **Over 100**—State, local, and territorial health departments directly funded to strengthen public health infrastructure including emergency response and disease surveillance.
- **200**—Number of overseas outbreaks that CDC responded to and helped resolve in 2024 alone, before they reached the United States, including hemorrhagic fevers, cholera, hepatitis, mpox, respiratory illnesses, measles, and polio
- **\$10 million**—Savings to the U.S. government, with \$12,000 in savings to each state or local health department, since CDC began creating medical illustrations previously acquired through commercial licensing.
- **\$51.3 million**—Awarded to 26 American Indian and Alaska Native Tribal nations and regional tribally designated organizations from across CDC since 2023 to strengthen the people, services, and systems needed to prevent disease, promote health, and protect communities from emerging health threats and longstanding health challenges.
- **450** — Chemicals, nutrition indicators, and clinical biomarkers measured by CDC’s Environmental Health Laboratory, providing actionable information on Americans’ environmental exposures and health status.
- **14+** — Environmental health emergencies CDC responded to last year, providing expertise to health departments and healthcare providers to protect people in affected areas and first responders.
- **2 days -> 4 hours** — RREDI has taken emergency response activation time from 2 days to 4 hours. For example, in 2022 it took 2 days to get data systems and hundreds of CDC and state users online for the 2022 mpox response. In 2024, this took only 4 hours to do the same for the 2024 mpox response activation.

*References:

*Unless otherwise noted, all information and calculations are from CDC program data.

Cross-Cutting Activities and Program Support Funding History ¹	
Fiscal Year	Dollars (in Millions)
FY 2022 Final (PPHF)	\$160.000
FY 2022 Final (BA)	\$333.570
FY 2023 Final (PPHF)	\$160.000
FY 2023 Final (BA)	\$563.570
FY 2024 Final (PPHF)	\$160.000
FY 2024 Final (BA)	\$939.520
FY 2025 Enacted (PPHF)	\$160.000
FY 2025 Enacted (BA)	\$939.520
FY 2026 President's Budget (PPHF)	\$0.000
FY 2026 President's Budget (BA)	\$779.520
FY 2026 President's Budget (PHS Eval)	\$105.000

¹ FY 2024 and FY 2025 Levels reflect two proposed budget structure realignments to the Cross-Cutting Activities and Program Support Account – 1) Global Public Health Protection from the Global Health account and 2) Environmental Health Laboratory and Environmental Health Threats Prevention from the Environmental Health account.

Public Health Leadership and Support Budget Request

This budget line supports cross-cutting activities including communications, policy, and science, that enable CDC to manage with efficiency, transparency, and accountability. CDC will continue to provide public health leadership to the nation and fulfill its responsibilities for responsive and timely communication to the public, key partners, and Congress. Staff offices will continue to work across the agency to maintain responsive communications, legislative, and policy functions. With support from this line, CDC carries out the following activities:

- Ensures CDC's science, programs, and recommendations are accessible, understandable, and actionable and maximize public trust and credibility.
- Identifies high-value prevention and public health policies and interventions; increases the understanding and use of credible evidence of preventions' impacts by policymakers, health care, and public health professionals; and catalyzes collaboration among public health, health care, and other sectors.
- Guides CDC's policy development and coordinates review of policies and other documents across the agency and with other federal agencies to ensure consistent federal policies.
- Receives and responds to requests for information and assistance from Congress, Government Accountability Office (GAO) and the Office of the Inspector General (OIG) to facilitate audits and engagements.
- Operates the Office of Rural Health to advance strategies to meet the unique public health challenges of rural populations.

Budget Request

CDC's FY 2026 budget request for Public Health Leadership and Support is **\$113,570,000**.

These funds will continue to support national public health coordination, communication, and partnerships.

Program Accomplishments

CDC responded to more than 4,000 unique correspondences on more than 1,000 topic areas from stakeholders, including Congress, academia, the business sector, employers, and other federal, state, and local partners.

Infectious Diseases Rapid Response Reserve Fund Budget Request

The Infectious Diseases Rapid Response Reserve Fund (IDRRRF) was created by Congress in 2019, following the epidemics of Ebola in West Africa and Zika in the Americas – two public health emergencies in which CDC lacked sufficient funding for early response. The IDRRRF is designed as a flexible and immediate source of funds for CDC to use to respond quickly to an urgent problem on the ground and has the potential to spread and threaten the national security and health of Americans.

To date, IDRRRF funds have supported CDC’s response to Ebola Virus Disease (EVD) in Africa in 2019, with subsequent responses in 2021 and 2022; early and aggressive response to the global outbreak of COVID-19 in 2020; and the mpox outbreak in the United States in 2022. In 2023, IDRRRF supported CDC’s mpox response activities and provide capacity to detect and respond to Ebola outbreaks in Africa, including possible reintroduction of Ebola related to prior outbreaks. In 2024, IDRRRF supported responses to Clade I Mpox and Marburg virus.

Budget Request

CDC’s FY 2026 budget request of **\$25,000,000** for the Infectious Diseases Rapid Response Reserve Fund is level with FY 2025 enacted level. This continued investment allows CDC to respond quickly when an imminent public health emergency is detected, as with mpox, EVD, and other infectious diseases that threaten U.S. security.

Program Accomplishments

CDC used IDRRRF funds to respond to the following threats:

Mpox Disease (formerly known as monkeypox) is caused by infection with Monkeypox virus, which is in the same family as the virus that causes smallpox. Mpox comprises two types, or clades: clade II mpox caused the global outbreak that began in 2022. In comparison, clade I mpox results in more severe illness and deaths; a high proportion of cases have been reported in children younger than 15 years of age.

CDC is working with partners across the region on disease surveillance, laboratory capacity including testing materials, strengthening workforce capacity, case investigation, case management, infection prevention and control, border health, risk communication, and community engagement. CDC is also assisting with vaccine strategy since the best protection against mpox is two doses of the JYNNEOS vaccine for people who are eligible.

Marburg Virus Disease is a rare but severe viral hemorrhagic fever that causes symptoms ranging from fever and headache to unexplained bleeding and death. It can be transmitted through direct contact with someone who is sick or recently died from Marburg virus disease, contaminated objects, or animals with Marburg infection. No FDA-approved vaccine or treatment for Marburg exists. CDC used IDRRRF funds to support Rwanda in containing the outbreak; increase readiness efforts at U.S. ports of entry, increase U.S. laboratory capacity to detect Marburg; and heighten awareness of the Rwandan outbreak and of Marburg virus disease among clinicians, health departments, clinical labs and the public through a Health Alert Network [health advisory](#).

Public Health Infrastructure and Capacity Budget Request

States and local communities continue to face life-threatening infectious disease outbreaks. Meeting these challenges requires people, services, and systems to protect health in every community. After decades of underinvestment, the need for sustained public health infrastructure investment is deep and largely unmet, with an estimated \$4.5 billion annual gap in foundational public health capabilities in the United States.¹ With a stronger infrastructure, public health departments will be able to help maintain every American's health by tracking diseases, stopping outbreaks, and monitoring data.

Jurisdictions have expressed the need to build capacity to respond to emergencies and provide essential services like tracking the spread of an emerging disease. Jurisdictions also emphasized a need for sustainability to support and maintain a more robust public health system.

Budget Request

CDC's FY 2026 budget request of **\$260,000,000** for Public Health Infrastructure and Capacity is **\$90,000,000** below the FY 2025 enacted level. In FY 2026, CDC will continue to directly fund state, local, tribal, and territorial health departments to support jurisdictions' public health infrastructure by enhancing workforce capacity, cultivating robust community partnerships, and strengthening public health outcomes. With this investment, health departments will strengthen their abilities to effectively respond to a range of public health threats, while maintaining programs and services in other areas of longstanding public health need.

Program Accomplishments

In 2024, CDC awarded \$245,000,000 in Public Health Infrastructure and Capacity base funds to 106 jurisdictions including all 50 states, 22 cities, 26 counties, and eight territories and freely associated states for foundational capabilities. Over the five-year grant period, these funds will be used to create a stronger, more resilient public health system that is ready to face future health threats.

Public Health Infrastructure Grant: Foundational Capabilities¹

(dollars in millions)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	106	106	106
- New Awards	0	0	0
- Continuing Awards	106	106	106
Average Award	\$2.311	\$2.311	\$2.311
Range of Awards	\$0.493-10.514	\$0.493-10.514	\$0.493-10.514
Total Awards	\$245.000	\$245.000	\$245.000

¹ Awards noted for Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems Grant Activity 2: -Foundational Capabilities, awarded December 2024.

¹ DeSalvo K, Parekh A, Hoagland GW, et al. Developing a financing system to support public health infrastructure. *Am J Public Health*. 2019;109(10):1358-1361. doi:[10.2105/AJPH.2019.305214](https://doi.org/10.2105/AJPH.2019.305214)[PubMedGoogle ScholarCrossref](#)

Center for Forecasting and Outbreak Analytics Budget Request

Recent outbreaks highlighted a critical gap in the nation’s public health infrastructure—the capability to quickly model the severity of infectious disease outbreaks and forecast their trajectories. CDC’s Center for Forecasting and Outbreak Analytics (CFA) is the only U.S. government entity with the primary mission of delivering infectious disease forecasts and analytics to support outbreak response.

Since its establishment in 2021, CFA has published analytics to inform responses to outbreaks of Marburg, Ebola, mpox, and acute pediatric hepatitis. In FY 2023, CFA continued progress towards its four goals:

- 1) PREDICT – Deliver actionable analysis and response-ready modeling tools.
- 2) INFORM – Generate practical decision support products.
- 3) INNOVATE – Drive technological and analytic innovation.
- 4) ADVANCE – Build a world-class forecasting and outbreak analytics organization.

The U.S. lacks capacity—and no market yet exists—for forecasting and modeling future disease transmission and communicating with state and local jurisdictions about specific public health threats. Therefore, as the nation’s lead for health security, CDC is coordinating the work needed to advance U.S. capacity. CFA is building, testing, and improving open-source models and tools for pandemic-prone diseases.

CDC is committed to communicating forecasts and outbreak projections to decision-makers clearly. Innovation is a key component of CFA’s strategy and requires meaningful partnerships with academic institutions, the private sector, and state and local health departments.

Budget Request:

CDC’s FY2026 budget request for CFA is **\$50,000,000** in PHS Evaluation Funds. In FY2026, CDC will continue to:

- Apply the best available modeling methods and latest technologies to data analysis to continue advancing U.S. capacity to forecast and model infectious disease outbreaks
- Model outbreaks with multiple streams of data, advanced analytics, and forecasts.
- Build state and local capacity to implement forecasting and modeling tools during outbreaks.
- Support Insight Net, a network of public health experts dedicated to creating, testing, and implementing next-generation data analytic tools. With a focus on infectious disease outbreaks, Insight Net’s data tools are supporting state, tribal, local, and territorial health departments’ public health readiness and response capabilities.

Recent outbreaks in the U.S. have highlighted a critical gap in the nation’s public health infrastructure—specifically the capability to quickly model the severity of infectious disease outbreaks and forecast their trajectories. CFA is focused on addressing these needs by creating, testing, and improving open-source models and other tools for outbreak analytics.

Program Accomplishments

CDC is improving response capabilities by developing real-time forecasting and modeling tools for infectious diseases. These models and forecasts guide public health action, quickly delivering insights on epidemic trends, hospital admissions, and future outbreak scenarios. CFA’s data scientists and Insight Net partners have developed 40 tools, with 11 more in development, to support infectious disease outbreak response. As the only U.S. government entity dedicated to disease forecasting, CFA equips leaders with precise, localized insights to protect communities. One example is the *Current Epidemic Trends* forecast for COVID-19 and Influenza. Whereas previous estimates used data on hospital admissions, CDC is incorporating data on emergency department visits which improves forecast resiliency and expands the signals that can be forecasted. This enabled

CDC to catch the earliest signal of the summer 2024 surge of COVID-19 and the influenza surge in winter 2025. Since its establishment in 2021, CFA has provided modeling, forecasting, and other analytic support to 14 outbreak responses, including 6 responses in 2024 for measles, influenza A, H5N1, clade I mpox, and Marburg. Advancing capacity and developing tools for use at state and local outbreak response remains a priority for the Center.

Response Ready Enterprise Data Integration Platform (RREDI)

The One CDC Data Platform (1CDP) and its emergency response operations component, the Response Ready Enterprise Data Integration Platform (RREDI), provide the critical capabilities for data analysis and data management necessary for CDC and USG-wide public health emergency responses. 1CDP and RREDI provide a secure, centralized platform for real-time access and sharing of integrated data. The platform enables rapid information sharing with decisionmakers across the USG and with state and local health departments during public health responses. CDC and its partners use RREDI during public health events and emergencies to integrate data from hundreds of sources across federal, state, and local public health, to provide essential tools and capabilities for responses, and for rapid information sharing.

Budget Request

CDC's FY 2026 budget request for RREDI is **\$55,000,000**. In FY 2026, CDC will continue development and use of tools for preparedness and response functions. CDC will expand deployment of enterprise response capabilities in 1CDP/RREDI, including solutions for streamlined ingestion, standardized data management, automated alerting, and coordination with STLTs and USG partners. CDC will maintain platform operations, including training, platform security, and user onboarding. CDC will integrate both new and existing data assets and expand the provisioning of data to federal and non-federal partners for increased data usability. CDC will continue to support public health response operations at all levels of public health, as well as those of federal and non-federal partners.

Program Accomplishments

CDC developed tools for preparedness and response functions and deployed enterprise response capabilities. CDC will continue to maintain platform operations and integrate new and existing data assets and expand data usability to support public health response operations.

Environmental Health Laboratory Budget Request

CDC develops and uses laboratory tests to identify harmful environmental exposures, nutritional deficiencies, and disease markers, facilitating disease detection and treatment. New methods often address emerging concerns like per- and polyfluoroalkyl substances (PFAS) exposures. CDC also funds state laboratories to develop their capacity for detecting environmental exposures. To protect national security, CDC maintains laboratory readiness for identifying and mitigating health risks during natural and man-made disasters, including chemical agent, radiological, and nuclear events. CDC ensures the accuracy of clinical tests for over 45 disease markers and provides reference intervals to help healthcare providers identify patients with abnormal test results, ensuring accurate diagnoses and reducing medical costs. For example, CDC's Newborn Screening Program is the world's only program that assures the quality of laboratories' newborn screening test results, leading to the early detection and treatment of newborn disorders and preventing the severe disability or death of over 6,000 American infants annually.

Budget Request

CDC's FY 2026 budget request for Environmental Health Laboratory is **\$70,750,000**. In FY 2026, CDC will continue providing diagnostic methods and exposure information for over 440 chemicals and maintain readiness to respond to environmental health emergencies. CDC will continue to support state capacity and national emergency preparedness through the State Biomonitoring Cooperative Agreement as well as the Laboratory Response Network CDC will also distribute over 700,000 reference materials and maintain the Newborn Screening Center of Excellence to continue assisting states with the implementation of newborn screening programs.

Program Accomplishments

In 2024, CDC used a newly developed laboratory method to identify the strain of anthrax affecting a patient in Louisiana in a matter of hours, instead of the days required for other methods. This informed the selection of the correct antibody treatment. CDC monitoring of the patient's anthrax toxin blood levels during treatment also revealed that the patient would require multiple antibody doses, instead of the standard one dose, to ensure survival. CDC is currently the only laboratory in the United States able to make these rapid, critical measurements for this toxin in human blood samples.

State Biomonitoring Cooperative Agreements

(dollars in millions)	FY 2024	FY 2025	FY 2026
	Final	Enacted	President's Budget
Number of Awards	6	*	*
- New Awards	6	*	*
- Continuing Awards	0	*	*
Average Award	\$0.833	*	*
Range of Awards	\$0.728-0.900	\$0.350- 0.900	
Total Awards	\$5.00	*	*

*Grant award estimates under development

Newborn Screening Cooperative Agreements

(dollars in millions)	FY 2024	FY 2025	FY 2026
	Final	Enacted	President's Budget
Number of Awards	5	*	*
- New Awards	0	*	*
- Continuing Awards	5	*	*
Average Award	\$0.397	*	*
Range of Awards	\$0.348-0.445	*	*
Total Awards	\$1.987	*	*

*Grant award estimates under development

Environmental Health Threats Prevention Budget Request

Funding to Environmental Health Threats Prevention enables CDC to detect and respond to emerging environmental health threats, including preventing disease related to natural and man-made disasters. CDC serves as a crucial resource with expertise that jurisdictions depend on to identify and implement measures to protect people from disease related to environmental exposures. CDC also deploys staff to assist jurisdictions with investigating illnesses with unknown environmental origins and provides surge capacity for health departments during environmental health emergencies.

Budget Request

CDC's FY 2026 budget request for Environmental Health Threats Prevention is **\$17,000,000**. Funding will support health departments as they identify and address environmental exposures; develop tools, guidance, and trainings to assist with preventing environmental-related disease; and support responses to environmental health emergencies, including natural disasters and chemical exposures. CDC will also protect national security by maintaining readiness to respond to chemical agent, radiological, and nuclear events.

Program Accomplishments

- In 2024, CDC responded to the contamination of Diamond Shroomz mushroom products with a toxin that sickened 180 individuals, led to 73 hospitalizations, and resulted in three deaths. CDC experts coordinated with America's Poison Centers to monitor for cases of illness, provided information for healthcare clinicians on how to identify and manage patients, and supported 34 states with their responses to cases in their jurisdiction.

Global Public Health Protection Budget Request

CDC is the U.S. government's lead agency for infectious disease outbreak response and implementor of global health security activities aimed at keeping Americans safe at home and abroad. Epidemics and public health crises can weaken economies and destabilize societies, making early containment critical. CDC's global presence is a frontline defense for the United States, enabling the agency to track disease trends, detect outbreaks early, and act quickly to contain threats. CDC's unique technical expertise, leadership, and trusted in-country relationships are essential for reducing transmission and stopping infectious disease outbreaks.

CDC advances the U.S. government's Global Health Security Strategy and the National Biodefense Strategy by leading the response to public health emergencies, including training and deploying outbreak investigators, facilitating international cooperation on and adherence to International Health Regulations (IHR) and global health security architecture standards, and strategically assisting countries around the world to build and improve their disease surveillance capacities and laboratory capabilities.

Budget Request

CDC's FY 2026 budget request of **\$293,200,000** for Global Public Health Protection is level with the FY 2025 enacted level. This request will enable CDC to continue its mission to prevent, detect, and respond to global health threats before they reach U.S. borders.

