Public Health Service (PHS) Agencies: Overview and Funding, FY2010-FY2012

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Summary

Within the Department of Health and Human Services (HHS), eight agencies are designated components of the U.S. Public Health Service (PHS): (1) the Agency for Healthcare Research and Quality (AHRQ), (2) the Agency for Toxic Substances and Disease Registry (ATSDR), (3) the Centers for Disease Control and Prevention (CDC), (4) the Food and Drug Administration (FDA), (5) the Health Resources and Services Administration (HRSA), (6) the Indian Health Service (IHS), (7) the National Institutes of Health (NIH), and (8) the Substance Abuse and Mental Health Services Administration (SAMHSA). This report gives a brief overview of each agency and summarizes its funding for FY2010 and FY2011, as well as its FY2012 budget request.

The total amount of funding available to the agency (i.e., total program level) includes discretionary budget authority provided in annual appropriations acts, plus additional funding from other sources. These include mandatory funding provided in laws other than annual appropriations acts, notably the Patient Protection and Affordable Care Act (PPACA).

AHRQ and NIH are primarily research agencies. AHRQ conducts and supports health services research to improve the quality of health care. For FY2011, AHRQ's total program level is $392 million, which is $11 million (2.7%) below the FY2010 amount. NIH conducts and supports basic, clinical, and translational biomedical and behavioral research. For FY2011, NIH's total program level is $30.926 billion, which is $317 million (1.0%) lower than FY2010.

Three PHS agencies—IHS, HRSA, and SAMHSA—provide health care services or help fund systems that do so. IHS supports a health care delivery system for American Indians and Alaska Natives. For FY2011, IHS's total program level is $5.134 billion, which is $34 million (0.7%) above the FY2010 amount. HRSA funds programs and systems to improve access to health care among the uninsured and medically underserved. For FY2011, HRSA's discretionary budget authority is $6.272 billion, and its total program level is $9.665 billion. Budget authority decreased by $1.221 billion (16.3%) from FY2010 to FY2011, but this drop was more than offset by an increase in mandatory funding from PPACA and funds from other sources. Overall, HRSA's total program level increased by $1.598 billion (19.8%) from FY2010 to FY2011. SAMHSA funds mental health and substance abuse prevention and treatment services. For FY2011, SAMHSA's discretionary budget authority is $3.380 billion, which is $52 million (1.5%) below the FY2010 level. With the slight increase in PPACA funds, however, SAMHSA's FY2011 total program level of $3.599 billion is $16 million (0.4%) above the FY2010 amount.

CDC, the federal government's lead public health agency, coordinates and supports a variety of population-based programs to prevent and control disease, injury, and disability. For FY2011, CDC's discretionary budget authority (including ATSDR) is $5.726 billion, and its total program level is $10.870 billion. Budget authority decreased by $741 million (11.5%) from FY2010 to FY2011. However, that cut was largely offset by PPACA funds and funding from other sources. Overall, CDC's program level decreased by only $6 million. FDA, which regulates drugs, medical devices, food, and tobacco products, receives a significant portion of its funding from industry user fees. For FY2011, FDA has a total program level of $3.690 billion, which includes $2.457 billion in direct appropriations and $1.233 billion in user fees. Relative to FY2010, these amounts represent a 4.0% increase in direct appropriations and a 33.7% increase in user fees, which now account for one-third of FDA's funding.

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Introduction

The Department of Health and Human Services (HHS) has designated eight of its 11 operating divisions (agencies) as components of the U.S. Public Health Service (PHS). The PHS agencies are (1) the Agency for Healthcare Research and Quality (AHRQ), (2) the Agency for Toxic Substances and Disease Registry (ATSDR), (3) the Centers for Disease Control and Prevention (CDC), (4) the Food and Drug Administration (FDA), (5) the Health Resources and Services Administration (HRSA), (6) the Indian Health Service (IHS), (7) the National Institutes of Health (NIH), and (8) the Substance Abuse and Mental Health Services Administration (SAMHSA).[1] ATSDR is administered by the Director of the CDC and is included in the discussion of CDC in this report.

The programs and activities of five of the PHS agencies—AHRQ, CDC, HRSA, NIH, and SAMHSA—are mostly authorized under the Public Health Service Act (PHSA).[2] While some of FDA's regulatory activities are also authorized under the PHSA, the agency and its programs largely derive their statutory authority from the Federal Food, Drug, and Cosmetic Act (FFDCA).[3] Many of the IHS programs and services are authorized by the Indian Health Care Improvement Act,[4] while ATSDR was created by the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA, the "Superfund" law).[5]

The missions and key functions of the PHS agencies vary. Two of them are primarily research agencies. NIH conducts and supports basic, clinical, and translational medical research, and AHRQ conducts and supports research on the quality and effectiveness of health care services and systems. Three agencies—IHS, HRSA, and SAMHSA—provide health care services or support systems that do so. IHS supports a health care delivery system for American Indians and Alaska Natives. Health services are provided through tribally contracted and operated health programs, and through services purchased from private providers. HRSA funds programs and systems to improve access to health care among low-income populations, pregnant women and children, persons living with HIV/AIDS, rural and frontier populations, and others who are medically underserved. SAMHSA funds community-based mental health and substance abuse prevention and treatment services.

CDC and ATSDR are public health agencies that develop and support public health prevention programs and systems, such as disease surveillance and provider education programs, for a full spectrum of acute and chronic diseases and injuries, including public health emergencies and bioterrorism. The PHS agencies have limited, if any, regulatory responsibilities with the exception of FDA; its mission is largely regulatory, ensuring the safety of foods and the safety and effectiveness of drugs, vaccines, medical devices, and other health products.

[1] HHS also includes the Office of the Secretary (OS) and three human services agencies that are not part of the Public Health Service: the Administration for Children and Families (ACF), the Administration on Aging (AoA), and the Centers for Medicare and Medicaid Services (CMS). For more information on HHS and links to each agency's website, see http://www.hhs.gov/.

[2] 42 U.S.C. §§ 201 et seq.

[3] 21 U.S.C. §§ 301 et seq.

[4] 25 U.S.C. §§ 1601 et seq.

[5] 42 U.S.C. § 9604(i).

AHRQ, CDC, HRSA, NIH, and SAMHSA receive most of their funding through the annual appropriations act for the Departments of Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS-ED). Funding for ATSDR and IHS is provided through the Interior, Environment, and Related Agencies (Interior/Environment) appropriations act. FDA receives its funding through the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies (Agriculture) appropriations act.

Report Roadmap

For each PHS agency, this report provides a brief overview of the agency's statutory authority and principal activities and includes a table summarizing its funding for FY2010 and FY2011, as well as the FY2012 budget request. The FY2010 amounts reflect the funding provided in the agency's FY2010 appropriations act, with subsequent minor adjustments.[6] The FY2011 amounts are based on the funding provided by the full-year continuing resolution (CR)—the Department of Defense and Full-Year Continuing Appropriations Act, 2011—that was enacted on April 15, 2011, marking the completion of the FY2011 regular appropriations cycle more than six months after the start of the fiscal year.[7] Both the FY2010 and FY2011 amounts in the funding tables in this report are taken from each agency's FY2011 operating plan.[8] Also included in each table is a column showing the change in funding between FY2011 and FY2010. The FY2012 amounts represent the funding levels requested in the President's FY2012 budget,[9] which are summarized in the HHS FY2012 Budget in Brief.[10]

The funding tables show the agencies' *discretionary budget authority* and *program level* for each fiscal year. Discretionary budget authority represents the funding provided in the annual Labor-HHS-ED or other applicable appropriations acts.[11] Program level indicates the total amount of funding available to the agency, which includes discretionary budget authority plus additional

[6] The FY2010 Labor-HHS-ED appropriations act was incorporated as Division D in the Consolidated Appropriations Act, 2010, which was signed into law on December 16, 2009 (P.L. 111-117, 123 Stat. 3034). The FY2010 Interior/Environment appropriations act was signed into law on October 30, 2009 (P.L. 111-88, 123 Stat. 2904). The FY2010 Agriculture appropriations act was signed into law on October 21, 2009 (P.L. 111-80, 123 Stat. 2090).

[7] P.L. 112-10, 125 Stat. 38. The FY2011 full-year CR includes the FY2011 Department of Defense (DOD) appropriations act and extends funding for the other 11 regular appropriations acts through the end of FY2011. While P.L. 112-10 generally maintains funding at FY2010 levels, it includes numerous specified spending reductions. It also includes a 0.2% across-the-board rescission that applies to discretionary spending accounts (and programs within each account) other than the DOD and certain funds related to the global war on terrorism or designated as an emergency. Prior to the enactment of P.L. 112-10, Congress passed seven FY2011 interim CRs that sequentially extended funding for federal government operations from October 1, 2010, through April 15, 2011. The President signed four interim CRs during the last Congress (P.L. 111-242, 124 Stat. 2607; P.L. 111-290, 124 Stat. 3063; P.L. 111-317, 124 Stat. 3454; and P.L. 111-322, 124 Stat. 3518) and three this Congress (P.L. 112-4, 125 Stat. 6; P.L. 112-6, 125 Stat. 23; and P.L. 112-8, 125 Stat. 34). For more information on the FY2011 CRs, see CRS Report RL30343, *Continuing Resolutions: Latest Action and Brief Overview of Recent Practices*, by Sandy Streeter.