Program Accomplishments

CDC responded to over 200 outbreaks in 2024 before they reached the United States, including hemorrhagic fevers, cholera, hepatitis, mpox, respiratory illnesses, measles, and polio. CDC worked with host country counterparts to identify the source of these outbreaks and scale up testing and diagnostics to stop the spread of disease and end the outbreaks. CDC will continue to partner with Ministries of Health and national public health institutes to advance global health security by providing specialized epidemiologic, laboratory and emergency response expertise aimed at strengthening real-time surveillance and outbreak response for emerging infectious diseases before they spread to the United States.

BUILDINGS AND FACILITIES

(dollars in millions)		FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
	Budget Authority	\$40.000	\$40.000	\$40.000	\$0
	Total Request	\$40.000	\$40.000	\$40.000	\$0
	-- Buildings and Facilities	\$40.000	\$40.000	\$40.000	\$0

Safe, secure, and fully operational laboratories and facilities equip CDC with the infrastructure needed to protect Americans through infectious disease surveillance and rapid responses to outbreaks and other public health emergencies. CDC's laboratories and facilities must be in top condition for CDC staff to respond to health threats such as such as measles, mpox, and the highly pathogenic avian influenza outbreak (H5N1 bird flu).

Buildings and Facilities (B&F) funds allow CDC to conduct maintenance and repairs to stave off the physical decline of facilities. Laboratories are particularly vulnerable to deterioration and require almost constant oversight to prevent equipment and system failures. Such failures can threaten safety of individuals in the building and on campus, require costly emergency repairs, and hinder CDC's ability to perform essential laboratory functions.

Budget Request

CDC's FY 2026 budget request of **\$40,000,000** for Buildings and Facilities is level with the FY 2025 enacted level. This funding exclusively supports renovations to existing buildings, and repair and improvements (e.g., laboratory ventilation upgrades, structural repairs, roof replacements, and electrical and mechanical repairs) needed to restore, maintain, and improve CDC's assets. This investment will allow CDC to limit increases in the total backlog of maintenance and repairs of \$238,510,000 across all CDC campuses.

CDC prioritizes repair and improvement (R&I) projects by need and available funding within the following categories:

- Execution of fire and life safety required improvements
- Mission-critical support projects
- Replacement of technologically antiquated mechanical and electrical infrastructure
- Improvement of operational efficiency, and increased resiliency in alignment with federal requirements
- Reduction of the current backlog of maintenance and repair

Critical program support initiatives and facilities maintenance planned for FY 2026 will address these urgent needs, ensuring CDC facilities remain operational, safe, and capable of supporting the agency's mission.

Program Accomplishments

CDC strategically invests in R&I of outdated or inefficiently operating laboratories to ensure that all U.S. locations are safe and remain capable of supporting the nation's public health mission. Over the past two years, CDC has saved lease space costs by closing seven leased facilities in the Atlanta, Georgia area and an eighth that will occur in 2026. Consolidating leasing expenses allows other efficiencies such as reducing costs of security services. For example, the Johnny Isakson Public Health Research Building on the CDC Chamblee Campus is projected to save \$85 million in lease avoidance costs over the course of the next 30 years.

Buildings and Facilities Funding History	
Fiscal Year	Dollars (in millions)
FY 2021	\$30.000
FY 2022	\$30.000
FY 2023 Final	\$40.000
FY 2024 Final	\$40.000
FY 2025 Enacted	\$40.000
FY 2026 President's Budget	\$40.000

WORKING CAPITAL FUND

CDC FY 2026 WORKING CAPITAL FUND TABLE

(dollars in thousands)

CDC Programs	FY 2025 Estimate	FY 2026 Estimate¹
Immunization and Respiratory Diseases	\$81,355	TBD
Viral Hepatitis, STI and TB Prevention	\$59,695	TBD
Emerging and Zoonotic Infectious Diseases	\$108,786	TBD
Chronic Disease Prevention and Health Promotio ²	\$52,458	N/A
Birth Defects, Developmental Disabilities, Disability and Health ²	\$11,704	N/A
Environmental Health ²	\$32,242	N/A
Injury Prevention and Control ²	\$29,206	N/A
Public Health Scientific Services	\$105,207	TBD
Occupational Safety and Health ²	\$48,650	N/A
Global Health	\$66,571	\$0
Public Health Preparedness and Response	\$42,889	TBD
CDC Wide Activities	\$19,268	TBD
CDC Program Total	\$658,030	TBD
Other CDC Funding Sources		
<i>Agency for Toxic Substances and Disease Registry</i>	\$9,869	TBD
<i>Energy Employees Occupational Illness Compensation Program Act (EEOICPA)²</i>	\$2,711	N/A
<i>World Trade Center Health Program²</i>	\$11,078	N/A
<i>PEPFAR</i>	\$49,878	TBD
<i>Other Reimbursable Income</i>	\$32,969	TBD
Other CDC Programs Contributions Total	\$149,977	TBD
Total CDC Programs Contributions	\$808,007	TBD

¹To date, the FY 2026 WCF Operating budget is not yet approved.²In alignment with the HHS reorganization, the 2026 Budget moves these programs from CDC to the Administration for Healthy America.

The Working Capital Fund (WCF) is a revolving fund with extended availability and serves as the funding mechanism for centralized business services support across CDC. Business service offices provide services to CDC programs and the WCF bills programs for the services consumed based on pre-established rates. Services include office and other space management, information technology, financial transactions, human resources support and security services.

WCF promotes efficiency through more effective cost control in two primary ways. First, it provides business service offices with better information on the amount of customer demand for their services. With this information, business service offices can target inefficient processes and performance issues and enhance overall resource planning. Second, by providing customers with visibility into service costs, it incentivizes programs to understand the factors that drive the costs of services they consume and to exercise greater control over the incurred costs.

In FY 2014, CDC base operations funding (Business Services Support) was transferred to all program budget lines to cover costs to establish and maintain the Working Capital Fund. The WCF supports CDC's core operations to achieve the agency's public health mission.

REIMBURSEMENTS AND TRUST FUNDS¹

(dollars in millions)	FY 2023 Actual	FY 2024 Actual	FY 2025 Estimate	FY 2026 Estimate
Reimbursements and Trust Funds	\$715.224	\$718.206	\$656.463	\$656.463

¹ Reimbursement and Trust Fund Levels reflect anticipated collections.

CDC's reimbursable activities provide scientific and programmatic expertise to other agencies and organizations. CDC has a long history of partnering with other federal agencies in the shared interest of improving public health and prevention programs. Examples of these activities include:

- CDC will continue its longstanding agreements with other agencies of the Public Health Service and HHS to provide scientific and programmatic expertise in areas such as genetic diseases, laboratory tests, investigations, and training and model screening programs. In addition to reimbursable agreements and user fees, CDC receives funds from Cooperative Research and Development Agreements (CRADAs) to enhance and facilitate collaboration between the agency's laboratories and various partners.
- CDC will continue to work with the Assistant Secretary for a Healthy Future and FEMA providing support of the Department's public health and medical response and recovery missions including, but not limited to, Stafford Act declarations, Public Health Emergencies (PHEs), and National Special Security Events (NSSEs) on direct mission agreements.
- CDC will continue to process Intra-Departmental Delegation of Authority (IDDA) providing an alternative to allocations and transfers (where non-expenditure transfers are permissible) which enables HHS OpDivs to assist each other in areas such as grant issuance. Use of an IDDA must not result in an unauthorized augmentation of an appropriation.

PERFORMANCE BY ACTIVITY

IMMUNIZATION AND RESPIRATORY DISEASES

Immunization Program and Program Implementation and Accountability

Performance Measure for Long Term Objective: Ensure that children and adolescents are appropriately vaccinated

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
1.2.1c Achieve and sustain immunization coverage in children 19 to 35 months of age for one dose of MMR vaccine (Intermediate Outcome)	FY 2023: 91.1% Target: 90% (Target Exceeded)	90%	90%	Maintain
1.2.1h Achieve and sustain immunization coverage of at least 90% in children 19- 35 months of age for at least 4 doses of pneumococcal conjugate vaccine (Intermediate Outcome)	FY 2023: 81.4% Target: 90% (Target Not Met)	90%	90%	Maintain
1.2.1i Achieve and sustain immunization coverage of at least 80% in children 19- to 35- months of age for 2-3 doses of rotavirus (Intermediate Outcome)	FY 2023: 75.1% Target: 80% (Target Not Met)	80%	80%	Maintain
1.2.2a Achieve and sustain immunization coverage of at least 80% in adolescents 13 to 15 years of age for 1 dose of Tdap (tetanus and diphtheria toxoids and acellular pertussis) (Intermediate Outcome)	FY 2023: 88.8% Target: 90% (Target Not Met)	90%	90%	Maintain
1.2.2b Achieve and sustain immunization coverage of at least 80% in adolescents 13 to 15 years of age for 1 dose of meningococcal conjugate vaccine (MenACWY) (Intermediate Outcome)	FY 2023: 86.9% Target: 87% (Target Met)	87%	87%	Maintain
1.L.1: Achieve and sustain vaccination coverage of at least 80% for receiving recommended doses of human papillomavirus (HPV) vaccine (among adolescents 13-15 years of age)	FY 2023: 57.3% Target: 60% (Target Not Met)	65%	65%	Maintain

Performance Measures for Long Term Objective: Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
1.3.1b Increase the percentage of adults aged 65 and older who are vaccinated with at least one dose of pneumococcal vaccine (Intermediate Outcome)	FY 2023: 64% Target: 85% (Target Not Met)	85%	85%	Maintain
1.3.2c Increase the percentage of non- institutionalized adults ages 19 to 64 at increased risk of pneumococcal disease who are vaccinated with at least one dose of pneumococcal vaccine (Intermediate Outcome)	FY 2023: 23.5% Target: 29% (Target Not Met but Improved)	29%	29%	Maintain
1.3.3a Increase the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza (Intermediate Outcome)	FY 2023: 51% Target: 70% (Target Not Met but Improved)	70%	70%	Maintain

¹Target was initially set without knowledge of 2025 funding

Performance Trends: Vaccination is one of the most important public health tools we use to prevent serious illness and death across the lifespan. CDC estimates that vaccination of children born during 1994–2023 helped prevent approximately 508 million illnesses and 1,129,000 deaths, saving nearly \$2.7 trillion in societal costs. CDC prioritizes achieving high vaccination coverage rates as it leads to population immunity, ultimately reducing disease incidence and preventing outbreaks of vaccine-preventable diseases. Over the past decade, CDC has demonstrated improvements in vaccination coverage rates across the lifespan, yet challenges remain.

Childhood Vaccination Coverage: Rotavirus vaccine coverage among children increased by 20 percentage points from 59% in FY 2010 to 79% in FY 2021; despite this progress, CDC noted that coverage rates fell to 75.1% in FY 2023, further missing the 80% target (Measure 1.2.1i). Since FY 2010, measles, mumps, and rubella (MMR) vaccinations exceeded 90% coverage rates (Measure 1.2.1c). However, CDC found that during the 2023-2024 school year routine vaccination coverage for kindergarteners decreased to <93% for selected routine vaccines like MMR; the vaccination exemption rate increased to 3.3% during the 2023-2024 school year compared to 3% (2022-2023 school year). Four dose coverage of pneumococcal conjugate vaccine (PCV13) was 81.4% in FY 2023, which is lower than rates in recent fiscal years (Measure 1.2.1h). Effective strategies to improve the fourth dose of PCV coverage are in place and CDC expects more children will become fully vaccinated in the future.

Adolescent Vaccination Coverage: Vaccine coverage for Tetanus, diphtheria, and acellular pertussis (Tdap) among adolescents aged 13-15 years increased from 74% in FY 2010 to 88.8% in FY 2023 (Measure 1.2.2a), nearly meeting the target of 90%. Meningococcal conjugate vaccine (MCV4) coverage increased from 65% in FY 2010 to 86.9% in FY 2023, which met the target of 87% (Measure 1.2.2b); however, this rate is slightly lower than the FY 2019 and 2020 results. In FY 2023, CDC revised the Measure 1.L.1 to align with the Healthy People 2030 HPV measure, Increase the proportion of adolescents who get recommended doses of the HPV vaccine — IID08. This change allows CDC to demonstrate the short term (e.g., one-year) impact of immunization program processes for the HPV vaccine. In FY 2022, vaccination coverage among adolescents 13-15 years of age receiving the recommended doses of HPV vaccine was 58.6%. In FY 2023, 57.3% of adolescents aged 13-15 years had received the recommended doses of HPV vaccine, falling short of the 60% target.

Adult Vaccination Coverage: CDC did not meet the FY 2023 target for pneumococcal vaccination coverage among noninstitutionalized adults aged 19-64 years at increased risk for pneumococcal disease; coverage has remained below 25% for the past four years (Measure 1.3.2c). CDC did not meet the FY 2023 target for pneumococcal vaccination coverage among adults 65 and older; coverage has remained below 70% for the past four years (Measure 1.3.1b). Seasonal influenza vaccination rates for adults ages 18 years old and over increased from 42% in FY 2015 to 51% in FY 2023 (Measure 1.3.3a), but these rates are falling short of the 70% target. Despite not meeting targets, CDC is demonstrating gradual improvements towards these goals and is implementing strategies to improve adult vaccination coverage, such as informing health care professionals about the Standards for Adult Immunization Practice.

CDC Programs Improving Vaccination Coverage Across the Lifespan: CDC continues to support progress on the performance measures described above. CDC's Routine Immunizations on Schedule for Everyone (Let's RISE) provides actionable strategies, resources, and data to support all Americans, especially children and teens, in getting back on-schedule with their routine immunizations to protect individuals and communities from vaccine-preventable disease, disability and outbreaks. CDC also supports 66 state, tribal, local, and territorial immunization programs to implement the Vaccines for Children and CDC's Discretionary Immunization Program. These two long-standing programs provide the foundation of our nation's immunization infrastructure. CDC works with immunization programs to support informed decision making about vaccines and ultimately increase vaccine coverage in communities across the nation.

Influenza Planning and Response

Performance Measures for Long Term Objective: Protect Americans from infectious diseases – Influenza

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
1.M Number of virus specimens received and fully characterized using deep sequencing from global National Influenza Centers for use in determining vaccine strain selection annually (Output)	FY 2024: 8,686 Target: 4,500 (Target Exceeded)	*	4,500	*

1.P Percentage of select influenza partners reporting data routinely into CDC monitored global surveillance reporting systems (Output)	FY 2024: 97% Target: 90% (Target Exceeded)	*	95%	*
1.Q The number of state/territorial/local health departments with full and partial laboratorians and/or influenza coordinators trained and funded through Epidemiology and Laboratory Capacity (ELC) grant (Output)	FY 2024: 57 Target: 57 (Target Met)	*	57	*
1.R Increase the percentage of influenza partner countries with a respiratory disease surveillance system that demonstrates qualitative improvements by meeting two quality indicators (Output)	FY 2024: 71% Target: 70% (Target Exceeded)	*	Discontinued	N/A
1.R.1: Percentage of influenza partners with a respiratory disease surveillance system that meets two quality indicators (Output)	FY 2024: 71% (Baseline)	*	70%	*

¹ Performance targets under development.

Domestic Influenza Surveillance Performance Trends: CDC continues to work to increase testing and surveillance capacity for influenza. This includes integrating surveillance systems to monitor and test for multiple respiratory pathogens and improving laboratory capacity by conducting trainings on sequencing and the use of new diagnostics that can detect both influenza and other respiratory pathogens. CDC enhances state, tribal, local, and territorial (STLT) capacity to gather influenza epidemiology and laboratory data for surveillance of seasonal and novel influenza viruses through technical assistance, trainings, and resources. Assisting STLT health departments by directly supporting laboratorians or influenza coordinators is essential in order to enhance and maintain robust domestic surveillance systems to detect circulating seasonal and novel influenza viruses and inform public health action. In FY 2024, there were 57 jurisdictions with full and/or partially funded STLT laboratorians or influenza coordinators (Measure 1Q).

CDC training and support of influenza surveillance coordinators provides a trained workforce that are able to immediately respond to outbreaks of novel influenza, including the ongoing outbreak of highly pathogenic avian influenza A (H5N1) in wild birds, wild mammals and poultry in the U.S. This capacity proved invaluable when avian influenza A (H5N1) spread to U.S. dairy cattle in 16 states and resulted in 70 human cases between April 2024 and May 2025. The U.S. Government stood up an interagency response to address this outbreak in cattle and the subsequent human cases. Influenza surveillance infrastructure in states was essential to monitor for novel influenza cases and influenza surveillance coordinators at health departments were leading key outbreak activities, including setting up symptom monitoring and testing for people exposed to infected cattle, which lead to detection of human infections of influenza A (H5N1).

During FY 2024, CDC influenza laboratories received and characterized over 8,000 virus specimens using genomic sequencing to inform seasonal influenza vaccine strain selection (Measure 1.M). An increased number of specimens were sequenced this year due to increased seasonal activity in the U.S. over a prolonged duration, as well as greater sequencing by states for the ongoing influenza A (H5N1) response, which included enhanced influenza surveillance and testing throughout the summer months, when influenza testing would typically decrease. CDC has worked extensively with its state and local partners to determine an appropriate representative sample of virus specimens to fully characterize, a process called “right-sizing” and is a significant program performance enhancement, aimed at sequencing specimens across a range of populations to achieve more targeted results efficiently while streamlining resources. While a targeted range of 4,000-7,000 viruses fully characterized using genomic sequencing is appropriate for seasonal influenza epidemics in order to understand patterns of different influenza types and subtypes and to provide the data needed to make recommendations for the composition of seasonal influenza vaccines, systems need to be scalable to quickly sequence many more viruses for novel or pandemic viruses. CDC built the sequencing infrastructure to have flexibility to respond when public health concerns arise. Sequencing has been a critical component of the ongoing influenza A (H5N1) response to be able to detect cases occurring in the community.

Global Influenza Surveillance Performance Trends: CDC strengthens the health of Americans by equipping partner nations’ capacity to improve and sustain influenza detection and response capabilities through timely reporting into their respective influenza surveillance systems and submitting influenza testing data to global influenza surveillance systems. CDC’s efforts to strengthen international influenza epidemiological and virological surveillance and pandemic preparedness have increased as measured by the number of CDC-funded partners routinely reporting influenza data, as measured by routine reports to CDC monitored global surveillance networks. These numbers went from 40% in FY 2005 to 97% in FY 2024. Although the emergence of SARS-CoV-2 virus led to a temporary decrease in FY 2020 to 59%, the percent of countries reporting to global surveillance systems CDC monitors has continued to increase since FY 2020 with a reporting rate of 97% in FY 2024 (Measure 1.P). Additionally, all but 2 partners reported flu data during 80% of the reporting weeks during FY 2024. We believe this ongoing increase signals a return to pre-pandemic surveillance levels and a stabilization of the overall sentinel surveillance systems. The CDC restructured influenza program operation continues to effectively support partner countries directly, efficiently, and effectively, with the mission to promote global health security at home and abroad. CDC- supported entities continued to leverage influenza surveillance staff and infrastructure to support integrated surveillance for respiratory diseases including Respiratory Syncytial Virus (RSV).

CDC recognizes the importance of collecting data globally on influenza-like illness or severe acute respiratory infection to characterize circulating influenza viruses. Similar to the U.S. domestic surveillance for influenza, it is critical to monitor circulation year-round to identify anomalies and threats at the source and before they cross borders, crucial to informing our domestic needs. CDC is updating its performance measure related to global influenza surveillance and will retire its current measure 1.R and replace it with Measure 1.R.1 in FY 2026. As a result of the success achieved to date in improving global influenza surveillance capacity, much of our focus has moved to ensuring global influenza surveillance capacities are sustained. The new measure focuses on the continued maintenance of high-quality influenza surveillance systems, as the previous metric focused on system improvements as surveillance systems were being built. In FY 2024, 71% of partners met the quality measurement and continue to demonstrate focus on effective, efficient systems.

VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS, AND TUBERCULOSIS

Viral Hepatitis

Performance Measures for Long Term Objective: Reduce the rates of viral hepatitis in the United States

Measure	Most Recent Result and Target	FY 2025 Target ^{1,2}	FY 2026 Target ²	FY 2026 +/-FY 2025
2.6.4 Increase the number of health departments (states and District of Columbia) reporting acute and chronic viral hepatitis data of sufficient quality to be included in national surveillance reports (Output)	FY 2022: 40 Target: 45 (Target Not Met but Improved)	*	45	*
2.6.7 Reduce estimated new hepatitis A virus infections (Outcome)	FY 2022: 4,500 Target: 4,450 (Target Not Met but Improved)	*	3,100	*
2.6.8 Reduce estimated new hepatitis B virus infections (Outcome)	FY 2022: 13,800 Target: 18,700 (Target Exceeded)	*	8,520	*
2.6.9 Reduce estimated new hepatitis C virus infections (Outcome)	FY 2022: 67,400 Target: 36,617 (Target Not Met but Improved)	*	16,640	*
2.6.10 Reduce reported rate of hepatitis C- related deaths per 100,000 population (Outcome)	FY 2022: 2.89/100,000 Target: 3.19/100,000 (Target Exceeded)	*	2.06/100,000	-*
2.6.11 Reduce reported rate of hepatitis B- related deaths per 100,000 population (Outcome)	FY 2022: 0.44/100,000 Target: 0.39/100,000 (Target Not Met)	*	0.24/100,000	*

¹Performance targets under development.

²CDC has set its viral hepatitis targets based on the HHS National Viral Hepatitis Strategic Plan (NVHSP) elimination targets. The NVHSP goals are based on calendar year and apply to surveillance data results reported that year (i.e., the 2026 targets in the strategic plan apply to 2024 surveillance data).

Performance Trends: In the U.S., hepatitis A virus (HAV), hepatitis B virus (HBV), and hepatitis C virus HCV) are the main causes of viral-induced hepatitis. After a decade of continuous increases, the rate of reported acute hepatitis C cases decreased slightly in 2022, from 1.6 per 100,000 population in 2021 to 1.5 per 100,000 population. The highest rates were observed among adults 20-59 years of age, and injection drug use was the most commonly reported risk factor. From 2014 to 2021, the U.S. experienced an almost 130% increase in the number of estimated cases of acute hepatitis C, from 30,500 in 2014 to 69,800 in 2021. In 2022, this number decreased to 67,400 – missing the target but demonstrating an improvement from 2021 (Measure 2.6.9). CDC data revealed that from 2013-2022, only 34% of persons *diagnosed* with hepatitis C were cured (i.e., had evidence of viral clearance) during this time, indicating that far too few people diagnosed with hepatitis C are accessing curative treatment. The rate of reported hepatitis C-related deaths during 2022 was 2.89 deaths per 100,000 population, representing a 34.6% decrease from the mortality rate during 2016 of 4.42 deaths per 100,000 population, and exceeding the goal of no more than 3.19 deaths per 100,000 (Measure 2.6.10).

In 2022 there were an estimated 13,800 new hepatitis B virus infections in the U.S., a 3.8 percent increase from 2021 (Measure 2.6.8). Among the 54% of cases with at least some available risk behavior data reported in 2022, injection drug use was the most commonly reported risk factor (24%). In 2022, the rate of reported hepatitis B-related deaths (or mortality) was 0.44 per 100,000 population -- slightly higher than the target of 0.39 per 100,000 (Measure 2.6.11).

Hepatitis A cases increased over 800% from 2016–2019 due to large outbreaks involving dozens of states associated with person-to-person transmission among people who use drugs and people experiencing homelessness. During 2022, there were an estimated 4,500 hepatitis A virus infections (Measure 2.6.7) representing a large improvement from 2022. Nearly twice as many hepatitis A–related deaths were reported during 2016–2022 compared with 2009–2015. Increased hepatitis A vaccination coverage, particularly among adults at increased risk for infection with hepatitis A virus or for severe disease from infection, is critical to preventing future hepatitis A deaths.

Accurate and complete case identification is especially needed to rapidly detect and prevent new viral hepatitis infections and ensure that persons receive appropriate care or curative treatment (hepatitis C) to prevent transmission and avoid premature death. To ensure that more states and local jurisdictions have the capacity for high-quality, comprehensive viral hepatitis surveillance, CDC works with states to ensure providers navigate patients through the entire cascade. These efforts increase the number of states submitting quality data to CDC. In FY 2024 (corresponding to data for the year 2022), 37 states reported acute and chronic viral hepatitis data, an increase from 2021 (Measure 2.6.4).

Sexually Transmitted Infections

National Level Performance Measures and CDC Contextual Indicators for Long Term Objective: Reduce pelvic inflammatory disease in the United States

Contextual Indicators	Most Recent Result
2.7.6e Increase the proportion of sexually active women aged 16-24 enrolled in commercial health plans who are screened for chlamydia infections	FY 2023: 49.7%
2.7.6f Increase the proportion of sexually active females enrolled in Medicaid plans who are screened for chlamydia infections: Females aged 16-24 years	FY 2023: 59.9%
2.7.7 Reduce the rate of symptomatic gonorrhea cases in men	FY 2023: 175.1

Performance Measures for Long Term Objective: Reduce syphilis rates (all stages and congenital syphilis) in the United States

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/-FY 2025
2.9.1 Reduce the rate of primary & secondary syphilis in women aged 15-44 (per 100,000 population) ² (Outcome)	FY 2023: 17.7/100,000 Target: 8.5/100,000 (Target Not Met but Improved)	*	16.3/100,000	*
2.9.2 Reduce the rate of congenital syphilis (per 100,000 live births) (Outcome)	FY 2023: 105.8/100,000 Target: 62.3/100,000 (Target Not Met)	*	54.2/100,000	*
2.9.4 Increase the proportion of potential congenital syphilis cases averted (Outcome)	FY 2023: 61.6% Target: 75% (Target Not Met but Improved)	*	75%	*
2.9.5 Reduce the rate of primary and secondary syphilis (Outcome)	FY 2023: 15.8/ 100,000 Target: 13.3/100,000 (Target Not Met but Improved)	*	13.0	*

¹ Performance targets under development.

² Baseline and targets updated to align with HHS Healthy People 2030 (STI-03).

Performance Trends: Sexually transmitted infections (STIs) impact the health of millions in the U.S. each year. More than 26 million STIs occur in the U.S. each year, costing the healthcare system nearly \$18 billion in lifetime direct medical care costs when including sexually transmitted HIV. CDC's long-term STI objectives are to eliminate congenital syphilis, prevent primary and secondary (P&S) syphilis, prevent antimicrobial resistant gonorrhea, and prevent STI-related pelvic inflammatory disease (PID), ectopic pregnancy, and infertility. Private and public health plans have improved screening rates for chlamydia, increasing from 2020 to 2023 (commercially insured, 48.4% to 49.7% [Measure 2.7.6e]; Medicaid, 57.9% to 59.9% [Measure 2.7.6f]). Although there is an upward trend in chlamydia testing among sexually active women aged 15-25 years, the slower pace of growth in testing rates could be attributed to the 2009 revisions in the American College of Obstetricians and Gynecologists (ACOG) Pap testing guidelines, as well as a potential rise in the use of long-acting reversible contraceptives.

In 2023, a total of 601,319 cases of gonorrhea were reported, making it the second most common nationally notifiable STI in the U.S. for that year. After reaching a historic low in 2009, rates of reported gonorrhea increased through 2021; however, the overall rate of gonorrhea decreased 9.2% from 2021 to 2022 and then decreased 7.7% from 2022 to 2023. From 2022 to 2023, rates decreased among men and women, most age groups, and most race/Hispanic ethnicities, and decreases were observed in 40 states. During 2022-2023, the rate of reported gonorrhea among men decreased from 3.4% (236.3 to 228.3 per 100,000) and the rate among women decreased 14.1% (152.1 to 130.7 per 100,000). The rate of symptomatic gonorrhea cases in men decreased from 214 cases per 100,000 in 2022 to 175.1 cases per 100,000 in 2023 (Measure 2.7.7).

In 2023, 209,253 cases of syphilis (all stages including congenital syphilis) were reported, which is the greatest number of cases reported since 1950 and an increase of 1% since 2022. Although the number of reported cases of syphilis (all stages) increased 1% when comparing 2023 to 2022, the rate of reported cases of syphilis per 100,000 persons was relatively stable (<1% change, 61.1 to 61.3 per 100,000); however, trends varied by stage of syphilis. Rates of unknown duration or late syphilis increased 12.2% (from 26.3 to 29.5 per 100,000). Cases of syphilis staged for surveillance as unknown duration or late syphilis reflect diagnoses that likely occurred after the infectious period (i.e., more than a year earlier) and are often identified through routine screening. Recent increases in cases staged as unknown duration or late syphilis may, in part, reflect delayed diagnosis of infections occurring during disruptions of STI prevention and care services.

CDC identified a new baseline (10.8/100,000) for reducing the rate of P&S syphilis among women aged 15-44 in 2020, which better reflects the current state of syphilis rates and efforts to reduce them. The rate of P&S syphilis among women aged 15-44 decreased from 19.1 cases per 100,000 in 2022 to 17.7 cases per 100,000 in 2023 (Measure 2.9.1). In 2023, the total rate of P&S syphilis across sexes decreased to 10.7% to 15.8 cases per 100,000 from 17.7 cases per 100,000 in 2022, missing the target (Measure 2.9.5).

Congenital Syphilis (CS) is a preventable disease, which could be eliminated through consistent screening before and during pregnancy and timely treatment of infected women. In 2023, 3,882 cases of congenital syphilis were reported, including 279 congenital syphilis-related stillbirths and neonatal/infant deaths. This is the largest number of cases of congenital syphilis since 1992. The national congenital syphilis rate of 105.8 cases per 100,000 live births in 2023 represents a 3% increase relative to 2022 (Measure 2.9.2). Although the majority of congenital syphilis cases were reported from a few states, in 2023, almost all jurisdictions (48 states and the District of Columbia) reported at least one case of congenital syphilis.

Elimination of CS would contribute to reductions in lost pregnancies, stillbirths, infant deaths, and preterm/low birth weight infants. The proportion of potential congenital syphilis cases averted in 2023 was 61.6%, remaining level with 2022 (Measure 2.9.4). Nearly 9 in 10 CS cases might have been prevented with timely testing and adequate treatment during pregnancy.

Tuberculosis

Performance Measures for Long Term Objective: Decrease the rate of cases of tuberculosis (TB) among U.S. born persons in the United States

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/-FY 2025
2.8.1 Decrease the rate of cases of tuberculosis among U.S.-born persons (per 100,000) population) (Outcome)	FY 2023: 0.80/100,000 Target: 1.0/100,000 (Target Exceeded)	*	0.5/100,000	*
2.8.2 Increase the percentage of newly diagnosed TB patients who complete treatment within 12 months (where ≤12 months of treatment is indicated) (Outcome)	FY 2021: 86.8% Target: 92% (Target Not Met)	*	93%	*
2.8.3 Increase the percentage of culture- positive TB cases with initial drug susceptibility results reported (Outcome)	FY 2023: 92.3% Target: 98.5% (Target Not Met)	*	98.5%	*
2.8.4 For contacts to sputum acid-fast bacillus smear-positive TB cases who have started treatment for newly diagnosed latent TB infection, increase the proportion of TB patients who complete treatment (Outcome)	FY 2022: 79.7% Target: 75% (Target Exceeded)	*	82%	*

¹ Performance targets under development.

Performance Trends: In 2023, the U.S. reported a total of 9,633 tuberculosis (TB) cases (2.9/100,000 population) for 2023, representing an increase of 1,301 cases (16%) as compared with 2022. Reported TB incidence increased from 2.5 per 100,000 persons in 2022 to 2.9 per 100,000 persons in 2023. U.S. TB case rates are 29 times higher than the national TB elimination goal of one case per million population, disproportionately affecting certain racial and ethnic populations and those spending time in close contact with one another, for example, in homeless shelters, correctional facilities, and long-term care facilities. Among persons born in the U.S., the incidence rate in 2023 was 0.8 per 100,000 (Measure 2.8.1), which was unchanged from 2022 and exceeds the annual target.

Treating TB disease until cured is credited with keeping multidrug-resistant (MDR) TB disease in the U.S. steady at approximately one percent of the total number of new TB cases per year. In 2024, CDC funded 61 state, local, and territorial health departments to prevent and control tuberculosis. CDC supports public health laboratory testing for drug resistance and use of Advanced Molecular Detection (AMD) tools to genetically map TB specimens to develop a database to better understand and halt the spread of the disease. For example, AMD methods, such as whole genome sequencing, have enabled CDC to identify extensive ongoing TB transmission within the U.S., particularly among high-risk populations. Detecting recent transmission more accurately allows state and local TB programs to focus limited resources and prevent ongoing transmission. In 2023, 92.3% of culture-positive TB cases underwent initial drug susceptibility testing, which is lower than the target of 98.5% (Measure 2.8.3). In an effort to ensure high quality test results, CDC operates the Model Performance Evaluation Program, which analyzes the performance and practices of clinical, commercial and public health laboratories in the U.S. that perform drug susceptibility testing. Accurate and timely reporting of test results is essential for the success of TB surveillance, prevention, and treatment programs.

In addition to preventing drug resistance, completion of treatment for TB disease immediately reduces the spread of TB. In 2021, 86.8% of patients with TB disease completed a curative course of treatment for TB within 12 months (Measure 2.8.2). Completion of therapy may be more difficult for people with health problems such as HIV infection, diabetes, substance use disorders, and persons experiencing homelessness or who have been incarcerated. CDC allocates federal funding to provide resources to programs that serve larger proportions of populations for which therapy may be difficult.

CDC-funded recipients conduct contact investigations for every case of infectious TB disease, evaluating more than 38,000 people every year. CDC measures each step of the care cascade for people who were exposed to someone with infectious TB disease beginning with the identification of contacts, medical evaluation for TB disease or latent TB infection, and initiation of treatment as needed. CDC reported that in 2022, 79.7% of persons at highest risk for TB disease completed treatment for latent TB infection, exceeding the target of 75% (Measure 2.8.4).

Untreated TB disease can be fatal. If people who are sick are not promptly diagnosed and treated, people in close contact with them can get sick as well. During FY 2024, TB programs continued to report lack of access to TB first-line drugs. The unstable supply is largely driven by the small number of manufacturers. When one company has an issue with production lines or decides to discontinue a product, there are few, if any other producers ready to compensate with increased production. Since 2016, through the HHS Program Support Center, CDC has maintained a small stockpile of critical drugs used in treating TB disease and latent TB infection during an FDA-defined shortage.

EMERGING AND ZOOONOTIC INFECTIOUS DISEASES

Emerging Infectious Diseases

Performance measure for Long Term Objective: Build and Strengthen health information systems capacity in state and local health departments

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
3.G Proportion of test orders and results processed through Electronic Test Orders and Result Reporting (ETOR) at the PHL (Output)	FY 2024: 49% Target: 75% (Target Not Met)	*	80%	*

¹Performance targets under development.

Performance measures for Long Term Objective: Protect Americans from death and serious harm caused by medical errors and preventable complications of healthcare

Measure	Most Recent Result and Target	FY 2025 Target ³	FY 2026 Target	FY 2026 +/- FY 2025
3.3.3a Reduce the central line-associated bloodstream infection (CLABSI) standardized infection ratio (SIR) in acute care hospitals (Outcome) ¹	FY 2023: 1.0 (Baseline)	0.84	0.76	-0.08
3.3.2b Reduce invasive healthcare-associated Methicillin-resistant Staphylococcus aureus (MRSA) infections ² (Outcome)	FY 2022: 53,700 Target: 47,190 (Target Not Met)	41,040	39,990	-1,050

¹Target based on 40% reduction by 2028 from 2023 baseline via the HHS HAI Action Plan.

²Rebaselined and targets updated to reflect 2020-2025 National Action Plan for Combating Antibiotic-Resistant Bacteria.

³Target was initially set without knowledge of 2025 funding.

Performance Trends: Electronic Test Order Reporting (ETOR) replaces paper-based orders and results, which accelerates workflows at the public health labs; streamlines ordering from and sending results back to clinicians, hospitals, and commercial laboratories; and decreases errors and duplicate reporting. While laboratories rapidly established ETOR solutions and reporting during the pandemic, reduced COVID testing has slowed and the proportion of reporting in FY 2024 at public health laboratories has decreased accordingly (Measure 3.G) and CDC anticipates continued progress but at a slower rate as test options for reporting expand.

HAI-AR Prevention: CDC provides national leadership in healthcare-associated infection (HAI) and antimicrobial resistance (AR) prevention and provides the scientific foundation for preserving quality care, improving patient safety, and advancing U.S. healthcare practices. Reducing HAIs across all healthcare settings supports HHS' mission to prevent infections, improve patient safety, combat AR and its complications, as well as reduce excess U.S. healthcare costs. In 2024, CDC updated the national baseline used to calculate all HAI standardized infection ratios (SIRs) and standardized utilization ratios (SURs) based on 2022 NHSN data. CDC released data for 2023 based on the previous baseline for the CLABSI SIR with a result of 0.72, representing a 28% decrease compared to the 2015 baseline and 12% reduction since 2022 (Measure 3.3.3a). This decrease was largely driven by reductions in infections reported from intensive care units (ICUs). The 2021 increase in CLABSI was likely due to the increased burden on healthcare providers and strain on infection prevention and control programs within healthcare facilities by the COVID-19 pandemic and the burden of infections has approached pre-pandemic levels. CDC did meet other targets, e.g., CAUTI and CDI.