[8] The PHS agency FY2011 operating plans are posted on the HHS website at http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html. The plans, which were required by P.L. 112-10, Division B, Title VIII, Section 1863, reflect the 0.2% across-the-board rescission included in the law.

[9] Information on the President's FY2012 HHS budget is available at http://www.hhs.gov/about/hhsbudget.html.

[10] The HHS FY2012 Budget in Brief is available at http://www.hhs.gov/about/hhsbudget.html.

[11] Budget authority does not represent cash provided to, or reserved for, agencies. Instead, the term refers to authority provided by federal law to enter into financial obligations, such as purchasing services or awarding grants, that will result in immediate or future expenditures, or outlays, of federal government funds.

funding from other sources. These include (1) user fees; (2) PHS evaluation set-side funds (see discussion below under "PHS Program Evaluation Set-Aside"); and (3) funding provided in laws other than annual appropriations acts, notably the health reform law (see discussion below under "PPACA Funding").[12]

Each funding table shows the amounts for all the major budget items, which are summed to give the agency's total program level. At the bottom of the table, any user fees, set-aside funds, PPACA funds, and other non-discretionary funds are then subtracted from the program level to show the agency's discretionary budget authority. Most tables include one or more non-add entries either to highlight the funding for specific programs within a larger budget line or, in some instances, to indicate the allocation of user fees or PPACA funds. Each table is also accompanied by a brief discussion of the changes (mostly reductions) in the agency's budget for FY2011, followed by an overview of the President's FY2012 budget request for the agency. For a summary of PHS agency funding for FY2011, see the text box below ("PHS Agency FY2011 Funding At-a-Glance").

On June 16, 2011, the House passed the FY2012 Agriculture appropriations act (H.R. 2112), which includes funding for FDA. Details of the agency's funding for FY2012, as recommended by the House, are included in the FDA section below. This report will be updated once the House Appropriations Committee completes its work on the FY2012 Labor-HHS-ED and Interior/Environment appropriations acts, which fund the other PHS agencies.

PHS Program Evaluation Set-Aside

Four PHS agencies—CDC, HRSA, NIH, and SAMHSA—are subject to a budget tap called the PHS Program Evaluation Set-Aside (set-aside). PHSA Section 241 authorizes the Secretary to use a portion of eligible appropriations to assess the effectiveness of federal health programs and to identify ways to improve them.[13] The set-aside has the effect of redistributing appropriated funds for specific purposes among the HHS agencies. Although the PHSA limits the set-aside to no more than 1% of program appropriations, in recent years the annual Labor-HHS-ED appropriations act has specified a higher maximum amount of funds that may be set aside for evaluation and other uses. The FY2010 Labor-HHS-ED appropriations act capped the set-aside at 2.5%.[14] The FY2011 full-year CR act for FY2011 adopted the same value by reference. For FY2012, the President's budget proposes to increase the set-aside to 3.2%.

Following passage of the annual appropriations act, the HHS Budget Office calculates the amount of set-aside funds to be tapped from donor appropriations. It then makes allocations to recipient agencies and programs, including several offices within the Office of the Secretary, first taking into account the amounts that have been specified in the appropriations act.[15] The set-aside funds

[12] Amounts provided in laws other than annual appropriations acts are referred to as mandatory funding.

[13] Most of the funds appropriated for CDC, HRSA, NIH, and SAMHSA are subject to the PHS evaluation tap. Exceptions, by HHS convention, include funds appropriated for certain block grants administered by those agencies (prevention, substance abuse, and mental health), for program management activities, and for buildings and facilities, as well as some programs not authorized by the PHSA, such as HRSA's maternal and child health block grant.

[14] See Division D, Section 205 of the Consolidated Appropriations Act, 2010 (P.L. 111-117, 123 Stat. 3256).

[15] For further details, see Chapter I of HHS, Office of the Assistant Secretary for Planning and Evaluation, *Evaluation: Performance Improvement 2009*, Washington, DC, 2010, pp. 6-8, http://aspe.hhs.gov/pic/perfimp/2009/report.pdf. See also *Use of Public Health Service Evaluation Set-Aside Authority for FY 2005*, and more recent reports to be posted in summer 2011, available at http://aspe.hhs.gov/rcc/sar.shtml.

that an agency receives are not included in its discretionary budget authority but are counted towards the overall program level. AHRQ is almost entirely funded by evaluation set-aside funds (see **Table 1**). By convention, PHS agency budget tables show only the amount of set-aside funds received. They do not subtract the amount of the evaluation tap from donor agencies' appropriations.

PPACA Funding

The Patient Protection and Affordable Care Act (PPACA), as amended, includes numerous mandatory appropriations that together provide billions of dollars to support new and existing grant programs and other activities within HHS.[16] Multiple PPACA provisions appropriated funds for specified programs and activities within the PHS agencies. These amounts are itemized and included as part of each agency's program level in the funding tables below. Each provision is identified by its PPACA section number.

In addition, PPACA established three multi-billion dollar trust funds to support programs and activities within the PHS agencies.

- The Community Health Center Fund (CHCF) will provide a total of $11 billion in supplemental funds over the five-year period FY2011 through FY2015 for HRSA's health centers program and the National Health Service Corps.[17] Note that PPACA also included a separate $1.5 billion appropriation for health center construction and renovation.[18]
- The Patient-Centered Outcomes Research Trust Fund (PCORTF) will support comparative effectiveness research over the 10-year period FY2010 through FY2019 with a mixture of appropriations and transfers from the Medicare Part A and Part B trust funds.[19] A portion of the PCORTF funding is allocated for AHRQ.
- The Prevention and Public Health Fund (PPHF), for which PPACA provides an annual appropriation in perpetuity, is intended to support prevention, wellness, and other public health programs and activities authorized under the PHSA.[20]

Transfers from all three PPACA trust funds are also itemized and included as part of each agency's program level in the funding tables below. Two separate tables summarizing the allocation of CHCF and PPHF funds for FY2010, FY2011, and FY2012 and additional information about the funds are provided in **Appendix A** and **Appendix B**, respectively.[21]

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[16] P.L. 111-148, 124 Stat. 119. A consolidated version of PPACA, prepared by the Office of the Legislative Counsel, U.S. House of Representatives, is available at http://statutes.legcoun.house.gov/PDF/ppacacon.PDF. It includes the amendments made by the health-related provisions in the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029), as well as changes made by other public laws enacted through the end of the 111th Congress (i.e., P.L. 111-159; P.L. 111-173; P.L. 111-226, Sec. 202; P.L. 111-309; and P.L. 111-312 Sec. 101(b)).

[17] PPACA Sec. 10503(a)-(b).

[18] PPACA Sec. 10503(c).

[19] PPACA Sec. 6301(d)-(e).

[20] PPACA Sec. 4002. Note that H.R. 1217, which passed the House on April 13, 2011, would eliminate the PPHF and rescind all unobligated funds.

[21] For more information on the appropriations and other funds in PPACA, see CRS Report R41301, *Appropriations and* (continued...)

PHS Agency FY2011 Funding At-a-Glance

Agency for Healthcare Research and Quality (AHRQ)

For FY2011, AHRQ's total program level is $392 million, which is $11 million (2.7%) below the FY2010 amount. While the agency received a $25 million cut in PHS evaluation set-aside funds, which account for most of its funding, it had a $14 million increase in PPACA funds. See **Table 1**.

Centers for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR)

For FY2011, CDC's discretionary budget authority (including ATSDR) is $5.726 billion, and its total program level is $10.870 billion. Budget authority decreased by $741 million (11.5%) from FY2010 to FY2011. However, that cut was largely offset by the transfer of funds from the PPHF and other sources. Overall, CDC's program level decreased by only $6 million. See **Table 2**.

Food and Drug Administration (FDA)

For FY2011, FDA has a total program level of $3.690 billion, which includes $2.457 billion in direct appropriations and $1.233 billion in user fees. Relative to FY2010, these amounts represent a 4.0% increase in direct appropriations and a 33.7% increase in user fees, which now account for 33.4% of FDA's funding. See **Table 3**.

Health Resources and Services Administration (HRSA)

For FY2011, HRSA's discretionary budget authority is $6.272 billion, and its total program level is $9.665 billion. Budget authority decreased by $1.221 billion (16.3%) from FY2010 to FY2011. This reduction in HRSA's discretionary funding was more than offset by an increase in mandatory funding from PPACA and funds from other sources (i.e., user fees, set-aside funds), which increased from $575 million in FY2010 to $3.394 billion in FY2011. Overall, the agency's total program level increased by $1.598 (19.8%) from FY2010 to FY2011. See **Table 4**.

Indian Health Service (IHS)

For FY2011, IHS's total program level is $5.134 billion, which is $34 million (0.7%) above the FY2010 amount. See **Table 5**.

National Institutes of Health (NIH)

For FY2011, NIH's total program level is $30.926 billion, which is $317 million (1.0%) lower than FY2010. Most institutes and centers are down by about 1% compared with their FY2010 levels; however, the Buildings and Facilities account is 50% lower. See **Table 6**.

Substance Abuse and Mental Health Services Administration (SAMHSA)

For FY2011, SAMHSA's budget authority is $3.380 billion, which is $52 million (1.5%) below the FY2010 level. With the slight increase in PPHF transfers, however, the agency's FY2011 total program level of $3.599 billion is $16 million (0.4%) above the FY2010 level. See **Table 7**.

Agency for Healthcare Research and Quality (AHRQ)

Agency Overview

AHRQ is the federal agency charged with supporting research designed to improve the quality of health care, increase the efficiency of its delivery, and broaden access to the most essential health

(...continued)

Fund Transfers in the Patient Protection and Affordable Care Act (PPACA), by C. Stephen Redhead.

services. To accomplish these goals, the agency supports research aimed at reducing the costs of care, promoting patient safety, and increasing the effectiveness of health care services.

AHRQ has evolved from a succession of agencies concerned with fostering health services research and health care technology assessment. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) added a new PHSA Title IX and established the Agency for Health Care Policy and Research (AHCPR), a successor agency to the former National Center for Health Services Research and Health Care Technology Assessment (NCHSR). AHCPR was reauthorized in 1992 (P.L. 102-410). On December 6, 1999, President Clinton signed the Healthcare Research and Quality Act of 1999 (P.L. 106-129), which renamed AHCPR as the Agency for Healthcare Research and Quality (AHRQ) and reauthorized it through FY2005.[22]

Table 1 presents funding levels for AHRQ programs for FY2010 through the FY2012 request. The AHRQ budget is organized according to program areas, including (1) Healthcare Costs, Quality and Outcomes (HCQO) Research; (2) the Medical Expenditure Panel Surveys (MEPS); and (3) program support. HCQO research focuses on six priority areas, which are summarized in the text box below. Generally, AHRQ gets its entire budget from the PHS evaluation set-aside. The set-aside funds are included in the agency's overall program level amount but are not counted as appropriated funds; thus, the agency's discretionary budget authority shows up as zero in the table. Additional funds are provided from the Patient-Centered Outcomes Research Trust Fund (PCORTF) and the Prevention and Public Health Fund (PPHF), both established by PPACA and described earlier in the introduction to this report.

Healthcare Costs, Quality and Outcomes (HCQO) Research Areas

Health Information Technology. Research evaluating HIT and its impact on the quality and efficiency of health care.

General Patient Safety Research. Research on reducing and preventing medical errors, with a focus on healthcare-associated infections (HAIs).

Patient-Centered Health Research. Research comparing the effectiveness of different treatment options (previously referred to as Comparative Effectiveness Research).

Crosscutting Activities. Research on quality of health care that spans multiple priority areas including, for example, the annual National Healthcare Quality and National Healthcare Disparities Reports.

Value. Research and projects supporting value in health care, focusing on reducing cost and improving quality.

Prevention/Care Management. Research on improving the delivery of primary care and preventive services.

[22] See the AHRQ website at http://www.ahrq.gov.

Table 1. Agency for Healthcare Research and Quality (AHRQ)

(Dollars in Millions)

Program or Activity	FY2010	FY2011	FY11/FY10 Change	FY2012 Request
Health Costs, Quality and Outcomes (HCQO) Research				
Health Information Technology	28	28	0	28
General Patient Safety Research	91	66	-25	65
Patient-Centered Health Research	21	29	8	46
PCORTF transfer (non-add)	*(0)*	*(8)*	*(8)*	*(24)*
Crosscutting Activities	112	112	0	92
Value	4	4	0	4
Prevention/Care Management	21	28	7	23
PPHF transfer (non-add)	*(6)*	*(12)*	*(6)*	*(0)*
Subtotal, HCQO Research	***276***	***266***	***-11***	***257***
Medical Expenditure Panel Surveys (MEPS)	59	59	0	59
Program Support	68	68	0	74
Total, Program Level	**403**	**392**	**-11**	**390**
Less Funds From Other Sources				
PHS Evaluation Set-Aside Funds	397	372	-25	366
PCORTF Transfers	0	8	8	24
PPHF Transfers	6	12	6	0
Total, Budget Authority	**0**	**0**	**0**	**0**

Sources: Funding amounts for FY2010 and FY2011 are taken from the AHRQ FY2011 Operating Plan, available at http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html. The amounts for FY2012 are taken from the AHRQ FY2012 congressional budget justification, available at http://www.hhs.gov/about/hhsbudget.html.

Note: Individual amounts may not add to subtotal or totals due to rounding.

FY2011 Funding

The FY2011 full-year CR (P.L. 112-10) reduces PHS evaluation set-aside funding for AHRQ by $25 million, from $397 million as provided in FY2010 to $372 million, a 6% reduction. The agency's operating plan specifies that the General Patient Safety Research program is to absorb the entire reduction (see **Table 1**). However, this cut in the agency's funding is partially offset by a $6 million increase in PPHF funds for Prevention/Care Management research, and a transfer of $8 million in PCORTF funds to boost funding for Patient-Centered Health Research. Overall, AHRQ's FY2011 program level is $11 million (3%) below the FY2010 level. The across-the-board 0.2% rescission established under P.L. 112-10 does not affect funding for AHRQ because the agency receives no discretionary appropriation.

FY2012 Budget Highlights

The President's FY2012 budget request would reduce AHRQ's total program level by $13 million (3%) from the FY2010 enacted level of $403 million to $390 million (see **Table 1**). The total proposed FY2012 program level includes $366 million in evaluation set-aside funding and $24 million from PCORTF. Notable changes in program area funding levels include those for Patient-Centered Health Research and General Patient Safety Research. Funding for Patient-Centered Health Research would increase by $25 million from FY2010 levels, with an additional $24 million from the PCORTF. Funding for General Patient Safety Research would decrease by $26 million from the FY2010 level. HHS notes that $25 million of this reduction may be attributed to a one-time investment in medical malpractice liability reform projects.

Centers for Disease Control and Prevention (CDC)

Agency Overview

According to the Centers for Disease Control and Prevention (CDC), its mission is "to promote health and quality of life by preventing and controlling disease, injury, and disability."[23] CDC is the nation's principal public health agency, coordinating and supporting a variety of population-based disease and injury control activities. It is organized into a number of centers, institutes, and offices (CIOs), some focused on specific public health challenges (such as injury prevention), others on general public health capabilities (such as surveillance and laboratory services).[24] As noted earlier, the Agency for Toxic Substances and Disease Registry (ATSDR) is administered by the CDC Director.

Often CDC's activities are not specifically authorized but are based in broad, permanent authorities in the PHSA.[25] Four CDC operating divisions are explicitly authorized. The National Institute for Occupational Safety and Health (NIOSH) was established in permanent authority in the Occupational Safety and Health Act of 1970.[26] The National Center on Birth Defects and Developmental Disabilities (NCBDDD) was established in PHSA Section 317C by the Children's Health Act of 2000. The National Center for Health Statistics (NCHS) was established in PHSA Section 306 by the Health Services Research, Health Statistics, and Medical Libraries Act of 1974. ATSDR was established in the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA, the "Superfund" law).[27]

CDC provides financial and technical assistance to state, local, municipal, tribal, and foreign governments, and to academic and non-profit entities. About 75% of the agency's funding is used for these extramural purposes. CDC has few regulatory responsibilities.

[23] See the CDC website at http://www.cdc.gov/.

[24] Information about CDC's organization is available at http://www.cdc.gov/about/organization/cio.htm.

[25] For example, PHSA Section 301 authorizes the Secretary of HHS to conduct research and investigations as necessary to control disease, and Section 317 authorizes the Secretary to award grants to states for preventive health programs.

[26] 29 U.S.C. § 671.

[27] 42 U.S.C. § 9604(i). Appropriations authorities for NCBDDD, NCHS, and ATSDR have expired, but the programs continue to receive annual appropriations.

Most CDC programs are funded through the annual Labor-HHS-ED appropriations act, while ATSDR is funded separately through the Interior/Environment annual appropriations. **Table 2** presents funding levels for CDC programs for FY2010 through the FY2012 request. In addition to the annual discretionary appropriations, amounts for each year include three mandatory appropriations: (1) for the Vaccines for Children (VFC) program; (2) for activities to support the Energy Employees Occupational Illness Compensation Program (EEOICPA); and (3) appropriations provided under PPACA.[28] CDC also receives annual funds through the PHS evaluation set-aside and through authorized user fees, and may also receive funding through supplemental appropriations and other transfers.