The number of healthcare-associated MRSA cases in FY 2022 (Measure 3.3.2b), increased from the 2020 baseline to 53,700. While hospital onset MRSA infections decreased significantly from 2021 to 2022, there was an increased burden of healthcare-associated community-onset (HACO) infections driving this increase in healthcare-associated MRSA cases. CDC will continue to provide support, technical expertise, and resources to

public health and healthcare partners to reduce MRSA and CLABSI infections across healthcare settings, including continuing to monitor the long-term impact of the COVID-19 pandemic on infection prevention. Preliminary 2022 hospital onset MRSA data shows significant declines from 2021, potentially signaling future decreases in healthcare-associated MRSA cases.

Vector-Borne Diseases

Performance measure for Long Term Objective: Protect Americans from Infectious Diseases—Vector-borne

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
3.H Number of states that report tick surveillance data to CDC's vector surveillance system (ArboNET) (Output)	FY 2024: 42 Target: 38 (Target Exceeded)	*	46	*

¹Performance targets under development.

Performance Trends: CDC serves as a national and international leader in the prevention of vector-borne viral, bacterial, and rickettsial diseases. Vector-borne diseases are now some of the most common nationally reported diseases in the U.S., with cases rising with the expansion of mosquito and tick vectors and more vector-borne pathogens discovered or introduced in the U.S.

Approximately three-quarters of reported vector-borne disease cases are tickborne disease cases. This measure reflects state capacity to conduct tick surveillance, which is a vital component to preventing and controlling tickborne disease and one of the core competencies for prevention and control. Vector surveillance allows public health departments to know which vectors are present in their area, which informs the selection and implementation of vector-borne disease prevention programs.

In FY 2024, CDC exceeded the target of having 38 states report tick surveillance data to CDC's vector surveillance system (Measure 3.H). A total of 42 states, plus the District of Columbia, reported tick surveillance data to CDC in FY 2023, justifying last year's adjustment for a more aggressive FY 2024 target and this year's adjustment to the FY 2025 and FY 2026 targets. The more rapid success that the program achieved can be attributed to continued increases in FY 2021-2024 CDC funding that was used to support vector surveillance within states and CDC's increase in the provision of technical assistance to support this activity within these states.

Antimicrobial Resistance

Performance measure for Long Term Objective: Reduce the spread of antimicrobial resistance

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
3.2.3b Maintain the proportion of hospitals with carbapenem-resistant <i>Klebsiella</i> spp. Or <i>Escherichia coli</i> (<i>E.coli</i>) healthcare-associated infections (Outcome)	FY 2023: 4.9% Target: 7.0% (Target Exceeded)	*	7.0%	*
3.2.4b Reduction in hospital-onset <i>Clostridioides difficile</i> infections standardized infection ratio (SIR) (Outcome) ¹	FY 2023: 1.0 (Baseline)	*	0.88	*

¹Performance targets under development.

Performance Trends: CDC is a leader in the fight to combat antimicrobial resistance (AR). CDC is committed to protecting America's health, safety, and interests through science, surveillance, and services. AR is a growing threat internationally, and some antimicrobial-resistant infections are already untreatable.

Carbapenem-resistant Enterobacterales (CRE) are a group of bacteria resistant to almost all antibiotics. Because of limited treatment options, CRE bloodstream infections can be fatal in nearly half of all cases. In FY 2023, the proportion of all *E.coli* or *Klebsiella* spp. that are carbapenem-resistant causing CLABSI or CAUTI in adult patients

was 4.9 percent (Measure 3.2.3b). CDC continues to implement “CDC’s Containment Strategy” through CDC’s AR Solutions Initiative and continues to make investments to better detect, track, and respond to CRE infections at the state and local levels and in Puerto Rico.

Clostridioides difficile infection (CDI) is a preventable, life-threatening bacterial infection that can occur in both inpatient and outpatient healthcare settings. Infections occur most often in people who have taken antibiotics for other health conditions. CDC provides data-driven strategies and tools for targeted intervention to the healthcare community to help prevent CDI, as well as resources to help the public safeguard their own health. While CDI reductions have continued, they have recently slowed, highlighting the need for ongoing improvement efforts, including continued efforts to improve appropriate use of diagnostics and antibiotics.

Food Safety

Performance measures for Long Term Objective: Protect Americans from infectious diseases – foodborne illnesses

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
3.C Increase the epidemiologic capacity of ELC Program G recipients for Salmonella, Listeria, and Shiga Toxin-producing E. coli (STEC), surveillance and outbreak investigations (Output)	FY 2023: 63% Target: 85% (Target Not Met)	*	85%	*
3.D Percentage of isolates of priority PulseNet pathogens (Salmonella, Shiga toxin-producing E. coli, and Listeria monocytogenes) sequenced and uploaded to the PulseNet National Database (Output)	FY 2023: 83% Target: 85% (Target Not Met)	*	90%	*
3.E Increase the percentage of cases with positive culture-independent diagnostic tests (CIDTs) for Shiga toxin-producing E. coli (STEC) and culture isolation attempted or specimen metagenomics obtained (Output)	FY 2022: 76% Target: 90% (Target Not Met)	*	90%	*

¹Performance targets under development.

Performance Trends: In 2023, CDC began transitioning to PulseNet 2.0, a cloud-based open-source analytic platform to enhance data analysis, management, and visualization capabilities of whole genome sequencing (WGS) data for outbreak detection and surveillance which will improve and streamline how CDC stores, processes, accesses, and shares data to detect outbreaks earlier and faster. Data indicates in FY 2023, 83% of isolates of priority PulseNet pathogens (Salmonella, Shiga toxin-producing E. coli (STEC), and Listeria monocytogenes) were sequenced and uploaded to the PulseNet National Database (Measure 3.D). These data did not meet the FY 2023 target, in part, because of the increase in receipt of specimens in the state public health laboratories’ in lieu of isolates. Lack of isolates and increase in culture-independent diagnostic tests (CIDTs) has hindered the labs’ ability to sequence all of their priority PulseNet organisms, however, CDC anticipates continued progress toward this target.

Every year, over 175 multistate clusters of foodborne disease are identified, which, in turn, will need to be investigated to determine if they are outbreaks. Tracking state epidemiologic interview capacity is important to help identify and address challenges in the availability of epidemiologic data critical for multistate foodborne outbreak investigations. The FY 2023 result of 63% of cases interviewed in multistate outbreaks of Salmonella, Listeria, and STEC (Measure 3.C) is below the FY 2023 target (85%). This may indicate a lack of staffing capacity to conduct all interviews due to turnover and difficulty hiring as well as insufficient training once positions have been filled. Additionally, there has been an increase in patients that are unreachable or refusing to be interviewed. All jurisdictions continued to report disruption of routine enteric disease activities due to mpox and the ongoing impact of COVID-19. This included staff being reassigned and decreased capacity to conduct enteric disease interviews and investigations. Continuing to monitor this measure will provide insight into capacity changes and challenges following COVID-19 and mpox.

Recent changes in diagnostic practices at clinical laboratories across the U.S. to more culture- independent methods is challenging CDC's ability to find outbreaks and monitor disease trends. CIDTs are commonly used by

physicians to rapidly diagnose their patients' diseases. These tests do not provide the data needed by CDC to link cases to outbreaks unless laboratories perform additional testing to isolate cultures, a process called reflex culture. Tracking the increased use of CIDs and the proportion of specimens for which reflex culture is performed is important to better understand surveillance data on enteric bacteria, identify foodborne disease outbreaks, and inform program decisions. FY 2023 data show that in about 76% with positive CIDs for STEC culture isolation was attempted or specimen metagenomics were obtained (Measure 3.E). This is below the FY 2023 target and indicates a lack of resources at state and local health departments related to reflex culture procedures.

National Healthcare Safety Network

Performance measure for National Healthcare Safety Network

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
3.3.4 Increase the number of hospitals and other selected health care settings that report into the National Healthcare Safety Network (NHSN) (Output)	FY 2023: 38,530 Target: 36,500 (Target Exceeded)	*	38,700	*

¹ Performance targets under development.

Performance Trends: CDC's National Healthcare Safety Network (NHSN) is the nation's most comprehensive and widely used surveillance and quality improvement system to identify emerging and enduring threats across healthcare, such as healthcare-associated infections (HAIs) and antimicrobial-resistant infections. NHSN data drive HAI prevention and improve quality of care at local, state, and national levels.

CDC continues to enroll and provide support for healthcare facilities in NHSN to report HAIs, including those caused by antimicrobial-resistant bacteria. To provide essential data for the COVID-19 response, CDC developed additional reporting modules for both hospitals and nursing homes. At the end of FY 2023, there were 38,530 facilities actively reporting data in NHSN (Measure 3.3.4). This includes all hospitals, more than 7,800 dialysis facilities, more than 5,700 outpatient clinics, and more than 17,600 nursing homes and other long term care facilities, including around 15,400 CMS-certified long term care facilities. CDC continues efforts to modernize NHSN, automate reporting, decrease reporting burden, and increase its value to providers and partners to prevent infections, enhance healthcare quality, and improve patient care.

Travel and Port Health Protection

Performance measures for Long Term Objective: Prevent the importation of infectious diseases to the U.S. in mobile human, animal, and cargo populations

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
3.4.9 Maintain the number of U.S. ports of entry that have demonstrated a validated capability to respond to a communicable disease event involving mobile populations in the previous 3 years (Output)	FY 2024: 51 Target: 49 (Target Exceeded)	*	51	*

¹ Performance targets under development.

Performance Trends: CDC enhances the public health security of U.S. communities and addresses infectious disease risks associated with international travel and globally mobile populations by preventing the importation and spread of disease into and within the U.S. CDC Port Health Stations are strategically located at 20 ports of entry and land-border crossings that cover approximately 80% of international travelers arriving in the U.S. Port health protection officers are available 24/7 and rapidly respond to health threats to prevent further spread of communicable diseases. Having a validated capability to respond to communicable disease events involving travelers at U.S. ports of entry is integral to CDC's preparedness for the next outbreak. Performing this task is made more effective, efficient, and resilient over time if all ports of entry can routinely demonstrate validated

public health response capabilities. In FY 2024, the number of U.S. ports of entry (POEs) that demonstrated a validated capability to respond to a communicable disease event involving mobile populations increased to 51 (Measure 3.4.9). CDC exceeded the FY 2024 target despite the challenges and resources required to respond to the mpox outbreak and the 2024 Marburg outbreak. CDC has continued its use of a “priority sub port” strategy based on travel volume and the status of preparedness plans to target POEs nearing a validated capability and to identify and recruit advocates at each CDC Port Health Station to serve as the lead for validating capabilities within their respective jurisdictions.

Parasitic Diseases and Malaria

Budget Output Measure for Long Term Objective: Decrease the burden of malaria through evidence- based guidelines, policies, programs, and practices

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
10.C.A The number of CDC authored publications that inform the evidence for malaria control and prevention programs (Output)	FY 2024: 71 Target: 155 (Target Not Met)	*	75	*

¹ Performance targets under development.

CDC Performance Measure for Long Term Objective: To deliver timely and accurate reference diagnostic laboratory services for the detection of parasites in specimens submitted by domestic and international public health partners to CDC

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
10.C.4 The percentage of laboratory test results reported within the expected turn-around time upon receipt by CDC labs (Outcome)	FY 2024: 94% Target: 90% (Target Exceeded)	*	90%	*

¹ Performance targets under development.

Performance Trends: Malaria prevention and treatment tools are among the most cost-effective interventions available to control and eliminate malaria. CDC’s research informs the development of new tools to manage and mitigate threats from drug and insecticide resistance, guides future program and policy decisions, and builds public health capacity through strategic partnerships to ensure U.S. health departments and other governments can quickly detect and stop potential malaria outbreaks from spreading further.

CDC continues to lead the development of evidence-based policy guidelines and peer-reviewed scientific publications to strengthen malaria prevention and control practices. Recent CDC co-authored research has identified a more effective dosing strategy for primaquine to prevent relapse of *Plasmodium vivax* malaria, a strain often seen in U.S. travelers. The agency is also closely monitoring the spread of *Anopheles stephensi*, an invasive mosquito species, and has co-authored findings that emphasize the urgent need for expanded vector control in regions like Ethiopia to prevent widespread transmission. These efforts not only reduce the burden of malaria in other countries, they also help protect Americans traveling to malaria-endemic regions.

Overall, the number of CDC authored peer-reviewed publications decreased from 77 in FY 2023 to 71 in FY 2024, which did not meet the current target (Measure 10.C.A). All publications contribute to growing the evidence base to support policy and program needs. CDC anticipates some variation in the number of publications from year to year based on the publication process and the timelines for study initiation, completion, and data analysis, as well as competing demands such as supporting and leading emergency response.

CDC's parasitic disease labs serve as global and national resources for ensuring efficient and high-quality analyses, essential to timely and accurate diagnosis and treatment. In FY 2024, CDC analyzed and reported results for 94% of submitted specimens in a timely manner (within the expected turnaround times posted in the CDC test directory for each test), exceeding the target of 90% (Measure 10.C.4). Since FY 2023, CDC has been focused on test modernization efforts to introduce technical improvements and conduct validations for nearly all of the parasitic disease tests. Maintaining momentum in test modernization will ensure CDC's parasitic diseases labs can continue to fill the technical gap and laboratory capacity which is not readily available at the state and local levels. These improvements include adapting new methods using newer laboratory instrumentation typically available in state and local public health laboratories. CDC is utilizing new test methods incorporating recombinant antigens for serology tests to ensure reagent sustainability. CDC is developing external protocols to share with state and local public health laboratories, including a recently improved malaria PCR assay which was made available to all public health and clinical labs in January 2025. CDC plans to complete these improvements by the end of FY 2026.

PUBLIC HEALTH SCIENTIFIC SERVICES

Public Health Workforce and Career Development

Performance Measures for Long Term Objective: Develop and implement training to provide for competent, sustainable, and empowered public health workforce able to meet emerging and future health challenges.

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/-FY 2025
8.B.4.2 Increase the number of CDC trainees in state, tribal, local, and territorial public health agencies ¹ (Output)	FY 2024: 283 Target: 294 (Target Not Met)	*	294	*
8.B.4.4 Increase the number of times health professionals earn free Continuing Education (CE) from CDC, demonstrating successful achievement of knowledge (Output)	FY 2024: 482,926 Target: 613,000 (Target Not Met)	*	680,000	*

¹ Performance targets under development.

Performance Trends: CDC fellowship programs promote on-the-job training and mentored learning through unique work experiences across public health critical disciplines allowing CDC fellows and trainees to fill critical workforce needs at CDC and in state, tribal, local, and territorial (STLT) public health agencies, while working in public health careers. Field placement of these fellows offers jurisdictions direct support from CDC and provides fellows and trainees an opportunity to work alongside professionals across a variety of public health settings. After completing CDC fellowships, graduates are qualified to apply for jobs with public health agencies, and data shows that most CDC fellowship graduates stay in public health positions. CDC placed 283 CDC trainees in STLT public health agencies in FY 2024 (Measure 8.B.4.2). This did not meet our FY 2024 target for CDC trainees in STLT public health agencies, in part because the number of trainees that can be placed in the field is dependent on funding. CDC expects trainee placements in STLT public health agencies to continue to reduce to levels prior to short-term emergency supplemental funding.

An effectively trained public health workforce is our first line of defense against disease outbreaks, natural disasters, and other health threats domestically and globally. CDC designs, develops, and accredits quality learning opportunities and ensures these opportunities are available to the public health and health care workforce. The accredited learning opportunities CDC provides help ensure public health workers can maintain licensure and certification requirements, improve knowledge and skills, and ultimately enhance their overall competency. In FY 2024, over 205,000 unique health professionals earned free continuing education (CE) credit over 482,000 times, valued at an estimated \$9.1 million (Measure 8.B.4.4). This did not meet our FY 2024 target for earned CE credit by unique users. Significant increases in FY 2020-FY 2021 were largely driven by health

professionals seeking CE credit for COVID-19 related training content. FY 2024 CE attainment remains higher than pre-pandemic baselines but demonstrates more modest year-over-year trends as demand for immunization and COVID-19-related CE returns to pre-COVID levels.

State, Tribal, Local and Territorial Support

Performance Measures for Long Term Objective: Improve the capacity and performance of state, tribal, local, and territorial public health agencies to more efficiently and effectively manage and deliver high quality programs and services to protect the public's health

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
8.C.1 (State) Increase the percentage of nationally PHAB accredited state public health agencies (Intermediate Outcome)	FY 2024: 82% Target: 84% (Target Not Met but Improved)	86%	87%	+1
8.C.2 (Local) Increase the percentage of nationally PHAB accredited local public health agencies (Intermediate Outcome)	FY 2024: 17% Target: 18% (Target Not Met but Improved)	20%	21%	+1

¹Target was initially set without knowledge of 2025 funding.

Performance Trends: CDC support and resources to state, tribal, local, and territorial public health departments help improve the effectiveness, efficiency, and quality of public health programs. Additionally, CDC assists health departments in meeting nationally recognized, practice-focused, and evidence-based standards of the Public Health Accreditation Board (PHAB). Meeting these standards provides health departments with tools to improve the quality and performance of STLT public health programs and services and better positions them to rapidly respond to emerging threats and challenges. PHAB has accredited 441 health departments—42 states, six tribes, and 393 local health departments. Accredited health departments serve approximately 90% of the U.S. population. CDC partially met the FY 2024 target of 84% with 82% for state accreditation and partially met the target of 18% with 17% of local agencies accredited or reaccredited (Measures 8.C.1-2). Health departments not applying for or achieving reaccreditation can impact the proportion of accredited sites. Twenty-six local health departments are no longer accredited, mostly due to not applying for reaccreditation as a result of financial or staff considerations.

Science and Public Health Information

Performance Measures for Long-Term Objective: Improve access to and reach of scientific public health information among key audiences to maximize health impact

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/-FY 2025
16.A Increase the electronic media reach of the Morbidity and Mortality Weekly Report (MMWR) through use of mechanisms such as the MMWR website and social media outlets, as measured by page views, social media followers, and email subscribers (Output)	FY 2024: 19,165,238 Target: 31,500,000 (Target Not Met)	*	21,993,998	*
16.B Increase the electronic media reach of CDC Vital Signs through use of Vital Signs-specific metrics, as measured by Vital Signs page views and email subscribers (Output)	FY 2024: 876,301 Target: 3,053,739 (Target Not Met)	*	Discontinued	*

¹ Performance targets under development.