Table 2. Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)

(Dollars in Millions)

Program or Activity	FY2010	FY2011	FY11/FY10 Change	FY2012 Request
Immunization and Respiratory Diseases	721	748	27	722
PPHF transfer (non-add)	*(0)*	*(100)*	*(100)*	*(62)*
Vaccines for Children (VFC)[a]	3,761	3,899	138	4,031
HIV/AIDS, Viral Hepatitis, STDs and Tuberculosis Prevention	1,079	1,076	-3	1,188
PPHF transfer (non-add)	*(30)*	*(0)*	*(-30)*	*(30)*
Emerging and Zoonotic Infectious Diseases	281	304	23	349
PPHF transfer (non-add)	*(20)*	*(52)*	*(32)*	*(60)*
Chronic Disease Prevention and Health Promotion	989	1,115	126	1,186
PPHF transfer (non-add)	*(59)*	*(301)*	*(242)*	*(460)*
Childhood Obesity Demonstration (PPACA Sec. 4306; non-add)	*(25)*	*(0)*	*(-25)*	*(0)*
Birth Defects, Developmental Disabilities, Disability and Health	144	136	-8	144
Environmental Health	181	170	-11	138
PPHF transfer (non-add)	*(0)*	*(35)*	*(35)*	*(9)*
Injury Prevention and Control	149	144	-5	168
PPHF transfer (non-add)	*(0)*	*(0)*	*(0)*	*(20)*
Preventive Health and Health Services Block Grant	100	80	-20	0
Public Health Scientific Services	441	468	27	494
PPHF transfer (non-add)	*(32)*	*(72)*	*(40)*	*(70)*
Occupational Safety and Health (NIOSH)	430	371	-59	315
EEOICPA (mandatory; non-add)[b]	*(55)*	*(55)*	*(0)*	*(55)*
World Trade Center Program (non-add)[c]	*(71)*	*(22)*	*(-49)*	*(0)*

[28] CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*, by C. Stephen Redhead.

Program or Activity	FY2010	FY2011	FY11/FY10 Change	FY2012 Request
Global Health	347	340	-6	381
Public Health Leadership and Support	194	163	-32	163
PPHF transfer (non-add)	*(50)*	*(41)*	*(-9)*	*(41)*
Buildings & Facilities	69	0	-69	30
Business Services Support	367	362	-5	417
Public Health Preparedness and Response	1,522	1,415	-107	1,453
State and Local Preparedness Grants (non-add)	*(761)*	*(664)*	*(-97)*	*(651)*
Strategic National Stockpile (non-add)	*(596)*	*(591)*[d]	*(-5)*	*(655)*[d]
PPHF transfer (non-add)	*(0)*	*(10)*	*(10)*	*(0)*
User Fees	2	2	0	2
ATSDR (from Interior/Environment Appropriations)	100	77	-23	76
Medical Monitoring (PPACA Sec. 10323(b); non-add)[e]	*(23)*	*(0)*	*(-23)*	*(0)*
Total, Program Level	**10,877**	**10,870**	**-6**	**11,255**
Less Funds From Other Sources				
Vaccines for Children (VFC)	3,761	3,899	138	4,031
EEOICPA	55	55	0	55
PHS Evaluation Set-Aside Funds	352[f]	352[f]	0	490[g]
PHSSEF Transfers	0	225	225	30
PPHF Transfers	192	611	419	753
Other PPACA Funds	48	0	-48	0
User Fees	2	2	0	2
Total, CDC/ATSDR Budget Authority	**6,466**	**5,726**	**-741**	**5,894**
Less ATSDR Budget Authority	77	77	0	76
Total, CDC Budget Authority	**6,389**	**5,649**	**-740**	**5,818**

Sources: Funding amounts for FY2010 and FY2011 are taken from the CDC FY2011 Operating Plan, available at http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html. The amounts for FY2012 are taken from the CDC FY2012 congressional budget justification, available at http://www.hhs.gov/about/hhsbudget.html. Additional sources are noted below.

Notes: Individual amounts may not add to subtotals or totals due to rounding. The amounts for FY2011 reflect the 0.2% across-the-board rescission in P.L. 112-10.

a. The Vaccines for Children (VFC) program provides free pediatric vaccines to doctors who serve eligible children. VFC is funded entirely as an entitlement through federal Medicaid appropriations. Amounts for FY2011 and FY2012 are estimates.

b. Funds for CDC's responsibilities under the Energy Employee Occupational Illness Compensation Program are mandatory. See CRS Report RL33927, *Selected Federal Compensation Programs for Physical Injury or Death*, coordinated by Sarah A. Lister and C. Stephen Redhead.

c. Beginning July 1, 2011 (i.e., for the final quarter of FY2011), the World Trade Center Program previously funded through discretionary appropriations is replaced by a mandatory program. See CRS Report R41292, *Comparison of the World Trade Center Medical Monitoring and Treatment Program and the World Trade Center*

Health Program Created by Title I of P.L. 111-347, the James Zadroga 9/11 Health and Compensation Act of 2010, by Scott Szymendera and Sarah A. Lister.

d. The FY2011 amount includes $69 million transferred from the Public Health and Social Services Emergency Fund (PHSSEF), a fund administered by the HHS Secretary. P.L. 111-32, the Supplemental Appropriations Act, 2009, provided $7.7 billion to the PHSSEF for the response to the H1N1 influenza pandemic. The FY2012 request proposed to use $30 million in unexpended funds from the PHSSEF for Strategic National Stockpile purchases.

e. Funds appropriated in PPACA Sec. 10323(b) for HHS to provide grants for health screenings for individuals who may have been exposed to asbestos near a mine in Libby, Montana. For this purpose, PPACA appropriated $23 million in total for the period of FY2010-FY2014, and $20 million for each five-fiscal year period thereafter. Funds are available until expended.

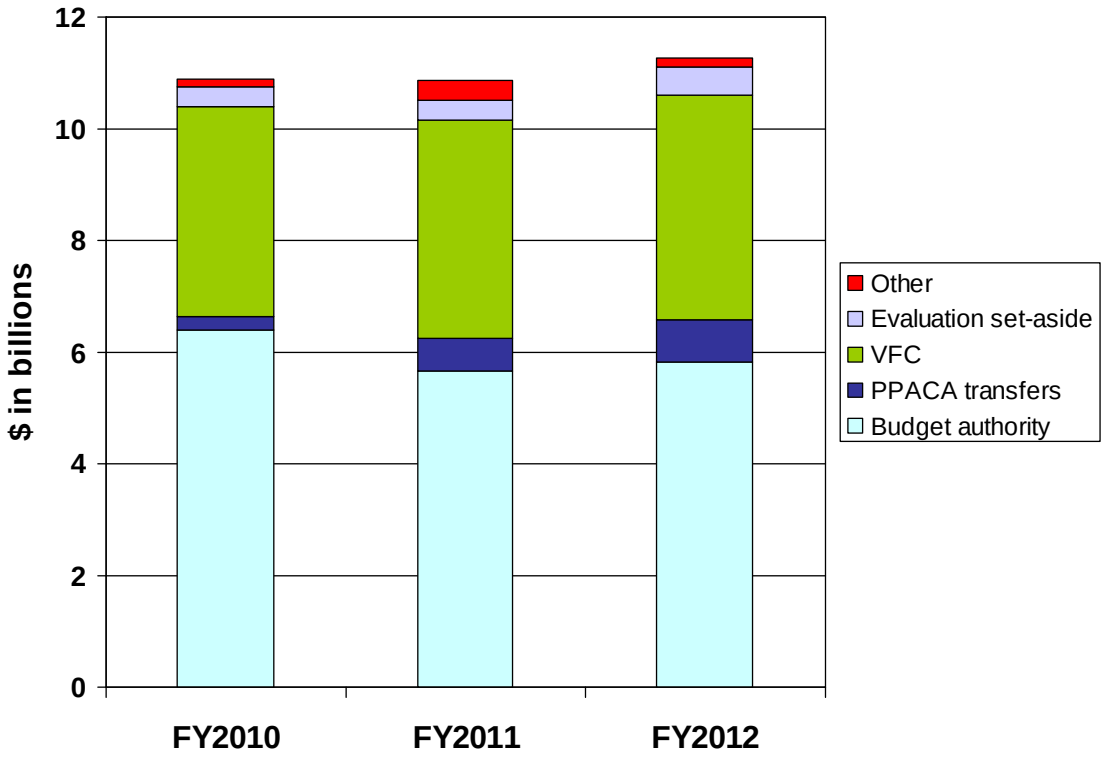
f. This amount includes $13 million for Immunization and Respiratory Diseases, $248 million for Public Health Scientific Services, and $92 million for NIOSH.

g. The request proposed $13 million for Immunization and Respiratory Diseases, $218 million for Public Health Scientific Services, and $260 million for NIOSH. FY2012 congressional budget justification for CDC, All Purpose Table, p. 29, http://www.cdc.gov/fmo/topic/Budget%20Information/index.html.

FY2011 Funding

The FY2011 full-year CR provided $5.649 billion in discretionary budget authority for CDC, $740 million (12%) less than the FY2010 amount. However, the CDC/ATSDR program level for FY2011 decreased by only $6 million (less than 1%) from the FY2010 amount. Increases in several mandatory funds and transfers largely offset the decrease in budget authority. Notably, CDC received $611 million in transfers from the PPHF for FY2011, $419 million more than for FY2010. Annual growth in transfers for the Vaccine for Children (VFC) program, as well as a $225 million transfer from the Public Health and Social Services Emergency Fund, also contributed to minimizing the decrease in the FY2011 program level. These components of the CDC budget are displayed in **Figure 1**.

Figure 1. Components of the CDC Budget, FY2010–FY2012



Sources: Adapted by CRS from the Department of Health and Human Services, FY2012 Budget in Brief, available at http://www.hhs.gov/about/hhsbudget.html; and CDC's FY2012 congressional budget justification, available at http://www.cdc.gov/fmo/topic/Budget%20Information/index.html. Additional sources as per **Table 2**.

Notes: "Other" includes ATSDR, EEOICPA, and user fees. In addition, the amount for FY2011 includes a transfer from the Public Health and Social Services Emergency Fund, and the amount for FY2012 includes a requested transfer of supplemental appropriations from P.L. 111-32.

A number of CDC programs that received funding for FY2010 were not funded for FY2011. Many of these are earmarks that were eliminated pursuant to the FY2011 full-year CR (P.L. 112-10). In addition, CDC did not request funding for buildings and facilities for FY2011, saying that it had sufficient carryover funds from FY2010 to meet its needs for the current fiscal year.[29] CDC did request buildings and facilities funds for FY2012. Finally, the Communities Putting Prevention to Work program, originally funded through the FY2009 stimulus package, was slated for elimination in the agency's FY2012 request.[30] CDC plans to use $145 million in FY2011 funds from the PPHF for Community Transformation Grants (CTG), authorized in PPACA Section 4201, which support objectives similar to those of the Communities Putting Prevention to

[29] CDC, "Justification of Estimates for Appropriations Committees, FY2011," p. 14, http://www.cdc.gov/fmo/topic/Budget%20Information/index.html.

[30] CRS Report R40181, *Selected Health Funding in the American Recovery and Reinvestment Act of 2009*, coordinated by C. Stephen Redhead. See also CDC, "Justification of Estimates for Appropriations Committees, FY2012," p. 40, http://www.cdc.gov/fmo/topic/Budget%20Information/index.html.

Work program.[31] CTG awards competitive grants to state, local and tribal governments and non-profit entities to implement evidence-based community preventive health activities.[32]

FY2012 Budget Highlights

The Administration requested $5.818 billion in CDC budget authority through Labor-HHS-ED appropriations, and $76 million for ATSDR through Interior/Environment appropriations. In addition, the Administration requested $490 million in PHS evaluation set-aside funds, and proposes to transfer $753 million in FY2012 PPHF funds for various CDC activities.

The Administration proposed to eliminate the Preventive Health and Health Services block grant, saying that state health departments receive substantial CDC funding through other existing activities.[33] It also proposed to use $705 million of its requested chronic disease funds (including $158 million from the PPHF) to establish a new grant program, the Coordinated Chronic Disease Prevention and Health Promotion Grant Program (CCDPP), by combining the following existing programs: Nutrition, Physical Activity and Obesity; Health Promotion; Heart Disease and Stroke; Diabetes; Cancer Prevention and Control; Prevention Centers; Arthritis and Other Chronic Diseases; and non-HIV/AIDS School Health.[34] The CCDPP would address risk factors for the five chronic diseases (i.e., heart disease, cancer, stroke, diabetes, and arthritis) that have the most impact on death and disability. Tobacco programs would continue to be funded separately.

The Administration proposed using $221 million from the PPHF for Community Transformation Grants, discussed earlier.

The Administration did not request FY2012 budget authority for NIOSH, recommending instead that the full amount requested—$260 million, which is exclusive of the mandatory EEOICPA funds—be provided through evaluation set-aside funds.

Food and Drug Administration (FDA)

Agency Overview

FDA regulates the safety of foods; the safety and effectiveness of human drugs, biological products (e.g., vaccines), medical devices, and radiation-emitting products; and the manufacture, marketing, and distribution of tobacco products. The agency also regulates animal drugs and feeds.[35]

[31] FY2011 CDC operating plan, p. 2, http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html; and CDC, "Justification of Estimates for Appropriations Committees, FY2012," p. 134, http://www.cdc.gov/fmo/topic/Budget%20Information/index.html.

[32] HHS, "Affordable Care Act Funds to Help Create Healthier U.S. Communities," press release, June 16, 2011, http://www.hhs.gov/news.

[33] CDC, "Justification of Estimates for Appropriations Committees, FY2012," p. 128, http://www.cdc.gov/fmo/topic/Budget%20Information/index.html.

[34] Ibid, p. 135 ff. HIV/AIDS-related school health activities would be transferred to CDC's HIV/AIDS, Viral Hepatitis, STDs and Tuberculosis Prevention budget.

[35] See the FDA website at http://www.fda.gov.

Seven centers within FDA represent the broad program areas for which the agency has responsibility: the Center for Biologics Evaluation and Research (CBER), the Center for Devices and Radiological Health (CDRH), the Center for Drug Evaluation and Research (CDER), the Center for Food Safety and Applied Nutrition (CFSAN), the Center for Veterinary Medicine (CVM), the National Center for Toxicological Research (NCTR), and the Center for Tobacco Products (CTP). Other offices have agency-wide responsibilities.

The Federal Food, Drug, and Cosmetic Act (FFDCA) is the principal source of FDA's statutory authority.[36] FDA is also responsible for administering certain provisions in other laws, most notably the PHSA.[37] Although the FDA's authorizing committees in Congress are the committees with jurisdiction over public health issues—the Senate Committee on Health, Education, Labor, and Pensions, and the House Committee on Energy and Commerce—FDA's assignment within the appropriations committees reflects its origin as part of the Department of Agriculture. The appropriations subcommittees on Agriculture, Rural Development, FDA, and Related Agencies have jurisdiction over FDA's budget, even though the agency has been part of various federal health agencies (HHS and its predecessors) since 1940.

FDA's budget has two funding streams: direct appropriations (i.e., discretionary budget authority) and industry user fees.[38] In FDA's annual appropriation, Congress sets both the total amount of appropriated funds and the level of user fees to be collected that year. Appropriated funds are largely for salaries and expenses, with a much smaller amount for buildings and facilities. User fees, which account for 33% of FDA's total FY2011 program level, come from several programs. Major user fee programs provide support for FDA's prescription drug, medical device, and animal drug regulatory activities, whereas smaller amounts come from mammography quality and standards, and export and color certification fees. The agency's tobacco regulatory activities are entirely supported through user fees paid by tobacco product manufacturers and importers.

Combining direct appropriations and user fees, FDA had a total FY2010 program level of $3.284 billion and a total FY2011program level of $3.690 billion. **Table 3** displays FDA funding levels for FY2010 through the FY2012 request.

[36] 21 U.S.C. §§ 301 et seq.

[37] PHSA Section 351 (21 U.S.C. § 262) authorizes the regulation of biological products and states that FFDCA requirements apply to biological products licensed under the PHSA. A listing of all the laws containing provisions for which FDA is responsible is available at http://www.fda.gov/RegulatoryInformation/Legislation/default.htm.

[38] For additional information on the FDA budget, see CRS Report R41288, *Food and Drug Administration FY2011 Budget and Appropriations*, by Susan Thaul; and CRS Report RL34334, *The Food and Drug Administration: Budget and Statutory History, FY1980-FY2007*, coordinated by Judith A. Johnson.

Table 3. Food and Drug Administration (FDA)

(Dollars in Millions)

Program Area	FY2010	FY2011	FY11/FY10 Change	FY2012 Request
Foods	783	836	53	1,035
User fees (non-add)	—	—	—	*(80)*
Human Drugs	877	956	79	1,152
User fees (non-add)	*(415)*	*(479)*	*(64)*	*(654)*
Biologics	304	325	21	368
User fees (non-add)	*(99)*	*(113)*	*(14)*	*(143)*
Animal Drugs and Feeds	155	161	7	176
User fees (non-add)	*(20)*	*(22)*	*(2)*	*(29)*
Devices and Radiological Health	367	378	11	395
User fees (non-add)	*(53)*	*(56)*	*(3)*	*(66)*
Toxicological Research (NCTR)	59	61	2	60
Tobacco Products	217	421	205	455
User fees (non-add)	*(217)*	*(421)*	*(205)*	*(455)*
Headquarters and Office of the Commissioner	196	213	16	289
User fees (non-add)	*(55)*	*(63)*	*(7)*	*(91)*
GSA Rent	176	183	7	214
User fees (non-add)	*(31)*	*(32)*	*(1)*	*(46)*
Other Rent and Rent-Related Activities (including White Oak consolidation)	126	136	10	192
User fees (non-add)	*(22)*	*(36)*	*(14)*	*(42)*
Export and Color Certification	10	10	0	10
User fees (non-add)	*(10)*	*(10)*	*(0)*	*(10)*
Buildings & Facilities (B&F)	12	10	-2	13
National Center for Natural Products Research	3	0	-3	0
Total, Program Level	**3,284**	**3,690**	**406**	**4,360**
Less Funds from User Fees	922	1,233	311	1,616[a]
Total, Budget Authority	**2,362**	**2,457**	**95**	**2,744**

Sources: Funding amounts for FY2010 and FY2011 are taken from the FDA FY2011 Operating Plan, available at http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html. The amounts for FY2012 are taken from the FDA FY2012 congressional budget justification, available at http://www.hhs.gov/about/hhsbudget.html.