Performance Trends: CDC provides critical epidemiological data and recommendations for solving public health problems to approximately 140,000 clinicians and public health professionals through an extensive network of electronic communication channels for the *Morbidity and Mortality Weekly Report (MMWR)*. During FY 2024,

MMWR published approximately 240 reports. *MMWR* content is shared widely, with traditional and social media coverage averaging in the top three percent of all journal publications. Although *MMWR* did not meet its overall target for FY 2024, *MMWR* reached more than 19 million people and 35 % of *MMWR* reports rank in the top 1% of research (Measure 16.A). Targets for FY 2025 and FY 2026 have been revised to reflect 2020 pre-pandemic levels.

CDC *Vital Signs* is a science and communication program that targets the public, state and local health departments, healthcare professionals, and policymakers through an *MMWR* report, web page, and print, broadcast, social, and electronic media on a specific, important topic. Altmetric scores for four of the five *Vital Signs* releases were in the top 1% of more than 24.9 million research outputs tracked. In FY 2024, despite *Vital Signs* only publishing five issues, it continued to have impressive audience reach and media coverage (Measure 16.B). The May issue on drowning prevention garnered 3,945 news stories, with a potential audience reach of over 4 billion. Although *Vital Signs* has been a useful dissemination tool, it was sunset in May 2025 in favor of focusing efforts on *MMWR*. As such, the measure on target counts for electronic communication to the *Vital Signs* website will be retired in FY 2026.

Laboratory Safety and Surveillance

Performance Measures for Long Term Objective: Improve the efficiency and accuracy of public health and clinical laboratory testing

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/-FY 2025
17.A Increase registrations for CDC laboratory education and training courses and events as measured across all learning dissemination platforms (Output)	FY 2024: 439,722 Target: 67,661 (Target Exceeded)	*	115,146	*

¹ Performance targets under development.

Laboratory Standards and Services Performance Trends: A safe and prepared laboratory workforce is indispensable to protecting the health of people in our communities and to ensuring that national and global public health systems can detect and respond quickly to public health threats of all kinds. CDC met the urgent need to bolster laboratory training and public health emergency preparedness while reinvigorating its approach to engaging laboratory testing communities through initiatives including integrating microlearning videos into public YouTube playlists, improving ease of access to training platforms, and successful utilization of podcasts, interviews, and print and social media. This led to CDC exceeding program registration goals in FY 2024 by almost 400,000 registrants (the target was 67,661, as outlined by Measure 17.A). CDC's learning management system, OneLab REACH (Rapid Education and Capacity-building Hub) is OneLab's centralized online platform for free laboratory training. Since its launch in 2022, membership has grown to over 43,200 learners. In May 2023, CDC launched another new community of practice, OneLab TEST (Timely Education and Support of Testers), which supports testers in non-laboratory settings, such as drive through testing sites and nursing homes. This first-of-its-kind community of practice is a critical component of both disease detection and patient care. By the close of FY 2024, OneLab TEST garnered over 8,700 members. OneLab Network, the complementary community of practice supporting clinical and public health laboratory professionals grew to more than 19,500 members and represents more than 17,000 laboratories and professional organizations.

Performance Measures for Long Term Objective: Enhance and sustain nationwide and international laboratory capacity to gather, ship, and screen and test samples for public health threats and to conduct research and development that lead to interventions for such threats

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
17.1.A Sustain the percentage of Laboratory Response Network (LRN) laboratories that have demonstrated ability to rapidly detect select biological threat agents (Output)	FY 2024: 92% Target: 92% (Target Met)	*	92%	*

¹ Performance targets under development.

Performance Trends: The Laboratory Response Network (LRN) challenge panel program demonstrates the ability of LRN laboratories to rapidly identify biological threat agents and protect the health of the nation. These panels include exercises and evaluation tools that measure a laboratory's ability to successfully perform specific assays and utilize available electronic resources to submit results. Public health laboratories participating in CDC's LRN-B program are required to participate in all available challenge panels specific to their testing capacity. By the close of FY 2024, 92% of LRN laboratories passed the challenge panels distributed by the CDC LRN program (Measure 17.1.A). Future targets will remain fixed at 92% which provides CDC with confidence in the LRN network capabilities.

Data and Surveillance

Performance Measures for Long Term Objective: Lower barriers to data exchange across jurisdictions as part of an integrated strategy for public health surveillance and response

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/-FY 2025
18.A Increase the percentage of notifiable disease messages transmitted in HL7 format to improve the quality and streamline the transmission of established surveillance data (Output)	FY 2024: 67.7% Target: 40% (Target Exceeded)	*	Discontinued	*
18.B Increase the percentage of non-federal emergency department facilities that participate in the National Syndromic Surveillance Program to improve the coverage of syndromic surveillance data (Output)	FY 2024: 81% Target: 80% (Target Met)	*	85%	*
18.C: Decrease median Message Mapping Guide (MMG) adoption times to improve the quality and flexibility of the National Notifiable Diseases Surveillance System (NNDSS) (Output)	FY 2024: 168 business days (Baseline)	*	158 business days	*
18.D: Increase the percentage of rural critical access hospitals that use electronic case reporting (Output)	FY 2024: 44% (Baseline)	*	60%	*

¹ Performance targets under development.

Surveillance Performance Trends: CDC continues its efforts to advance public health technology, data, and interoperability standards replacing some of CDC's older legacy infrastructure with more modern data strategies and standards. These investments have helped position CDC to receive data more efficiently during routine ongoing surveillance and response related efforts. The National Notifiable Diseases Surveillance System (NNDSS) is a CDC collaboration with 60 state, local, and territorial public health jurisdictions to receive case surveillance data collected by 3,000 health departments for further analysis and use by CDC programs to better prevent and respond to disease outbreaks and inform public health interventions. Currently, more than 120 diseases and conditions are under continuous nationwide surveillance. As of June 2024, NNDSS processed an average of 310,000 HL7 case notifications per month, representing 67.7% of notifications (Measure 18.A). Although this result would suggest that NNDSS is exceeding its FY 2024 goal, most of this data is COVID-19 cases. Because this high volume of COVID-19 case data has outweighed other reported disease data since 2020 and diminished the

measure's value, CDC will retire Measure 18.A and replace it with a new measure focused on the speed of adoption of Message Mapping Guides (MMGs) by jurisdictions. This better captures the importance of rapid adoption when an emergency response occurs and the desired speed improvements of jurisdictional and CDC program partners.

The median adoption time of MMGs in the first six months of 2024, was 168 business days (Measure 18.C). Efforts began in 2024 to develop CaseBridge, a self-service web tool for jurisdictions, with the intention of eliminating some manual steps in the quality-assurance portions of the adoption process. The initial automation focus is on reducing the time it takes to complete one of the MMG validation steps that currently takes a median of 36 business days to complete. In addition to the efforts to speed up MMG onboarding, there will be continued work in 2025 and 2026 to modernize NNDSS, including moving functionality to a cloud infrastructure and delivering analytic-ready datasets to CDC disease program partners, using new analytical tools such as CDC's One Data Platform. These efforts can drive significant positive public health outcomes, such as improving CDC's ability to act more rapidly during response efforts, reducing burden for local and state jurisdictions, strengthening trust with case surveillance partners, and lowering CDC's case surveillance costs.

Electronic case reporting (eCR) automates the exchange of data between electronic health records and public health agencies. As of November 2024, eCR provided 74 state, tribal, local, and territorial public health jurisdictions with near real-time patient case reporting from >48,500 healthcare facilities. While eCR plays an important role in outbreak response nationwide, it is even more essential for underserved populations. Over 60 million people live in rural America with a 43% higher mortality rate than urban residents. Rural residents often live in poverty, are uninsured, and due to low numbers of rural primary care providers, frequently seek care at a critical access hospital (CAH). To ensure these individuals' cases are being reported, a new measure will track the percentage of rural critical access hospitals that use electronic case reporting. As of November 2024, critical access hospitals in production with eCR is slightly over 44%, exceeding the target (Measure 18.D). Because eCR automates case reporting from healthcare to public health in less than one minute, public health can respond quickly to protect rural residents in their jurisdictions. eCR also allows for bidirectional communication from the public health department back to the healthcare provider, including treatment or fact sheets about the condition reported.

The National Syndromic Surveillance Program (NSSP) provides local, state, and federal health officials with a near real time system for detecting, understanding, and monitoring health events. By tracking symptoms and diagnoses of patients in emergency departments and other automated data sources, including commercial laboratory data, analysts can detect unusual levels or changing patterns of illness. In 2023-2024, across all levels of government, NSSP data were used to provide critical insights for more than 40 responses addressing infectious diseases (e.g., H5 Influenza, Mpox, Measles, Dengue-Oropouche, COVID-19, RSV, and polio), injuries (e.g., overdose, poisonings, child abuse and elder abuse), and for monitoring mental health and mass gatherings, among others. Participation in NSSP is extensive, and NSSP continues its effort to expand participation. CDC uses a measure aimed at increasing the percentage of non-federal emergency department facilities that participate in NSSP to improve the coverage of syndromic surveillance data (Measure 18.B). As of November 2024, 81% of non-federal emergency department facilities report data to NSSP. These results show that NSSP has exceeded its fiscal year 2024 target.

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

State and Local Preparedness and Response Capability

Performance Measures for Long Term Objective: Integrate and enhance existing surveillance systems at the local, state, national, and international levels to detect, monitor, report, and evaluate public health threats

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
13.1.5 Increase the number of CDC programs using the HHS Protect/Response Ready Enterprise Data Integration platform (RREDI) for day-to-day surveillance and response events (Output)	FY 2024: 17 (Baseline)	*	27	*
13.1.6 Increase the number of users with access to RREDI for CDC partners in state, tribal, local, and territorial public health agencies and in other federal agencies (Output)	FY 2024: 1,051 (Baseline)	*	2,366	*
13.1.7 Increase the percentage of responses using RREDI to support use of a common operating picture for CDC and its partners (Output)	FY 2024: 60% (Baseline)	*	70%	*

¹ Performance targets under development.

Performance Trends: Response Ready Enterprise Data Integration (RREDI) is the emergency response arm of an enterprise-wide common operating platform called ONE CDC Platform (1CDP) that consolidates and integrates the data that jurisdictions share with CDC, to generate information for decision making related to protecting lives and improving health. Increasing the number of CDC programs using the 1CDP/RREDI platform will allow CDC to ensure the agency has a modernized infrastructure and a core data management platform to support a data ready public health ecosystem, and will allow for reduced implementation times/more real-time stand up for future responses. In FY 2024, there were 17 CDC programs using HHS Protect/RREDI for surveillance and response events (Measure 13.1.5).

The 1CDP/RREDI platform gives STLT and federal agency users a way to share data and collaborate with CDC programs and responses, review and analyze increased access to data, and provide increased situational awareness for decision making. Collaboration with STLT and agency partners was vital for responses like EVALI, COVID-19, and Mpox —the RREDI platform enabled real time data sharing, collaboration, and data dissemination. The current responses on the RREDI platform continue to expand their STLT and federal agency users thus ensuring transparent decision making and data sharing is occurring. At the end of FY 2024, there were 1,051 1CDP new users with RREDI access from state, tribal, local, and territorial public health agencies, and other federal agencies (Measure 13.1.6). Using RREDI allows CDC to have a centralized data repository, real-time data sharing, and data-informed decision making specific to public health emergency responses. Integrating data from across the response enables leaders to streamline operations, respond more quickly to public health emergencies, and improve decision making. At the end of FY 2024, the percent of responses using RREDI to support a common operating picture for CDC and its partners was 60% (Measure 13.1.7).

National Disaster Medical Systems

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
1.7 Maintain the percent of all NDMS intermittent staff that complete federally mandated safety and other trainings	FY 2024: 95% Target: 90% (Target Exceeded)	*	90%	*
1.7a Maintain the percent of deployed NDMS intermittent staff that complete federally mandated safety and other trainings	FY 2024: 100% Target: 96% (Target Exceeded)	*	96%	*

CDC FY 2026 Congressional Justification

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
1.8 Maintain the percent of new NDMS intermittent staff who complete all required onboarding training within their first year	FY 2024: 96.3% Target: 95% (Target Exceeded)	*	95%	*
1.9 Maintain the percentage of NDMS personnel who participate in fundamental field skills each year	FY 2024: 17% (Baseline)	*	Prior Result +20%	*

¹ Performance targets under development.

CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

Environmental Health Laboratory

Performance Measures for Program: Environmental Health Laboratory

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/-FY 2025
6.1.1 Number of environmental chemicals and nutritional indicators that are measured in surveys and studies of the U.S. population (Output)	FY 2024:450 Target: 420 (Target Exceeded)	*	455	*
6.1.3 Number of laboratories participating in DLS Quality Assurance and Standardization Programs to improve the quality of their laboratory measurements (Output)	FY 2024: 1,694 Target: 2,050 (Target Not Met but Improved)	*	2,060	*
6.1.4 Number of chronic disease biomarkers included in standardization programs that improve the quality of laboratory measurements (Output)	FY 2024: 47 Target: 28 (Target Exceeded)	*	48	*
6.D: Number of biomarkers of newborn disease covered by CDC newborn screening quality assurance materials (Output)	FY 2024: 77 Target: 77 (Target Met)	*	90	*
6.A Number of environmental chemicals for which methods were developed or improved (Output)	FY 2024: 68 Target: 70 (Target Not Met but Improved)	*	Discontinued	*
6.B Number of laboratory studies conducted to measure levels of environmental chemicals in exposed populations (Output)	FY 2024: 49 Target: 85 (Target Not Met)	*	92	*

¹ Performance targets under development.

Performance Trends: CDC develops and uses laboratory tests for chemical exposures, nutrition status, and disease biomarkers to identify environmental exposures and provide information about Americans' health status. In FY 2024, CDC measured and published data on 450 environmental chemicals and nutrition indicators (Measure 6.1.1), greatly exceeding the target. The FY 2025 target includes intention to add new measurements for several chemicals while cycling out measurements for infrequently detected chemicals. CDC collaborated on 49 studies of environmental chemicals in FY 2024 (Measure 6.B), fewer than expected. Results for this measure depend on the number of opportunities with collaborators, the size and complexity of required laboratory measurements, and proposed work's alignment with CDC mission and budget. In FY 2024, CDC collaborated on a complex PFAS study, reporting over 20,000 laboratory results in three months, and shifted priorities and resources to support emergency testing for multiple chemical exposure events. CDC expects an upward trend to resume in FY 2025, as resources and priorities allow. In FY 2024, CDC developed or improved 68 tests to measure environmental chemicals (Measure 6.A), a 41% increase over the FY 2023 result. Measures 6.B and 6.1.1 adequately measure CDC's expertise and success in laboratory exposure science; therefore, CDC will retire Measure 6.A in 2026, with 72 improved or new methods expected in FY 2025.

CDC provides voluntary quality assurance and standardization programs for clinical health laboratories that help ensure the accuracy and comparability the clinical laboratory measurements for disease biomarkers that healthcare providers interpret to make treatment decisions for their patients. In FY 2024, 1,694 laboratories used the CDC quality assurance and standardization programs (Measure 6.1.3), falling below the target but improving from 1,673 participating in FY 2023. CDC added priority biomarkers of hormone disorders to the standardization program in FY 2024, exceeding the target for Measure 6.1.4 by bringing the total number of disease biomarkers included in the program to 47. CDC set FY 2505 targets for Measures 6.1.3 and 6.1.4 to reflect expected resources and clinical laboratory participation. CDC also provides newborn screening quality assurance

materials to state newborn screening programs to help them identify and get treatment to newborns that would have died or experienced severe disability without early intervention. For 2024, CDC introduced Measure 6.D to monitor the number of disease biomarkers covered by newborn screening quality assurance materials. CDC's newborn screening quality assurance materials include 77 disease biomarkers as of FY 2024 (baseline), with CDC expecting to maintain this capacity in FY 2025 and add 13 new biomarkers in FY 2026.

Global Health Protection

Performance measures for Long Term Objective: To increase the number of public health staff skilled in epidemiology and surveillance in low and middle-income countries

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
10.F.1c Number of cumulative Field Epidemiology Training Program (FETP) – Frontline graduates (Output)	FY 2023: 16,352 Target: 15,974 (Target Exceeded)	17,122	17,464	+342
10.F.1d Number of cumulative Field Epidemiology Training Program (FETP) – Intermediate and FETP – Advanced graduates (Output)	FY 2023: 7,530 Target: 7,449 (Target Exceeded)	7,784	7,940	+156

¹Target was initially set without knowledge of 2025 funding.

Performance Trends: International Field Epidemiology Training Programs (FETP) are recognized worldwide as an effective means to strengthen countries' capacity in surveillance, epidemiology, and outbreak response. These graduates strengthen public health capacity so individual countries are able to transition from U.S.-led global health investments to more long-term host country ownership. Frontline is a three-month program that aims to increase the number of capable public health workers in a community setting. Intermediate is a nine-month program for mid-level health officials, and Advanced is a two-year, intensive program that aims to prepare leaders for work at the national level. All three tiers help countries meet International Health Regulation guidelines. As of FY 2023, there have been a cumulative total of 16,352 Frontline program graduates and 7,530 Intermediate/Advanced program graduates an increase over FY 2022 and exceeding the FY 2023 target (Measures 10.F.1c-d). By tracking the number of people who graduate from FETP –Frontline and Intermediate/Advanced programs every year, CDC can better gauge its impact on developing other countries' abilities to prevent, detect, and respond to disease outbreaks.

Buildings and Facilities

Performance Measures for Long Term Objective: Improve efficiency and sustainability of CDC Facilities

Measure	Most Recent Result and Target	FY 2025 Target ²	FY 2026 Target	FY 2026 +/- FY 2025
12.E.2 Increase the percent of CDC facilities (10,000 square feet and above) that meet the Guiding Principles for High Performance and Sustainable Federal Buildings (Efficiency)	FY 2024: 29.6% Target: 15% (Target Exceeded)	15% ¹	15% ¹	Maintain ¹
12.E.1a Improve energy (E) consumption per square foot ¹ (Efficiency)	FY 2024: 23.5% Target: 30% (Target Not Met)	30% ¹	30% ¹	Maintain ¹
12.E.1b Improve water (W) consumption per square foot (Efficiency)	FY 2024: 42.9% Target: 30% (Target Exceeded)	30% ¹	30% ¹	Maintain ¹

¹ Metrics and targets are based on the Energy and Policy Act of 2005.

² Target was initially set without knowledge of 2025 funding.