Notes: Individual amounts may not add to totals due to rounding. The amounts for FY2011 reflect the 0.2% across-the-board rescission in P.L. 112-10.

a. The President's FY2012 request includes $1.557 billion in user fees from currently authorized programs plus $60 million in proposed user fees that would require authorizing legislation to implement.

FY2011 Funding

The FY2011 full-year CR provides FDA with a total program level of $3.690 billion, which includes $2.457 billion in direct appropriations (discretionary budget authority) and $1.233 billion in user fees. Relative to FY2010 funding, these amounts represent a 4% increase in budget authority and a 34% increase in user fees, for an overall 12% increase in total program level.

FY2012 Budget Highlights

President's Request

The President requested a total program level of $4.360 billion for FDA. This is 33% more than FY2010, and 18% more than FY2011. The FY2012 request has two components: $2.744 billion in budget authority and $1.616 in user fees. The budget authority is 16% more than FY2010 and 12% more than FY2011. The requested user fees are 75% more than FY2010 and 31% more than FY2011. The requested user fee total for FY2012 includes $1.457 billion for ongoing user fee programs (prescription drugs, medical devices, animal drugs, animal generic drugs, tobacco, mammography screening, and drug export and certification); $99 million for new fee categories authorized in the Food Safety Modernization Act (food export certification, voluntary qualified importer program, food reinspection, and recall);[39] and $60 million for proposed, as yet unauthorized, fees (generic drugs, medical products reinspection, and international couriers).

FDA's FY2012 budget requested an increase in funding in the following four key areas: (1) an additional $218 million for the Transforming Food Safety and Nutrition Initiative to implement the Food Safety Modernization Act; (2) an additional $70 million for the Advancing Medical Countermeasures Initiative to develop products to respond to terrorist threats and naturally emerging diseases; (3) an additional $56 million for the Protecting Patients Initiative to work on developing a biosimilar approval pathway, improving the foreign and domestic supply chain of medical products, and other safety activities; and (4) an additional $49 million for the FDA Regulatory Science and Facilities Initiative both to strengthen its core regulatory scientific capacities to foster review of new and emergency technologies, and to ready the CBER-CDER Life Sciences-Biodefense Laboratory complex for FY2014 occupancy.[40]

House-passed Bill (H.R. 2112)

On June 16, 2011, the House passed H.R. 2112, the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2012. For FY2012, the bill would provide FDA with a total program level of $3.693 billion, comprised of $2.172 billion (59%) in direct appropriations (discretionary budget authority) and $1.520 billion (41%) in user fees. The budget authority would be 12% below FY2011 and 21% below the President's FY2012 request. User fees would be 23% above FY2011 and 6% below the President's request. Overall, the total program level would be a fraction (less than 0.1%) above FY2011 and 15% below the President's FY2012 request.

[39] P.L. 111-353, 124 Stat. 3885.

[40] FDA, "Justification of Estimates for Appropriations Committees, FY2012," pp. 4-5, http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Reports/BudgetReports/UCM243370.pdf.

Health Resources and Services Administration (HRSA)

Agency Overview

HRSA is the federal agency charged with increasing access to health care for those who are uninsured, underserved, vulnerable, or have special needs. The agency currently funds more than 3,000 grantees, including community-based organizations, colleges and universities, hospitals, state, local and tribal governments, and private entities to support health services projects. In addition, HRSA administers the health centers program, which provides grants to non-profit entities that provide primary care services to people who experience financial, geographic, cultural, or other barriers to health care. More information on HRSA's organization and functions is provided in the text box below.[41]

HRSA Bureaus

HRSA is headquartered in Rockville, MD, and is organized into six bureaus and nine offices. HRSA's nine offices perform a variety of support to HRSA programs. Some focus on specific populations or healthcare issues, while others provide technical assistance to HRSA's ten regional offices. Bureaus provide the following functions:

The **Bureau of Primary Health Care** administers the Health Centers program, providing access to primary care for individuals who are low-income, uninsured, or living where health care is scarce.

The **Bureau of Clinician Recruitment and Service** administers programs to attract and retain clinicians from diverse backgrounds to provide services in underserved communities and areas experiencing critical shortages of health care providers.

The **Bureau of Health Professions** provides grants for health professions training and development of diversity and cultural competence in the health workforce.

The **Maternal and Child Health Bureau** administers the Maternal and Child Health Block Grant and other programs that support the infrastructure for maternal and child health services.

The **HIV/AIDS Bureau** administers the Ryan White HIV/AIDS program, which is the largest discretionary grant program within HRSA and focused on HIV/AIDS care.

The **Healthcare Systems Bureau** provides national leadership and direction in targeted areas, such as organ and bone marrow transplantation, and poison control, among others.

The majority of HRSA's programs are authorized in the PHSA. Title III authorizes the Health Centers Program, National Health Service Corps, Children's Hospitals Graduate Medical Education Program, Organ Transplant and Bone Marrow Programs, Telehealth Program, and State Offices of Rural Health; Title VII authorizes programs for health workforce development; Title VIII authorizes programs for nursing workforce development; and Title XXVI consolidates all Ryan White HIV/AIDS programs. Several of the agency's programs are authorized under the Social Security Act, including the Maternal and Child Health Block Grant; the Maternal, Infant, and Early Childhood Home Visiting Program; and the Rural Health Policy Development

[41] See also HRSA's website at http://www.hrsa.gov.

programs. Finally, Section 427(e) of the Federal Mine Safety and Health Amendments Act (P.L. 95-164) authorizes the Black Lung Program, which supports clinics that provide services to retired coal miners and others.

Table 4 shows funding levels for HRSA's programs and activities for FY2010 through the FY2012 request, including transfers from the CHCF and the PPHF. The table also includes programs that received direct appropriations from PPACA.[42] Program level funding for the agency's major program areas is shown.

Table 4. Health Resources and Services Administration (HRSA)

(Dollars in Millions)

Program or Activity	FY2010	FY2011	FY11/FY10 Change[a]	FY2012 Request
Primary Care				
Health Centers	2,141	2,481	340	3,222
CHCF transfer (non-add)	—	*(1,000)*	*(1,000)*	*(1,200)*
Health Center Tort Claims	44	100	56	96
School-Based Health Centers (PPACA Sec.4101(a))[b]	50	50	0	50
Health Center Construction (PPACA Sec. 10503(c))	—	1,500	1,500	—
Other Primary Care[c]	18	18	0	18
Subtotal, Primary Care	***2,253***	***4,149***	***1,896***	***3,386***
Health Workforce[d]				
National Health Service Corps	141	315	174	418
CHCF transfer (non-add)	—	*(290)*	*(290)*	*(295)*
Training for Diversity[e]	97	97	0	108
Primary Care Training and Enhancement	237	39	-198	140
PPHF transfer (non-add)	*(198)*	*(0)*	*(-198)*	*(0)*
GME Payments for Teaching Health Centers (PPACA Sec. 5508(c))[f]	—	230	230	—
Teaching Health Centers Development Grants	—	—	—	10
Interdisciplinary, Community-Based Linkages	72	72	0	97
State Health Workforce Development Grants	6	0	-6	51
PPHF transfer (non-add)	*(6)*	*(0)*	*(-6)*	*(0)*
Public Health Workforce Development	24	30	5	25
PPHF transfer (non-add)	*(15)*	*(20)*	*(5)*	*(15)*
Nursing Workforce Development[g]	290	242	-48	333
PPHF transfer (non-add)	*(47)*	*(0)*	*(-47)*	*(0)*

[42] Further discussion of the CHCF, the PPHF, and programs that received mandatory funding in PPACA can be found in CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*, by C. Stephen Redhead.

Program or Activity	FY2010	FY2011	FY11/FY10 Change[a]	FY2012 Request
Children's Hospital GME Payments	317	268	-48	0
Other Health Workforce Programs[h]	41	41	0	70
Subtotal, Health Workforce	***1,225***	***1,333***	***108***	***1,252***
Maternal and Child Health				
Maternal and Child Health Block Grant	661	656	-4	654
Healthy Start	105	104	0	105
Early Childhood Home Visiting (PPACA Sec. 2951)	100	250	150	350
Family to Family Health Information Centers (PPACA Sec. 5507)	5	5	0	5
Other Maternal and Child Health Programs[i]	113	113	-1	121
Subtotal, Maternal and Child Health	***984***	***1,128***	***144***	***1,235***
Health Care Systems				
Medical School Development (PPACA Sec. 10503)	100	—	-100	N/A
State Health Access Grants	74	0	-74	0
Other Health Care Systems Programs[j]	93	87	-6	106
Subtotal, Health Care Systems	***267***	***87***	***-181***	***106***
Subtotal, HIV/AIDS	***2,315***	***2,337***	***21***	***2,401***
Subtotal, Rural Health	***185***	***138***	***-47***	***124***
Other Activities				
Congressional Projects	337	0	-337	0
Family Planning	317	299	-17	327
Healthy Weight Collaborative (PPHF transfer)	5	0	-5	5
Other Activities[k]	177	194	18	206
Subtotal, Other Activities	***836***	***493***	***-342***	***538***
Total, Program Level	**8,067**	**9,665**	**1,598**	**9,041**
Less Funds From Other Sources				
PHS Evaluation Set-Aside Funds	25	25	0	280
User Fees	24	24	0	33
PPHF Transfers	271	20	-251	20
CHCF Transfers	0	1,290	1,290	1,495
Other PPACA Funds	255	2,035	1,780	405
Total, Budget Authority	**7,492**	**6,272**	**-1,221**	**6,808**

Sources: Funding amounts for FY2010 and FY2011 are taken from the HRSA FY2011 Operating Plan, available at http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html. The amounts for FY2012 are taken from the HRSA FY2012 congressional budget justification, available at http://www.hhs.gov/about/hhsbudget.html.

Notes: Individual amounts may not add to subtotals or totals due to rounding. The amounts for FY2011 reflect the 0.2% across-the-board rescission in P.L. 112-10.

a. A zero in the FY2011/FY2010 change column indicates that the funding change, if any, is less than $500,000.

b. H.R. 1214, which passed the House on May 4, 2011, would repeal the PPACA appropriation for school-based health center construction and rescind all unobligated funds.

c. Other Primary Care programs are: Free Clinics Medical Malpractice, Hansen's Disease Programs, and Payments to Hawaii.

d. Health Workforce includes programs administered both by the Bureau of Health Professions and by the Bureau of Clinician Recruitment and Service. It does not include the Home Health Aide Demonstration, which was authorized and funded under PPACA Sec. 5507(a). The demonstration received an annual appropriation of $5 million for each of FY2010 through FY2012. Although this program is administered by HRSA, it is funded as part of the Administration for Children and Families Social Services Block Grant. The HHS 2012 Budget in Brief includes this program as part of HRSA, but it was not included in the FY2011 HRSA Operating Plan because it is not HRSA funded.

e. Training for Diversity includes the following programs: Loan Repayment/Faculty Fellowships, Centers of Excellence, Scholarships for Disadvantaged Students, and the Health Careers Opportunity Program.

f. H.R. 1216, which passed the House on May 26, 2011, would replace the mandatory appropriation in PPACA for this new program with an authorization of appropriations for each of FY2012 through FY2015, and rescind all unobligated funds.

g. Nursing Workforce Development includes the following programs: Nurse Loan Repayment and Scholarship Program; Advanced Education Nursing; Nursing Workforce Diversity; Nurse Education, Practice, and Retention; Nurse Faculty Loan Program; Comprehensive Geriatric Education; and Nurse Managed Health Centers.

h. Other Health Workforce programs are: Health Workforce Assessment, Oral Health Workforce, and Patient Navigator.

i. Other Maternal and Child Health programs are: Heritable Disorders, Congenital Disabilities, Autism and Other Developmental Disorders, Traumatic Brain Injury, Sickle Cell Service Demonstrations, Universal Newborn Screening, and Emergency Medical Services for Children.

j. Other Health Care Systems programs are: Organ Transplantation, Cord Blood Stem Cell Bank, C.W. Bill Young Cell Transplantation Program, Poison Control Centers, and 340B Drug Pricing Program.

k. Other Activities are: Program Management, Vaccine Injury Compensation Program, Health Education Assistance Loan Direct Operations, and National Practitioner Data Bank.

FY2011 Funding

The FY2011 full-year CR provided HRSA with a total discretionary budget authority of $6.272 billion, a decrease of $1.221 billion (16%) from FY2010. However, this reduction was more than offset by a substantial increase in PPACA funds. Total funding from PPACA and other sources (i.e., user fees, set-aside funds) increased from $575 million in FY2010 to $3.394 billion in FY2011. As a result, HRSA's total program level increased by $1.598 billion (20%), from $8.067 billion in FY2010 to $9.665 billion in FY2011 (see **Table 4**).

Discretionary funding for the heath centers program was reduced by $660 million in FY2011. However, the program received a $1 billion transfer from the CHCF, resulting in an overall funding increase of $340 million over FY2010. Similarly, discretionary funding for the NHSC was reduced by $117 million, but the program received a CHCF transfer of $290 million, resulting in a net increase of $174 million over the FY2010 program level.

Aside from the NHSC, funding for most of the other health workforce program areas either remained flat or decreased significantly. The Children's Hospital Graduate Medical Education (GME) program had its appropriation reduced by $48 million, while both the Primary Care Training and Enhancement and the Nursing Workforce Development programs saw their

supplemental FY2010 PPHF funding eliminated in FY2011. However, GME Payments for Teaching Health Centers, a new program authorized under PPACA, received a $230 million mandatory appropriation for FY2011.

Maternal and Child Health programs increased by $144 million overall, due almost entirely to the increase in mandatory funding for the new Maternal, Infant, and Early Childhood Home Visiting Program, which was authorized under PPACA. The Congenital Disabilities program, which received $0.5 million in FY2010, received no funding for FY2011.

The $47 million reduction in funding for rural health programs is largely attributable to a ban on earmark spending, which eliminated $45 million in funding for the Denali Project and the Delta Health Initiative. In addition, funding for Rural and Community Access to Emergency Devices (i.e., defibrillators) was reduced by $2 million, or 91%. Funding was not provided for the State Health Access Program (SHAP), as it is anticipated that programs authorized under PPACA will be sufficient to cover the populations formerly served by SHAP.

A total of $2.337 billion will be spent on the Ryan White HIV/AIDS program in FY2011, which represents a $21 million (1%) increase over FY2010. The HRSA operating plan includes a total of $885 million for the AIDS Drug Assistance Program (ADAP), which represents a $25 million (3%) increase in funding over FY2010.

Finally, as part of the ban on earmarks, funding is eliminated for Congressional Projects (i.e., congressionally directed spending on specified health facilities, including for construction and renovation).

FY2012 Budget Highlights

The President's FY2012 budget request would provide budget authority of $6.808 billion for HRSA, which represents a decrease of $684 million (9%) from FY2010 and an increase of $537 (9%) million over FY2011 funding. The Administration proposes to eliminate funding for a number of HRSA programs.[43] Several of these cuts are consistent with the final FY2011 budget. They include funding for Congressional Projects, the Denali Commission, and the Delta Health Initiative. The President's budget also would eliminate funding for certain rural health projects,[44] and for the Children's Hospital GME program.[45]

The President's budget requests $1.252 billion for health workforce programs. The budget seeks to expand the primary care workforce capacity, team-based health care services, and geriatric

[43] Terminated programs are discussed in Office of Management and Budget, *Fiscal Year 2012 Terminations, Reductions, and Savings, Budget of the U.S. Government*, Washington, DC, February 2011. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf.

[44] Including funding for rural access to emergency devices (defibrillators), rural hospitals, and for rural utility, sanitation, and other infrastructure projects.

[45] The Children's Hospital GME program provides funding to children's hospitals to support medical residency training in general pediatric medicine and pediatric specialties. The authorization of appropriations for the program expires at the end of FY2011. Both the House and the Senate are considering legislation (H.R. 1852, S. 958) that would reauthorize funding for the program through FY2016.

education. It would increase funding for certain other health workforce programs and would fund grants to develop Teaching Health Centers and provide GME payments for these centers.[46]

The FY2012 budget request proposes a $107 million increase in funding for Maternal and Child Health programs over the FY2011 level, which largely reflects a further increase in PPACA funding for the Maternal, Infant, and Early Childhood Home Visiting Program.

The FY2012 request would provide a total of $2.401 billion for the Ryan White HIV/AIDS program, an increase of $65 million over FY2011, including an additional $80 million for ADAP, bringing its total to $940 million, and an additional $5 million for Early Intervention programs.[47]

Indian Health Service (IHS)

Agency Overview

IHS provides health care for approximately 1.9 million eligible American Indians/Alaska Natives through a system of programs and facilities located on or near Indian reservations, and through contractors in certain urban areas.[48] IHS provides services in 35 states either directly or through facilities and programs operated by Indian tribes or tribal organizations through self-determination contracts and self-governance compacts negotiated with IHS.[49]

The Snyder Act of 1921[50] provides general statutory authority for IHS.[51] In addition, specific IHS programs are authorized by two acts: the Indian Sanitation Facilities Act of 1959[52] and the Indian Health Care Improvement Act (IHCIA).[53] The Indian Sanitation Facilities Act authorizes the PHS to construct sanitation facilities for Indian communities and homes, and IHCIA authorizes programs such as urban health, health professions recruitment, and substance abuse and mental health treatment, and permits IHS to receive reimbursements from the Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP), and from third-party insurers.