Performance Measures for Long Term Objective: Improve CDC's Buildings and Facilities processes and performance¹

Measure	Most Recent Result and Target	FY 2025 Target ⁴	FY 2026 Target	FY 2026 +/- FY 2025
12.2.1c Improve Condition Index (CI), as measured by the ratio of the functional replacement value (FRV) of an asset with its backlog of maintenance and repair (BMAR) needs (Output)	FY 2024: 82.65 Target ² : 90 (Target Not Met)	90	90	Maintain
12.2.1d Reduce non- mission dependency, as measured by the percentage of real property assets that are not deemed directly necessary to support the Agency's mission (Output)	FY 2024: 1.51% Target ² : 2% (Target Exceeded)	2%	2%	Maintain
12.2.1e Improve building utilization ³ (Output)	FY 2024: 3.42% Target ² : 5% (Target Exceeded)	5%	5%	Maintain
12.2.1f Improve buildings and facilities operating costs (Output)	FY 2024: \$12.88/sq. ft. Target ² : \$10.29/sq. ft. (Target Not Met)	\$10.29/sq. ft	\$10.29 / sq.ft	Maintain

¹ Targets are set by HHS and align to EO 13327; the Federal Real Property Council (FRPC) defines the metrics.

² Targets beyond FY 2016 are projected and are not established from FRPC.

³ Under-utilized (U); FRPC removed the metric Over-utilization (O) for FY 2013 and forward.

⁴ Target was initially set without knowledge of 2025 funding.

Performance Trends: CDC's mission is executed in a safe, sustainable, and dynamic workplace environment for approximately 25,000 CDC staff while ensuring efficiency, environmental stewardship, and appropriate management of agency assets. In FY 2024, CDC had 29.6% of its owned and active buildings 10,000 gross square feet (GSF) and above meet the Guiding Principles for High Performance and Sustainable Federal Buildings (Measure 12.E.2), far exceeding the target of 15%. CDC expects that we may see smaller gains with the demolition of older and poor performing buildings.

Past targets and baselines set for improving energy consumption (Measure 12.E.1a) were based on the Energy Policy Act of 2005. In FY 2023, CDC achieved a 24.7% reduction in energy intensity below the 2003 baseline (this is a correction from previous report). However, in FY 2024, this progress slightly regressed to 23.5% leaving the agency 6.5% below its target (Measure 12.E.1.a). This increase in energy use can be attributed to a combination of operational adjustments and warmer weather conditions. While the lower campus population in recent years allowed for reduced energy loads, the phased re-entry of employees over the prior two years has increased employee presence and thus energy consumption.

FY 2024 Highlights:

- CDC has recently completed mandated portfolio wide EISA building audits yielding specific recommendations for operational, energy, and water efficiencies.
- Chamblee Building 108 was completed recently (early FY 2025). The parking deck component is currently targeted to be completed in early calendar year 2025. The Building 108 and associated infrastructure project includes Guiding Principle Compliant design, campus-wide utility improvements, and LEED certification. This project also includes upgrades to the Chamblee Central Utility Plant to improve energy efficiencies and resiliency.

In FY 2024, CDC progressed on the water intensity goal improving to a 42.91% reduction from the 2007 baseline. This is a 14.7% year over year improvement more consistent with recent historical norms than what was seen in FY 2023 (Measure 12.E.1.b). In FY 2023, CDC achieved a 34.65% reduction in water use intensity below the 2007 baseline. In FY 2023, CDC observed an 11% increase in water consumption compared to FY 2022. This is likely

attributed to phased reentry of staff into facilities during 2022. In addition, record heat and warmer days in 2023 elevated demands for cooling and increased water consumption.

CDC did not meet its target for improving its condition index (CI) in FY 2024 (Measure 12.2.1c). There was a slight decrease in un-weighted CI from FY 2023 (82.74 CI) to FY 2024 (82.65 CI). CDC's weighted CI remained unchanged from FY 2023 (94.05 CI) to FY 2024 but still exceeds targeted goal of 90 CI. CDC moved to new software to manage our Integrated Facility Management Systems (IFMS) data. With the software transition came several unexpected anomalies, including the software re-populating completed deficiencies which inflated Backlog of Maintenance and Repair (BMAR). CDC is in the process of identifying the anomalies and cleaning them up in FY 2025, which will increase the CI. CDC also has large investments in both repair and improvement projects and new capital construction targeted specifically at improving or replacing some of CDC's assets with the poorest CI scores.

CDC exceeded its target for reducing non-mission dependency assets that are not deemed directly necessary to support CDC's mission (Measure 12.2.1d) in FY 2024 with a result of 1.51%. The under-utilization rate decreased from 4.8% in FY 2023 to 3.42% in FY 2024 (Measure 12.2.1.e). CDC will continue disposing under-utilized assets to meet or exceed this target.

CDC's operating costs remained unchanged from FY 2023 to FY 2024 (Measure 12.2.1f). Maintenance costs are largely affected by annual maintenance contract renewals. While energy costs have decreased by improved operating efficiencies, increases to utility rates have offset any additional potential savings. Most assets are not tabulated individually for maintenance costs or metered individually for energy costs. They are pro-rated according to square footage and asset type. It was found that some of this data needed adjustment beyond the yearly increases in utility and maintenance contracts. CDC also reiterates that the target for reduced operating costs does not consider high operating costs associated with laboratory assets. CDC's laboratories comprise approximately 44% of its square footage, resulting in disproportionately higher operating costs. Benchmarking studies have indicated CDC's asset portfolio is in the medium range of operating costs for similarly equipped institutional and private real asset portfolios with similar laboratory to non- laboratory asset ratios.

WORKING CAPITAL FUND

Performance Measures for Working Capital Fund

Measure	Most Recent Result and Target	FY 2025 Target ¹	FY 2026 Target	FY 2026 +/- FY 2025
15.2.2 Maintain the percent of invoices paid on time (Efficiency)	FY 2024: 99.9% Target: 98% (Target Exceeded)	98%	98%	Maintain
15.5.1 Maintain the variance between annual revenues and annual costs (Efficiency)	FY 2024: 10.8% Target: 3% (Target Not Met)	3%	3%	Maintain
15.5.2 Maintain the variance between estimated and actual cost (Efficiency)	FY 2024: 11.3% Target: 1% (Target Not Met)	1%	1%	Maintain
15.5.3 Maintain the percent of bills that require correction (Efficiency)	FY 2024: 0.1% Target: 9% (Target Exceeded)	9%	9%	Maintain

¹Target was initially set without knowledge of 2025 funding.

Performance Trends: CDC actively supports its goals and customers through fiscal stewardship and sound financial strategy. Annually, CDC has secured an unqualified audit opinion on the agency's financial statements since FY 1999. The Office of Management and Budget's Prompt Payment rule requires federal agencies to pay vendors in a timely manner and assesses late interest penalties against agencies that pay vendors after a payment due date. CDC has maintained a greater than 99% prompt payment level since FY 2013 (Measure 15.2.2). CDC will continue to exceed the 98% requirement of on time payments by ensuring program offices, the acquisition office, and the payment office communicate with each other and the agency's vendors.

CDC's Working Capital Fund (WCF) aims to achieve greater efficiency and transparency through the provision of Agency-wide business services. Currently, CDC estimates costs for business services 18 months prior to final fiscal year obligations being made. In FY 2024, CDC received supplemental funding after the start of the fiscal year and as a result did not meet its target (Measure 15.5.1). CDC will maintain its FY 2025 target in FY 2026, however and emergency response efforts will contribute to variation. In measuring performance from a Center, Institute, Office (CIO) perspective in FY 2024, the original cost estimate varied 11.3% from the actual costs charged (Measure 15.5.2). Due to continued process improvements, CDC also exceeded its target of 10% for monthly bills requiring correction (Measure 15.5.3). CDC will keep FY 2026 targets for these measures level with the previous year.

SUPPLEMENTAL TABLES

OBJECT CLASS TABLE – DIRECT

(dollars in thousands)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Personnel Compensation:				
Full-Time Permanent (11.1)	\$570,574	\$570,574	\$394,224	-\$176,350
Other than Full-Time Permanent (11.3)	\$68,907	\$68,907	\$43,484	-\$25,423
Other Personnel Comp. (11.5)	\$32,646	\$32,646	\$20,601	-\$12,044
Military Personnel (11.7)	\$50,985	\$50,985	\$32,175	-\$18,811
Special Personal Service Comp. (11.8)	\$1,628	\$1,628	\$1,027	-\$601
Total Personnel Compensation	\$724,739	\$724,739	\$491,511	-\$233,228
Civilian personnel Benefits (12.1)	\$244,717	\$244,717	\$236,331	-\$8,386
Military Personnel Benefits (12.2)	\$14,372	\$14,372	\$13,750	-\$622
Benefits to Former Personnel (13.0)	\$191	\$191	\$185	-\$7
Subtotal Pay Costs	\$984,019	\$984,019	\$741,777	-\$242,242
Travel (21.0)	\$32,480	\$32,480	\$30,560	-\$1,919
Transportation of Things (22.0)	\$5,692	\$5,692	\$5,356	-\$336
Rental Payments to GSA (23.1)	\$152	\$152	\$144	-\$7
Rental Payments to Others (23.2)	\$4,359	\$4,359	\$4,102	-\$258
Communications, Utilities, and Misc. Charges (23.3)	\$2,887	\$2,887	\$2,716	-\$171
NTWK Use Data TRANSM SVC (23.8)	\$0	\$0	\$0	\$0
Printing and Reproduction (24.0)	\$1,232	\$1,232	\$1,159	-\$73
Other Contractual Services (25):	\$1,113,090	\$1,113,090	\$1,047,311	-\$65,779
Advisory and Assistance Services (25.1)	\$485,988	\$485,988	\$457,268	-\$28,720
Other Services (25.2)	\$43,595	\$43,595	\$41,019	-\$2,576
Purchases from Government Accounts (25.3)	\$492,496	\$492,496	\$463,391	-\$29,105
Operation and Maintenance of Facilities (25.4)	\$14,003	\$14,003	\$13,176	-\$828
Research and Development Contracts (25.5)	\$19,817	\$19,817	\$18,646	-\$1,171
Medical Services (25.6)	\$2,202	\$2,202	\$2,072	-\$130
Operation and Maintenance of Equipment (25.7)	\$54,989	\$54,989	\$51,739	-\$3,250
Subsistence and Support of Persons (25.8)	\$0	\$0	\$0	\$0
Consultants, other and misc (25.9)	\$0	\$0	\$0	\$0
Supplies and Materials (26.0)	\$20,828	\$20,828	\$20,197	-\$631
Equipment (31.0)	\$22,942	\$22,942	\$21,587	-\$1,356
Land and Structures (32.0)	\$8,441	\$8,441	\$7,856	-\$585
Investments and Loans (33.0)	\$0	\$0	\$0	\$0
Grants, Subsidies, and Contrib (41.0)	\$2,388,305	\$2,388,305	\$2,154,615	-\$233,689
Insurance Claims and Indemnities (42.0)	\$208	\$208	\$194	-\$14
Interest and Dividends (43.0)	\$0	\$0	\$0	\$0
Refunds (44.0)	\$0	\$0	\$0	\$0
Subtotal Non-Pay Costs	\$3,600,617	\$3,600,617	\$3,295,798	-\$304,819
Total Budget Authority¹	\$4,584,636	\$4,584,636	\$4,037,575	-\$547,061
Average Cost per FTE				
Civilian FTEs	12,098	8,890	6,602	-2,289
Civilian Average Salary and Benefits	\$76	\$103	\$105	\$2
Percent change	N/A	36%	2%	-34%
Military FTEs	718	738	548	-190
Military Average Salary and Benefits	\$91	\$89	\$84	-\$5
Percent change	N/A	-3%	-5%	-3%
Total FTE^{2,3}	12,816	9,628	7,150	-2,478
Average Salary and Benefits	\$77	\$102	\$104	\$1,548
Percent change	N/A	33%	2%	-32%

¹ In alignment with the proposed HHS reorganization, FY 2024 and FY 2025 BA totals are comparably adjusted.

² Total FTEs represents Direct and Working Capital Fund (WCF) FTE. ATSDR and Reimbursable employees are not included.

³ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

OBJECT CLASS TABLE – PREVENTION AND PUBLIC HEALTH FUND

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
(dollars in thousands)				
Personnel Compensation:				
Full-Time Permanent(11.1)	\$47,815	\$47,815	\$0	-\$47,815
Other than Full-Time Permanent (11.3)	\$4,324	\$4,324	\$0	-\$4,324
Other Personnel Comp. (11.5)	\$2,187	\$2,187	\$0	-\$2,187
Military Personnel (11.7)	\$2,764	\$2,764	\$0	-\$2,764
Special Personal Service Comp. (11.8)	\$237	\$237	\$0	-\$237
Total Personnel Compensation	\$57,326	\$57,326	\$0	-\$57,326
Civilian personnel Benefits (12.1)	\$20,032	\$20,032	\$0	-\$20,032
Military Personnel Benefits (12.2)	\$882	\$882	\$0	-\$882
Benefits to Former Personnel (13.0)	\$0	\$0	\$0	\$0
Subtotal Pay Costs	\$78,241	\$78,241	\$0	-\$78,241
Travel (21.0)	\$1,941	\$1,941	\$0	-\$1,941
Transportation of Things (22.0)	\$164	\$164	\$0	-\$164
Rental Payments to GSA (23.1)	\$0	\$0	\$0	\$0
Rental Payments to Others (23.2)	\$49	\$49	\$0	-\$49
Communications, Utilities, and Misc. Charges (23.3)	\$10	\$10	\$0	-\$10
NTWK Use Data TRANSM SVC (23.8)	\$0	\$0	\$0	\$0
Printing and Reproduction (24.0)	\$57	\$57	\$0	-\$57
Other Contractual Services (25):	\$216,339	\$216,339	\$0	-\$216,339
Advisory and Assistance Services (25.1)	\$134,353	\$134,353	\$0	-\$134,353
Other Services (25.2)	\$2,117	\$2,117	\$0	-\$2,117
Purchases from Government Accounts (25.3)	\$76,868	\$76,868	\$0	-\$76,868
Operation and Maintenance of Facilities (25.4)	\$3	\$3	\$0	-\$3
Research and Development Contracts (25.5)	\$284	\$284	\$0	-\$284
Medical Services (25.6)	\$52	\$52	\$0	-\$52
Operation and Maintenance of Equipment (25.7)	\$2,661	\$2,661	\$0	-\$2,661
Subsistence and Support of Persons (25.8)	\$0	\$0	\$0	\$0
Consultants, other and misc (25.9)	\$0	\$0	\$0	\$0
Supplies and Materials (26.0)	\$62,486	\$62,486	\$0	-\$62,486
Equipment (31.0)	\$708	\$708	\$0	-\$708
Land and Structures (32.0)	\$0	\$0	\$0	\$0
Investments and Loans (33.0)	\$0	\$0	\$0	\$0
Grants, Subsidies, and Contributions (41.0)	\$533,939	\$533,939	\$0	-\$533,939
Insurance Claims and Indemnities (42.0)	\$0	\$0	\$0	\$0
Interest and Dividends (43.0)	\$0	\$0	\$0	\$0
Refunds (44.0)	\$0	\$0	\$0	\$0
Subtotal Non-Pay Costs	\$815,692	\$815,692	\$0	-\$815,692
Total Budget Authority	\$893,933	\$893,933	\$0	-\$893,933
Average Cost per FTE				
Civilian FTEs	538	730	0	-730
Civilian Average Salary and Benefits	\$139	\$102	-	-
Percent change	N/A	-26%	-	-
Military FTEs	25	56	0	-56
Military Average Salary and Benefits	\$148	\$65	-	-
Percent change	N/A	-56%	-	-
Total FTEs^{1,2}	563	786	0	-786
Average Salary and Benefits	\$139	\$100	-	-
Percent change	N/A	-28%	-	-

¹ PPHF FTEs based on direct hire estimates. The 2026 Budget eliminates funding from the Prevention and Public Health Fund (PPHF). FY 2026 estimates assume zero due to proposed PPHF elimination.

² PPHF Civilian Avg. Salary only includes partial compensation.

OBJECT CLASS TABLE – REIMBURSABLE¹

(dollars in thousands)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Personnel Compensation:				
Full-Time Permanent(11.1)	\$84,005	\$76,783	\$76,783	\$0
Other than Full-Time Permanent (11.3)	\$21,336	\$19,502	\$19,502	\$0
Other Personnel Comp. (11.5)	\$6,169	\$5,639	\$5,639	\$0
Military Personnel (11.7)	\$11,186	\$10,224	\$10,224	\$0
Special Personal Service Comp. (11.8)	\$135	\$124	\$124	\$0
Total Personnel Compensation	\$122,832	\$112,272	\$112,272	\$0
Civilian Personnel Benefits (12.1)	\$41,335	\$37,781	\$37,781	\$0
Military Personnel Benefits (12.2)	\$3,600	\$3,290	\$3,290	\$0
Benefits to Former Personnel (13.0)	\$0	\$0	\$0	\$0
Subtotal Pay Costs	\$167,767	\$153,344	\$153,344	\$0
Travel (21.0)	\$7,431	\$6,792	\$6,792	\$0
Transportation of Things (22.0)	\$2,048	\$1,872	\$1,872	\$0
Rental Payments to GSA (23.1)	\$0	\$0	\$0	\$0
Rental Payments to Others (23.2)	\$922	\$843	\$843	\$0
Communications, Utilities, and Misc. Charges (23.3)	\$1,022	\$934	\$934	\$0
NTWK Use, Data Transm Svc (23.8)	\$0	\$0	\$0	\$0
Printing and Reproduction (24.0)	\$53	\$48	\$48	\$0
Other Contractual Services (25):	<u>\$276,687</u>	<u>\$252,901</u>	<u>\$252,901</u>	<u>\$0</u>
Advisory and Assistance Services (25.1)	\$124,173	\$113,498	\$113,498	\$0
Other Services (25.2)	\$11,576	\$10,581	\$10,581	\$0
Purchases from Government Accounts (25.3)	\$91,169	\$83,331	\$83,331	\$0
Operation and Maintenance of Facilities (25.4)	\$9	\$8	\$8	\$0
Research and Development Contracts (25.5)	\$483	\$442	\$442	\$0
Medical Services (25.6)	\$85	\$78	\$78	\$0
Operation and Maintenance of Equipment (25.7)	\$49,193	\$44,964	\$44,964	\$0
Subsistence and Support of Persons (25.8)	\$0	\$0	\$0	\$0
Consultants, other and misc (25.9)	\$0	\$0	\$0	\$0
Supplies and Materials (26.0)	\$15,426	\$14,100	\$14,100	\$0
Equipment (31.0)	\$2,873	\$2,626	\$2,626	\$0
Land and Structures (32.0)	\$0	\$0	\$0	\$0
Investments and Loans (33.0)	\$0	\$0	\$0	\$0
Grants, Subsidies, and Contributions (41.0)	\$190,783	\$174,382	\$174,382	\$0
Insurance Claims and Indemnities (42.0)	\$53,194	\$48,621	\$48,621	\$0
Interest and Dividends (43.0)	\$0	\$0	\$0	\$0
Refunds (44.0)	\$0	\$0	\$0	\$0
Subtotal Non-Pay Costs	\$550,439	\$503,119	\$503,119	\$0
Total Budget Authority	\$718,206	\$656,463	\$656,463	\$0
Average Cost per FTE				
Civilian FTEs	277	111	85	-\$26
Civilian Average Salary and Benefits	\$552	\$1,260	\$1,645	\$385
Percent change	N/A	128%	31%	-98%
Military FTEs	29	15	14	-\$1
Military Average Salary and Benefits	\$510	\$901	\$965	\$64
Percent change	N/A	77%	7%	-70%
Total FTEs²	306	126	99	-\$27
Average Salary and Benefits	\$548	\$1,217	\$1,549	\$332
Percent change	N/A	122%	27%	-95%

¹ FY 2025 and FY 2026 reflect reimbursable ceiling estimates.² FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

DETAIL OF POSITIONS^{1,2,3,4}

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Executive Level⁴			
Subtotal			
Total-Executive Level Salary			
ES-6			
ES-5			
ES-4			
ES-3			
ES-2			
ES-1			
Total - SES	44	45	30
Total - SES Salary	\$8,220,991	\$7,740,499	\$6,396,244
GS-15	987	932	843
GS-14	2,928	2,913	2,648
GS-13	4,340	4,287	4,041
GS-12	2,061	2,010	1,915
GS-11	786	731	693
GS-10	22	23	20
GS-9	408	386	347
GS-8	52	47	46
GS-7	304	255	161
GS-6	12	14	12
GS-5	86	10	7
GS-4	3	4	3
GS-3	1	1	0
GS-2	2	0	0
GS-1	0	0	0
Subtotal	11,992	11,613	10,736
Total - GS Salary	\$1,396,693,766	\$1,445,633,047	\$1,440,735,710
Average ES level			
Average ES salary			
Average GS grade	12.0	12.0	12.0
Average GS salary	\$116,469	\$124,484	\$134,197
Average Special Pay Categories			
Average Comm. Corps Salary	\$144,241	\$156,552	\$168,334
Average Wage Grade Salary	\$70,806	\$70,096	\$81,746

¹ Includes special pays and allowances² Totals do not include reimbursable FTEs³ This table reflects "positions" not full-time equivalent(s) (FTEs)⁴ Executive level data not available

CDC FULL TIME EQUIVALENTS FUNDED BY THE AFFORDABLE CARE ACT, P.L. 111-148

(dollars in millions)		ACA Sec.	2016 Total	2016 FTEs	2017 Total	2017 FTEs	2018 Total	2018 FTEs	2019 Total	2019 FTEs	2020 Total	2020 FTEs	2021 Total	2021 FTEs	2022 Total	2022 FTEs	2023 Total	2023 FTEs	2024 Total	2024 FTEs	2025 Total	2025 FTEs	2026 Total	2026 FTEs
PPHF Program ^{1,2}																								
Healthcare-associated Infections (HAI)		4002	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$0.0	\$0.0
Million Hearts		4002	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$0.0	\$0.0
National Early Care Collaboratives		4002	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$0.0	\$0.0
Public Health Workforce		4002	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	\$0.0
Antibiotic Resistance Initiative		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total ³			\$20.0	9.5	\$20.0	9.5	\$20	9.5	\$20	9.5	\$20	9.5	\$20	9.5	\$20	9.5	\$20	9.5	\$20	9.5	\$20	9.5	\$0.0	\$0.0

¹Excludes employees or contractors who: Are supported through appropriations enacted in laws other than PPACA and work on programs that existed prior to the passage of PPACA; Spend less than 50% of their time on activities funded by or newly authorized in ACA; or who work on contracts for which FTE reporting is not a requirement of their contract, such as fixed price contracts.

²CDC tracks total contract costs for ACA activities in the Affordable Care Act Object Class Table but does not track individual contract staff.

³The 2026 Budget eliminates funding from the Prevention and Public Health Fund (PPHF).

(dollars in millions)		ACA Sec.	2016 Total	2016 FTEs	2017 Total	2017 FTEs	2018 Total	2018 FTEs	2019 Total	2019 FTEs	2020 Total	2020 FTEs	2021 Total	2021 FTEs	2022 Total	2022 FTEs	2023 Total	2023 FTEs	2024 Total	2024 FTEs	2025 Total	2025 FTEs	2026 Total	2026 FTEs
ACA Program ^{1,2}																								
Childhood Obesity PL 114-10		4306	\$0.0	0.0	\$10.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	\$0.0
Medical Monitoring in Libby, MT		1032 3	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$0.0	\$0.0
Total ³			\$4.0	0.9	\$14.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$0.0	\$0.0

¹Excludes employees or contractors who: Are supported through appropriations enacted in laws other than PPACA and work on programs that existed prior to the passage of PPACA; Spend less than 50% of their time on activities funded by or newly authorized in ACA; or who work on contracts for which FTE reporting is not a requirement of their contract, such as fixed price contracts.

²CDC tracks total contract costs for ACA activities in the Affordable Care Act Object Class Table but does not track individual contract staff.

³The 2026 Budget eliminates funding from the Prevention and Public Health Fund (PPHF).

PHYSICIANS' COMPARABILITY ALLOWANCE (PCA) WORKSHEET

1) Department and component:

Centers For Disease Control and Prevention

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

(Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)

CDC has found that SES salaries do not meet the threshold to attract top level senior officials for critical science-focused positions who are appointed under SES. The use of PCA is critical, as it allows CDC to recruit and retain top level senior officials who possess requisite scientific expertise, and whose national/international stature command salaries which exceed the SES salary level. In addition, Title V 602 Physicians who do not have a medical license should receive PCA.

3-4) Please complete the table below with details of the PCA agreement for the following years:

	PY 2024 (Actual)	CY 2025 (Estimates)	BY* 2026 (Estimates)
3a) Number of Physicians Receiving PCAs	1	2	2
3b) Number of Physicians with One-Year PCA Agreements	1	2	2
3c) Number of Physicians with Multi-Year PCA Agreements	0	0	0
4a) Average Annual PCA Physician Pay (without PCA payment)	183,300	358,376	358,376
4b) Average Annual PCA Payment	14,000	44,000	44,000

*BY data will be approved during the BY Budget cycle. Please ensure each column is completed.

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

The use of PCA has enabled successful recruitment and retention of physicians to key positions at CDC. It is anticipated that the failure to offer PCA to CDC physicians could have a negative impact on CDC's global mission.

6) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

The need will remain to pay PCA to any new physicians appointed under SES and Title 5 physicians with no medical license..

FY 2020-2026 CONSOLIDATED CDC GRANTS TABLE

These funds are awarded by formula.
 These funds are not awarded by formula.
 These funds are awarded partially by formula.

(dollars in millions)	FY 2020 Final	FY 2021 Final	FY 2022 Final	FY 2023 Final	FY 2024 Final	FY 2025 Enacted ¹	FY 2026 President's Budget	FY 2026 +/- FY 2025	% Formula
Immunization Cooperative Agreements									Δ
- Number of Awards	64	64	64	64	64	64	64	*	
- Total Awards	\$369.77	\$301.54	\$369.77	\$438.50	\$276.72	\$269.36	\$269.36	*	
Viral Hepatitis, STI and TB Prevention									●
- Number of Awards	N/A	N/A	N/A	N/A	62	*	*	*	
- Total Awards				\$205.18	\$205.18	*	*	*	
Epidemiology and Laboratory Capacity									●
- Number of Awards	N/A	N/A	64	64	65	*	*	*	
- Total Awards			\$197.04	\$173.00	\$364.44	*	*	*	
State Biomonitoring Cooperative Agreements									●
- Number of Awards	N/A	N/A	N/A	6	6	*	6	*	
- Total Awards				\$5.00	\$5.00	*	\$5.00	*	
Newborn Screening Cooperative Agreements									●
- Number of Awards	N/A	N/A	N/A	5	5	*	1	*	
- Total Awards				\$1.99	\$1.99	*	1.00	*	
National Syndromic Surveillance Program									●
- Number of Awards	51	51	51	51	51	*	51	*	
- Total Awards	\$6.56	\$6.56	\$6.56	\$6.00	\$6.00	*	6.00	*	
National Notifiable Diseases Surveillance System									●
- Number of Awards	64	64	64	64	64	*	64	*	
- Total Awards	\$8.84	\$11.03	\$11.03	\$11.03	\$11.03	*	\$11.03	*	
PHEP Awards									Δ
- Number of Awards	62	62	62	62	62	*	*	*	
- Total Awards	\$622.850	\$636.850	\$651.788	\$661.338	\$653.74	*	*	*	

Health Care Readiness and Recovery

- Number of Awards	N/A	N/A	N/A	N/A	62	*	0	*
- Total Awards					\$240.00	*	0	*

**Public Health Infrastructure Grant:
Foundational Capabilities**

- Number of Awards	N/A	N/A	N/A	106	106	106	106	0
- Total Awards				\$245.00	\$245.00	\$245.00	\$245.00	0

¹Grant award estimates are under development.

CDC CONSOLIDATED STATE TABLES

State Table: Discretionary (Section 317)¹

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget ²	FY 2026 +/- FY 2025
Alabama	\$4,466,964	\$4,476,749	\$4,476,749	\$0
Alaska	\$2,695,260	\$2,701,298	\$2,701,298	\$0
Arizona	\$7,950,457	\$7,966,413	\$7,966,413	\$0
Arkansas	\$4,038,158	\$4,046,436	\$4,046,436	\$0
California	\$38,204,302	\$38,281,605	\$38,281,605	\$0
Colorado	\$5,928,270	\$5,939,700	\$5,939,700	\$0
Connecticut	\$4,651,713	\$4,662,173	\$4,662,173	\$0
Delaware	\$1,614,212	\$1,617,990	\$1,617,990	\$0
District of Columbia	\$2,158,959	\$2,163,945	\$2,163,945	\$0
Florida	\$14,776,053	\$14,806,965	\$14,806,965	\$0
Georgia	\$10,605,434	\$10,626,347	\$10,626,347	\$0
Hawaii	\$3,311,908	\$3,319,755	\$3,319,755	\$0
Idaho	\$2,705,875	\$2,711,933	\$2,711,933	\$0
Illinois	\$9,351,527	\$9,372,587	\$9,372,587	\$0
Indiana	\$6,929,828	\$6,942,903	\$6,942,903	\$0
Iowa	\$3,517,088	\$3,525,069	\$3,525,069	\$0
Kansas	\$3,846,579	\$3,854,636	\$3,854,636	\$0
Kentucky	\$4,526,146	\$4,535,775	\$4,535,775	\$0
Louisiana	\$4,527,283	\$4,536,707	\$4,536,707	\$0
Maine	\$2,871,603	\$2,878,405	\$2,878,405	\$0
Maryland	\$4,819,904	\$4,831,221	\$4,831,221	\$0
Massachusetts	\$6,682,944	\$6,695,992	\$6,695,992	\$0
Michigan	\$9,564,286	\$9,585,137	\$9,585,137	\$0
Minnesota	\$6,047,543	\$6,059,161	\$6,059,161	\$0
Mississippi	\$3,880,051	\$3,888,631	\$3,888,631	\$0
Missouri	\$6,026,202	\$6,038,683	\$6,038,683	\$0
Montana	\$1,542,881	\$1,546,188	\$1,546,188	\$0
Nebraska	\$2,952,997	\$2,958,794	\$2,958,794	\$0
Nevada	\$3,696,321	\$3,704,572	\$3,704,572	\$0
New Hampshire	\$2,375,207	\$2,380,660	\$2,380,660	\$0
New Jersey	\$8,381,258	\$8,398,114	\$8,398,114	\$0
New Mexico	\$3,272,278	\$3,279,307	\$3,279,307	\$0
New York	\$8,446,037	\$8,464,530	\$8,464,530	\$0
North Carolina	\$8,915,278	\$8,933,004	\$8,933,004	\$0
North Dakota	\$2,125,000	\$2,129,794	\$2,129,794	\$0
Ohio	\$10,265,313	\$10,286,938	\$10,286,938	\$0
Oklahoma	\$5,392,472	\$5,403,975	\$5,403,975	\$0
Oregon	\$4,388,888	\$4,398,125	\$4,398,125	\$0
Pennsylvania	\$8,360,837	\$8,377,696	\$8,377,696	\$0
Rhode Island	\$2,221,345	\$2,226,717	\$2,226,717	\$0
South Carolina	\$4,599,981	\$4,610,122	\$4,610,122	\$0
South Dakota	\$1,602,842	\$1,606,610	\$1,606,610	\$0
Tennessee	\$6,921,393	\$6,935,501	\$6,935,501	\$0
Texas	\$24,454,801	\$24,500,829	\$24,500,829	\$0
Utah	\$3,197,754	\$3,204,922	\$3,204,922	\$0
Vermont	\$2,050,666	\$2,055,103	\$2,055,103	\$0

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget ²	FY 2026 +/- FY 2025
Virginia	\$6,806,774	\$6,820,707	\$6,802,707	\$0
Washington	\$7,362,787	\$7,377,267	\$7,377,267	\$0
West Virginia	\$2,412,158	\$2,417,220	\$2,417,220	\$0
Wisconsin	\$5,821,354	\$5,833,361	\$5,833,361	\$0
Wyoming	\$1,087,738	\$1,090,310	\$1,090,310	\$0
Subtotal States	\$314,352,912	\$315,006,584	\$315,006,584	\$0
Cities				
Chicago	\$6,970,015	\$6,981,408	\$6,981,408	\$0
Houston ³	\$2,849,474	\$2,856,837	\$2,856,837	\$0
New York City	\$10,204,988	\$10,226,027	\$10,226,027	\$0
Philadelphia	\$2,975,972	\$2,982,637	\$2,982,637	\$0
San Antonio ³	\$2,038,546	\$2,043,813	\$2,043,813	\$0
Subtotal Cities	\$25,038,995	\$25,090,722	\$25,090,722	\$0
Territories				
American Samoa	\$752,874	\$754,767	\$754,767	\$0
Guam	\$1,517,188	\$1,520,535	\$1,520,535	\$0
Marshall Islands	\$3,294,651	\$3,299,407	\$3,299,407	\$0
Micronesia	\$4,551,164	\$4,556,395	\$4,556,395	\$0
Northern Mariana Islands	\$1,266,607	\$1,269,742	\$1,269,742	\$0
Puerto Rico	\$3,952,299	\$3,960,960	\$3,960,960	\$0
Republic of Palau	\$569,497	\$570,329	\$570,329	\$0
Virgin Islands	\$1,561,622	\$1,565,601	\$1,565,601	\$0
Subtotal Territories	\$17,465,901	\$17,497,735	\$17,497,735	\$0
Total States/Cities/Territories	\$356,857,807	\$357,595,041	\$357,595,041	\$0
Other Adjustments⁴	\$71,535,263	\$71,904,959	\$71,904,959	\$0
Total Resources	\$428,393,070	\$429,500,000	\$429,500,000	\$0

¹ This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). Includes vaccine direct assistance and immunization infrastructure/operations grant funding. For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://www.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

² Starting in July 2025, the next 5-year cycle of the cooperative agreement IP25-0007: Strengthening Vaccine-Preventable Disease Prevention and Response will begin. totable does not reflect two new awardees and updated funding allocations that were not available at the time of print. The figures currently listed for FY 2026 are estimates.

³ Vaccine direct assistance for Houston and San Antonio is included with the state of Texas.

⁴ Other adjustments include vaccine in inventory at the centralized distribution center that has not been ordered by immunization providers, funds for centralized vaccine distribution activities, a centralized vaccine ordering system, and program support services.

State Table: Viral Hepatitis, STI and TB Prevention Programs State Funding^{1,2,3}

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Alabama	\$2,888,917	*	*	*
Alaska	\$1,381,149	*	*	*
Arizona	\$3,790,146	*	*	*
Arkansas	\$2,106,801	*	*	*
California	\$17,544,392	*	*	*
Colorado	\$2,882,415	*	*	*
Connecticut	\$1,838,107	*	*	*
Delaware	\$985,613	*	*	*
Florida	\$11,282,647	*	*	*
Georgia	\$6,754,910	*	*	*
Hawaii	\$1,790,743	*	*	*
Idaho	\$1,170,635	*	*	*
Illinois	\$4,270,578	*	*	*
Indiana	\$3,191,036	*	*	*
Iowa	\$1,893,213	*	*	*
Kansas	\$1,670,403	*	*	*
Kentucky	\$2,519,333	*	*	*
Louisiana	\$3,218,274	*	*	*
Maine	\$1,160,841	*	*	*
Maryland	\$3,130,259	*	*	*
Massachusetts	\$3,989,943	*	*	*
Michigan	\$4,521,979	*	*	*
Minnesota	\$2,979,193	*	*	*
Mississippi	\$2,137,625	*	*	*
Missouri	\$3,114,855	*	*	*
Montana	\$830,392	*	*	*
Nebraska	\$1,160,505	*	*	*
Nevada	\$2,050,571	*	*	*
New Hampshire	\$837,555	*	*	*
New Jersey	\$5,259,640	*	*	*
New Mexico	\$1,665,745	*	*	*
New York	\$4,578,130	*	*	*
North Carolina	\$5,325,056	*	*	*
North Dakota	\$852,961	*	*	*
Ohio	\$4,963,388	*	*	*
Oklahoma	\$2,592,903	*	*	*
Oregon	\$2,463,464	*	*	*
Pennsylvania	\$3,872,943	*	*	*
Rhode Island	\$1,227,213	*	*	*
South Carolina	\$2,832,143	*	*	*
South Dakota	\$597,512	*	*	*
Tennessee	\$3,357,154	*	*	*
Texas	\$16,206,359	*	*	*
Utah	\$1,466,238	*	*	*
Vermont	\$820,083	*	*	*
Virginia	\$4,382,036	*	*	*
Washington	\$4,508,059	*	*	*
West Virginia	\$1,581,215	*	*	*

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Wisconsin	\$2,479,847	*	*	*
Wyoming	\$814,498	*	*	*
Cities				
Baltimore	\$1,845,312	*	*	*
Chicago	\$3,323,522	*	*	*
Dallas	\$315,000	*	*	*
Houston	\$1,786,408	*	*	*
Los Angeles	\$8,614,110	*	*	*
New York City	\$9,827,932	*	*	*
Philadelphia	\$2,963,487	*	*	*
San Diego	\$1,752,508	*	*	*
San Francisco	\$2,201,985	*	*	*
Washington, D.C.	\$1,457,133	*	*	*
Territories				
Puerto Rico	\$1,686,397	*	*	*
Virgin Islands	\$467,891	*	*	*
Subtotal States	\$168,939,617	*	*	*
Subtotal Cities	\$34,087,397	*	*	*
Subtotal Territories	\$2,154,288	*	*	*
Total Resources	\$205,181,302	*	*	*

¹This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial awardees).

²FY 2025 and FY 2026 amounts are subject to funding availability and final appropriations.

³Grant award estimates are under development.

State Table: National Notifiable Diseases Surveillance System (NNDSS) Grants^{1,2,3,4}

	FY 2024 Final	FY 2025 Enacted⁵	FY 2026 President's Budget	FY 2026 +/- FY 2025
Alabama	\$6,000	*	\$6,000	*
Alaska	\$499,447	*	\$499,447	*
Arizona	\$325,723	*	\$325,723	*
Arkansas	\$162,710	*	\$162,710	*
California	\$175,375	*	\$175,375	*
Colorado	\$589,804	*	\$589,804	*
Connecticut	\$590,092	*	\$590,092	*
Delaware	\$25,000	*	\$25,000	*
District of Columbia	\$378,996	*	\$378,996	*
Florida	\$588,138	*	\$588,138	*
Georgia	\$292,923	*	\$292,923	*
Hawaii	\$244,237	*	\$244,237	*
Idaho	\$222,309	*	\$222,309	*
Illinois	\$221,019	*	\$221,019	*
Indiana	\$230,516	*	\$230,516	*
Iowa	\$55,187	*	\$55,187	*
Kansas	\$521,087	*	\$521,087	*
Kentucky	-	*	-	*
Louisiana	\$206,711	*	\$206,711	*
Maine	\$388,615	*	\$388,615	*
Maryland	\$571,270	*	\$571,270	*
Massachusetts	\$313,523	*	\$313,523	*
Michigan	\$513,301	*	\$513,301	*
Minnesota	\$604,518	*	\$604,518	*
Mississippi	\$21,989	*	\$21,989	*
Missouri	\$101,844	*	\$101,844	*
Montana	\$47,241	*	\$47,241	*
Nebraska	\$272,251	*	\$272,251	*
Nevada	\$494,081	*	\$494,081	*
New Hampshire	\$294,999	*	\$294,999	*
New Jersey	\$589,450	*	\$589,450	*
New Mexico	-	*	-	*
New York	\$636,783	*	\$636,783	*
North Carolina	\$263,454	*	\$263,454	*
North Dakota	\$351,141	*	\$351,141	*
Ohio	\$161,646	*	\$161,646	*
Oklahoma	\$16,147	*	\$16,147	*
Oregon	\$404,783	*	\$404,783	*
Pennsylvania	\$199,710	*	\$199,710	*
Rhode Island	\$136,014	*	\$136,014	*
South Carolina	\$64,573	*	\$64,573	*
South Dakota	\$228,477	*	\$228,477	*
Tennessee	\$376,318	*	\$376,318	*
Texas	\$180,495	*	\$180,495	*
Utah	\$1,052,903	*	\$1,052,903	*
Vermont	\$288,683	*	\$288,683	*
Virginia	\$41,914	*	\$41,914	*
Washington	\$351,963	*	\$351,963	*

	FY 2024 Final	FY 2025 Enacted ⁵	FY 2026 President's Budget	FY 2026 +/- FY 2025
West Virginia	\$427,676	*	\$427,676	*
Wisconsin	\$399,134	*	\$399,134	*
Wyoming	\$176,937	*	\$176,937	*
Territories				
Guam	\$267,745	*	\$267,745	*
Marshall Islands	\$70,495	*	\$70,495	*
Micronesia	\$3,733	*	\$3,733	*
Northern Mariana Islands	-	*	-	*
Palau	-	*	-	*
Puerto Rico	\$167,389	*	\$167,389	*
Virgin Islands	\$52,200	*	\$52,200	*
American Samoa	-	*	-	*
Cities				
Chicago	\$267,495	*	\$267,495	*
Houston	\$483,192	*	\$483,192	*
Los Angeles	\$704,329	*	\$704,329	*
New York City	\$293,684	*	\$293,684	*
Philadelphia	\$382,631	*	\$382,631	*
Number of Awards	59	*	59	*
Average Award	\$0.305	*	\$0.305	*
Range of Awards	\$0.003-\$1.053	*	\$0.003-\$1.053	*
Subtotal States	\$15,307,107	*	\$15,307,107	*
Subtotal Territories	\$561,562	*	\$561,562	*
Subtotal Cities	\$2,131,331	*	\$2,131,331	*
Total Resources	\$18,000,000	*	\$18,000,000	*

¹ This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <https://www.cdc.gov/funding/funding-profiles/>.

² CFDA Number:93.323 [Discretionary]

³ These funds are not awarded by formula.

⁴ Table includes core funding from the Surveillance, Epidemiology, and Public Health Informatics budget activity and other CDC.

⁵ FY 2025 grant award estimates are under development.

State Table: Public Health Emergency Preparedness Cooperative Agreement¹

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Alabama	\$9,066,094	*	*	*
Alaska	\$5,210,000	*	*	*
Arizona	\$13,007,079	*	*	*
Arkansas	\$6,989,403	*	*	*
California	\$44,882,292	*	*	*
Colorado	\$10,612,843	*	*	*
Connecticut	\$8,123,961	*	*	*
Delaware	\$5,426,073	*	*	*
Florida	\$33,336,079	*	*	*
Georgia	\$17,681,023	*	*	*
Hawaii	\$5,386,337	*	*	*
Idaho	\$5,742,299	*	*	*
Illinois	\$17,059,039	*	*	*
Indiana	\$12,101,913	*	*	*
Iowa	\$6,873,572	*	*	*
Kansas	\$7,154,030	*	*	*
Kentucky	\$8,576,091	*	*	*
Louisiana	\$8,919,448	*	*	*
Maine	\$5,210,000	*	*	*
Maryland	\$12,242,223	*	*	*
Massachusetts	\$13,927,467	*	*	*
Michigan	\$17,051,164	*	*	*
Minnesota	\$12,231,559	*	*	*
Mississippi	\$6,893,485	*	*	*
Missouri	\$11,168,375	*	*	*
Montana	\$5,510,000	*	*	*
Nebraska	\$5,807,091	*	*	*
Nevada	\$7,683,461	*	*	*
New Hampshire	\$5,378,731	*	*	*
New Jersey	\$16,937,507	*	*	*
New Mexico	\$6,958,927	*	*	*
New York	\$19,892,548	*	*	*
North Carolina	\$15,763,551	*	*	*
North Dakota	\$5,210,000	*	*	*
Ohio	\$18,334,549	*	*	*
Oklahoma	\$8,008,571	*	*	*
Oregon	\$8,471,350	*	*	*
Pennsylvania	\$20,247,797	*	*	*
Rhode Island	\$5,715,557	*	*	*
South Carolina	\$10,505,907	*	*	*
South Dakota	\$5,510,000	*	*	*
Tennessee	\$11,981,492	*	*	*
Texas	\$43,765,264	*	*	*
Utah	\$7,233,853	*	*	*

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Vermont	\$5,510,000	*	*	*
Virginia	\$16,335,770	*	*	*
Washington	\$13,364,241	*	*	*
West Virginia	\$5,531,898	*	*	*
Wisconsin	\$11,929,433	*	*	*
Wyoming	\$5,210,000	*	*	*
Localities				
Chicago	\$10,471,504	*	*	*
Washington, D.C.	\$5,747,189	*	*	*
Los Angeles County	\$21,467,817	*	*	*
New York City	\$20,523,321	*	*	*
Territories				
American Samoa	\$413,850	*	*	*
Guam	\$544,542	*	*	*
Marshall Islands	\$419,776	*	*	*
Micronesia	\$478,510	*	*	*
Northern Mariana Islands	\$408,982	*	*	*
Puerto Rico	\$6,653,125	*	*	*
Republic of Palau	\$370,357	*	*	*
Virgin Islands	\$466,932	*	*	*
Subtotal States	\$591,969,347	*	*	*
Subtotal Localities	\$59,613,188	*	*	*
Subtotal Territories	\$9,756,074	*	*	*

¹ Grant award estimates are under development.

Public Health Infrastructure Grant: Foundational Capabilities¹⁻⁴

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Alabama	\$3,663,591	\$3,663,591	\$3,663,591	\$0
Alaska	\$856,842	\$856,842	\$856,842	\$0
Arizona	\$5,424,624	\$5,424,624	\$5,424,624	\$0
Arkansas	\$2,368,361	\$2,368,361	\$2,368,361	\$0
California	\$27,037,900	\$27,037,900	\$27,037,900	\$0
Colorado	\$4,298,521	\$4,298,521	\$4,298,521	\$0
Connecticut	\$2,452,692	\$2,452,692	\$2,452,692	\$0
Delaware	\$1,013,538	\$1,013,538	\$1,013,538	\$0
District of Columbia	\$849,048	\$849,048	\$849,048	\$0
Florida	\$15,069,593	\$15,069,593	\$15,069,593	\$0
Georgia	\$7,053,621	\$7,053,621	\$7,053,621	\$0
Hawaii	\$1,234,512	\$1,234,512	\$1,234,512	\$0
Idaho	\$1,440,020	\$1,440,020	\$1,440,020	\$0
Illinois	\$8,521,455	\$8,521,455	\$8,521,455	\$0
Indiana	\$4,797,188	\$4,797,188	\$4,797,188	\$0
Iowa	\$2,211,422	\$2,211,422	\$2,211,422	\$0
Kansas	\$2,075,781	\$2,075,781	\$2,075,781	\$0
Kentucky	\$3,668,501	\$3,668,501	\$3,668,501	\$0
Louisiana	\$3,430,130	\$3,430,130	\$3,430,130	\$0
Maine	\$1,211,521	\$1,211,521	\$1,211,521	\$0
Maryland	\$4,346,858	\$4,346,858	\$4,346,858	\$0
Massachusetts	\$4,782,115	\$4,782,115	\$4,782,115	\$0
Michigan	\$6,768,801	\$6,768,801	\$6,768,801	\$0
Minnesota	\$3,905,589	\$3,905,589	\$3,905,589	\$0
Mississippi	\$2,451,029	\$2,451,029	\$2,451,029	\$0
Missouri	\$4,444,195	\$4,444,195	\$4,444,195	\$0
Montana	\$1,054,522	\$1,054,522	\$1,054,522	\$0
Nebraska	\$1,947,901	\$1,947,901	\$1,947,901	\$0
Nevada	\$2,748,659	\$2,748,659	\$2,748,659	\$0
New Hampshire	\$1,145,359	\$1,145,359	\$1,145,359	\$0
New Jersey	\$5,788,843	\$5,788,843	\$5,788,843	\$0
New Mexico	\$1,821,692	\$1,821,692	\$1,821,692	\$0
New York	\$14,466,752	\$14,466,752	\$14,466,752	\$0
North Carolina	\$7,346,974	\$7,346,974	\$7,346,974	\$0
North Dakota	\$867,861	\$867,861	\$867,861	\$0
Ohio	\$7,619,438	\$7,619,438	\$7,619,438	\$0
Oklahoma	\$3,744,969	\$3,744,969	\$3,744,969	\$0
Oregon	\$3,218,338	\$3,218,338	\$3,218,338	\$0
Pennsylvania	\$8,670,267	\$8,670,267	\$8,670,267	\$0
Rhode Island	\$1,054,912	\$1,054,912	\$1,054,912	\$0
South Carolina	\$3,550,984	\$3,550,984	\$3,550,984	\$0
South Dakota	\$952,126	\$952,126	\$952,126	\$0
Tennessee	\$5,567,916	\$5,567,916	\$5,567,916	\$0
Texas	\$21,948,412	\$21,948,412	\$21,948,412	\$0
Utah	\$2,033,161	\$2,033,161	\$2,033,161	\$0
Vermont	\$789,002	\$789,002	\$789,002	\$0
Virginia	\$5,616,891	\$5,616,891	\$5,616,891	\$0

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
Washington	\$4,893,269	\$4,893,269	\$4,893,269	\$0
West Virginia	\$1,550,586	\$1,550,586	\$1,550,586	\$0
Wisconsin	\$4,189,972	\$4,189,972	\$4,189,972	\$0
Wyoming	\$747,753	\$747,753	\$747,753	\$0
Territories				
America Samoa		\$471,974	471, 974	0
Guam	\$565,772	\$565,772	\$565,772	\$0
Micronesia	\$514,127	\$514,127	\$514,127	\$0
Puerto Rico	\$2,788,026	\$2,788,026	\$2,788,026	\$0
Virgin Islands	\$517,468	\$517,468	\$517,468	\$0
Northern Mariana Islands	\$476,550	\$476,550	\$476,550	\$0
Republic of Palau	\$453,958	\$453,958	\$453,958	\$0
Marshall Islands	\$498,118	\$498,118	\$498,118	\$0
Subtotal States	\$238,714,007	\$238,714,007	\$238,714,007	\$0
Subtotal Territories	\$6,285,993	\$6,285,993	\$6,285,993	\$0
Total Resources	\$245,000,000	\$245,000,000	\$245,000,000	\$0

¹ Table only reflects funds from CDC's annual appropriation.

² These funds are awarded by formula based on funding availability.

³ Awards noted for Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems Grant Activity 2: -Foundational Capabilities, awarded December 2024.

⁴ The number of continuing awards is 106, with an average award of \$2.311M and range of awards is \$0.493-\$10.514M for all years listed.

PROGRAMS PROPOSED FOR ELIMINATION IN THE FY 2026 BUDGET

(dollars in millions)

Program	FY 2025 Enacted ¹
Acute Flaccid Myelitis (AFM)	*
Prion Disease	*
Chronic Fatigue Syndrome (Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)	*
Harmful Algal Blooms	*
Healthcare-Associated Infections (HAI) (PPHF)	\$12.000
Global HIV/AIDS Program	\$128.921
Global Tuberculosis	*
Global Immunization Program, including Polio Eradication and Measles and Other Vaccine Preventable Diseases	*
Academic Centers for Public Health Preparedness	*
Preventive Health and Health Services Block Grant	\$160.000
ASPR Medical Reserve Corps (MRC)	*
ASPR Center for the HHS Coordination Operations and Response Element (H-CORE)	\$15.000

¹ Consistent with the FY 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be a separate PPA for 2025 and is rolled up within the account.

CDC SPECIFIC ITEMS

CENTERS FOR DISEASE CONTROL AND PREVENTION

Resource Summary

<i>(Dollars in Millions)</i>	FY 2024 Final	FY 2025 Enacted	FY 2026 Request ^{1,2}
Drug Resources by Function			
Harm Reduction	\$23.000	*	\$23.000
Total Drug Resources by Function	\$23.000	*	\$23.000
Drug Resources by Decision Unit			
Consolidated Hepatitis, STD and Tuberculosis Prevention ³ Grant	\$23.000	*	\$23.000
Total Drug Resources by Decision Unit	\$23.000	*	\$23.000
Drug Resources Personnel Summary			
Total FTEs (Direct Only) ⁴	8	*	7
Consolidated Hepatitis, STD and Tuberculosis Prevention ³ Grant	8	*	7
Drug Resources as a Percent of Budget			
Total Agency Budget ⁵	\$5,478.569	*	\$4,242.575
Drug Resources Percentage	0.4%	*	0.5%

¹ In alignment with the proposed HHS reorganization, the FY 2026 Request realigns funding and activities for Opioid Abuse and Overdose Prevention and Surveillance to the proposed Administration for a Healthy America (AHA).

² In alignment with the proposed HHS reorganization, the FY 2026 Request realigns Infectious Diseases and the Opioid Epidemic (IDO) into a new line, Consolidated Hepatitis, STD and Tuberculosis Prevention Grant.

³ Consistent with the 2025 operating plan, funding levels are displayed for statutory PPAs. This activity is not intended to be separate PPA for 2025 and is rolled up within the account.

⁴ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

⁵ Excludes ATSDR and mandatory programs; includes funding from the Prevention and Public Health Fund and PHS Evaluation Transfers.

Program Summary

MISSION

CDC is the nation's leading science-based, data-driven, service organization that protects the public's health. Overdose is the leading cause of death for 18–44-year-olds in this country. However, these deaths are preventable using the same data-driven approaches that CDC has used to fight infectious diseases over the last century.

CDC also continues to strengthen partnerships with public safety and scale up public health interventions like linking people with substance use disorders to care and increasing access to naloxone to support long-term recovery and reduce associated risks like rising rates of infectious diseases such as hepatitis C as well as stigma. Across the agency, CDC has dedicated efforts to reach those at greatest risk where public health action will have the greatest impact.

METHODOLOGY

CDC determined the drug control budget using the relevant amounts under the Full-Year Continuing Appropriations and Extension Act 2025, P.L. 119-4. CDC is committed to an approach that protects the public's health, safety, and well-being, and prevents drug overdose and associated risk factors.

BUDGET SUMMARY

In FY 2026, CDC requests **\$23,000,000** for drug control activities, which reflects funding by decision unit, Consolidated Hepatitis, STD and Tuberculosis Prevention Grant.

As the nation continues to respond to the overdose epidemic, it must also stop the rising infectious diseases associated with drug use, such as hepatitis C and other drug-use-associated skin and soft tissue infections.

The FY 2026 budget request reflects the proposal to realign the Infectious Diseases and the Opioid Epidemic funding line into the Consolidated Viral Hepatitis, Sexually Transmitted Infections (STIs) and Domestic TB funding lines. In FY 2026 CDC will support states in advancing proven strategies and interventions to prevent the infectious disease consequences of the opioid epidemic. CDC will continue to support the Strengthening Syringe Services Programs (SSP) infrastructure nationwide and further integrating SSPs into the United States' public health system.

SSPs are often implemented with other medical and social services vital to prevent disease transmission and improve the health of people who use drugs. With FY 2024 funds, CDC invested nearly \$8.9 million Infectious Diseases and Opioid Epidemic funding to strengthen 82 SSPs across 36 jurisdictions through the Strengthening Syringe Services Programs cooperative agreement. These efforts built on investments from FY 2022 and FY 2023, which fortified the capacity of SSPs to prevent infectious disease and enhance community protections. Due in part to CDC support, the funded SSPs have observed a 55% increase in direct service encounters and were able to expand services to locations and times to better meet community needs.

CDC is working to decrease stigma experienced by people who use drugs to increase access to services that save lives and improve health. Stigma prevents people from seeking help for SUDs (including stigma experienced in healthcare settings). CDC reduces stigma by addressing misinformation, endorsing non-stigmatizing language, and promoting awareness of stigma's impact including among populations disproportionately affected by substance use and overdose. In FY 2024, CDC invested approximately \$4.8 million from the [Integrated Viral Hepatitis Surveillance and Prevention Funding for Health Departments cooperative agreement](#) to support evidence-based services that reduce infectious disease morbidity and mortality associated with drug use in high-impact settings, including hospital emergency departments, correctional settings, and SSPs.