[46] For a description, see Section 5508 in CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in PPACA: Summary and Timeline*, coordinated by C. Stephen Redhead and Erin D. Williams.

[47] For more information about the Ryan White program, see CRS Report RL33279, *The Ryan White HIV/AIDS Program*, by Judith A. Johnson.

[48] U.S. Department of Health and Human Services, Indian Health Service, IHS Fact Sheet: IHS Year 2010 Profile, http://info.ihs.gov/Profile2010.asp. For more information on IHS programs, see CRS Report R40181, *Selected Health Funding in the American Recovery and Reinvestment Act of 2009*, coordinated by C. Stephen Redhead; and CRS Report RL33022, *Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues*, by Roger Walke.

[49] Authorized by P.L. 93-638, the Indian Self-Determination and Education Assistance Act of January 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. 450 §§ et seq.

[50] P.L. 67-85, as amended; 25 U.S.C. § 13.

[51] The Snyder Act established this authority as part of the Bureau of Indian Affairs within the Department of the Interior. The Transfer Act of 1954 (P.L. 83-568) transferred this authority to the U.S. Surgeon General.

[52] P.L. 86-121, 73 Stat. 267; 42 U.S.C. § 2004a.

[53] P.L. 94-437, 90 Stat. 1400, as amended; 25 U.S.C. §§ 1601 et seq.; and 42 U.S.C. §§ 1395qq and 1396j (and amending other sections). This act was reauthorized as part of PPACA. Changes made by the reauthorization are summarized in CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by PPACA: Detailed Summary and Timeline*, by Elayne J. Heisler.

Unlike most other PHS agencies, the IHS receives its appropriations through the Interior/ Environment appropriations act, not the Labor-HHS-ED appropriations act.

Table 5 shows IHS funding for FY2010 through the FY2012 request. The table includes funding under IHS's discretionary budget authority, as well as mandatory appropriations from the Special Diabetes Program for Indians[54] and funding that IHS receives from renting staff quarters and from collections from Medicare, Medicaid, CHIP, and other third-party insurers for services provided at IHS-funded facilities.

Table 5. Indian Health Service (IHS)

(Dollars in Millions)

Program or Activity	FY2010	FY2011	FY11/FY10 Change[a]	FY2012 Request
Clinical Services	3,845[b]	3,870[c]	25	4,284
Contract Health Services (non-add)[d]	*(779)*	*(780)*	*(1)*	*(949)*
Catastrophic Health Emergency Fund (non-add)[e]	*(48)*	*(48)*	*(0)*	*(58)*
Preventive Health	144	144	0	157
Special Diabetes Program for Indians[f]	150	150	0	150
Subtotal, Clinical and Preventive Services	***4,139***	***4,164***	***25***	***4,591***
Urban Health Projects	43	43	0	47
Indian Health Professions	41	41	0	42
Tribal Management/Self-Governance	9	9	0	9
Direct Operations	69	69	0	74
Contract Support Costs	398	398	-1	462
Subtotal, Other Health Services	***560***	***559***	***-1***	***633***
Maintenance and Improvement	60[g]	60[g]	0	65
Sanitation Facilities Construction	96	96	0	80
Health Care Facilities Construction	29	39	10	85
Facilities/Environmental Health Support	193	193	0	211
Medical Equipment	23	23	0	25
Subtotal, Health Facilities	***401***	***410***	***9***	***465***
Total, Program Level	**5,100**	**5,134**	**34**	**5,689**
Less Funds from Other Sources				
Collections	891	908	17	908
Rental of Staff Quarters	6	6	0	8
Special Diabetes Program for Indians[f]	150	150	0	150
Total, Budget Authority[h]	**4,052**	**4,069**	**17**	**4,624**

[54] P.L. 110-275, Section 303, 122 Stat. 2594; and P.L. 111-309, Section 112, 124 Stat. 3289.

Sources: Funding amounts for FY2010 and FY2011 are taken from the IHS FY2011 Operating Plan, available at http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html. The amounts for FY2012 are taken from the IHS FY2012 congressional budget justification, available at http://www.hhs.gov/about/hhsbudget.html.

Notes: Individual amounts may not add to subtotals or totals due to rounding. The amounts for FY2011 reflect the 0.2% across-the-board rescission in P.L. 112-10.

a. A zero in the FY2011/FY2010 change column indicates that the funding change, if any, is less than $500,000.

b. Includes $891 million received in collections from Medicare, Medicaid, CHIP, private insurance, and other programs.

c. Includes $908 million received in collections from Medicare, Medicaid, CHIP, private insurance, and other programs.

d. The Interior/Environment appropriations act refers to this program as "Contract Care."

e. This fund is authorized in Section 202 of the Indian Health Care Improvement Act.

f. These are appropriated funds made available to IHS for the Special Diabetes Program for Indians authorized by PHSA Section 330C.

g. Includes $6 million received from rental of staff quarters.

h. Note that neither collections nor rental of staff quarters are included as part of IHS's discretionary budget authority because under the IHCIA both are supposed to be in addition to annual appropriations.

FY2011 Funding

For FY2011 IHS received an appropriation of $4.069 billion, an increase of $17 million (0.4%) from FY2010. This increase will provide additional funding for hospitals and health clinic services and construction. In general, FY2011 funding for the majority of IHS programs remained constant or was reduced a small amount as required by the 0.2% across-the-board rescission included in P.L. 112-10. IHS also projects that it will receive $17 million more in collections than the agency received in FY2010, a 2% increase. Overall, therefore, the IHS program level will be $34 million (0.7%) higher than FY2010.

FY2012 Budget Highlights

The President's FY2012 budget proposes to increase IHS's discretionary budget authority by 12% from the FY2010 level. PPACA requires the FY2012 budget request to include amounts that reflect changes in the costs of health care and in the size of IHS's service population. HHS notes that the increased funding for IHS reflects those requirements.[55] In general, the President's FY2012 budget requests additional funding for IHS's programs. One notable exception is sanitation facility construction, which would receive $16 million (17%) less than in FY2010. HHS notes that this program has funding carried over from the prior fiscal year, which would allow IHS to maintain current activities with the funding level included in the budget request.[56]

[55] See Section 195 in CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by PPACA: Detailed Summary and Timeline*, by Elayne J. Heisler.

[56] HHS FY2012 Budget in Brief, at http://www.hhs.gov/about/hhsbudget.html.

National Institutes of Health (NIH)

Agency Overview

NIH is the primary agency of the federal government charged with the conduct and support of biomedical and behavioral research. It also has major roles in research training and health information dissemination. The NIH mission is "to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce the burdens of illness and disability."[57] NIH derives its statutory authority from the PHSA. Section 301 grants the Secretary of HHS broad permanent authority to conduct and sponsor research. In addition, Title IV, "National Research Institutes", authorizes in greater detail various activities, functions, and responsibilities of the NIH Director and the 27 institutes and centers (ICs). The annual Labor-HHS-ED appropriations act provides separate appropriations to 24 of the ICs, the Office of the Director (OD), and the Buildings and Facilities (B&F) account. NIH receives additional funds from the Interior/Environment appropriations act and from a mandatory appropriation for diabetes research.[58]

Table 6 shows funding for NIH for FY2010 through the FY2012 request.

Table 6. National Institutes of Health (NIH)

(Dollars in Millions)

Institutes and Centers (ICs)	FY2010[a]	FY2011[b]	FY11/FY10 Change[c]	FY2012 Request[d]
Cancer (NCI)	5,098	5,059	-40	5,196
Heart/Lung/Blood (NHLBI)	3,094	3,070	-24	3,148
Dental/Craniofacial Research (NIDCR)	413	410	-3	420
Diabetes/Digestive/Kidney (NIDDK)	1,959	1,942	-17	1,988
Neurological Disorders/Stroke (NINDS)	1,634	1,622	-12	1,664
Allergy/Infectious Diseases (NIAID)[e]	4,815	4,776	-39	4,916
General Medical Sciences (NIGMS)	2,048	2,034	-14	2,102
Child Health/Human Development (NICHD)	1,327	1,318	-10	1,352
Eye (NEI)	706	701	-5	719
Environmental Health Sciences (NIEHS), L-HHS appropriation	695	684	-11	701
NIEHS, Interior/Environment appropriation[f]	79	79	0	81
Aging (NIA)	1,108	1,100	-8	1,130
Arthritis/Musculoskeletal/Skin (NIAMS)	538	534	-4	548
Deafness/Communication Disorders (NIDCD)	418	415	-3	426

[57] National Institutes of Health, About the National Institutes of Health, at http://www.nih.gov/about/mission.htm.

[58] For more information on NIH, see CRS Report R41705, *The National Institutes of Health (NIH): Organization, Funding, and Congressional Issues*, by Judith A. Johnson and Pamela W. Smith.

Institutes and Centers (ICs)	FY2010[a]	FY2011[b]	FY11/FY10 Change[c]	FY2012 Request[d]
Mental Health (NIMH)	1,494	1,477	-16	1,517
Drug Abuse (NIDA)	1,067	1,051	-16	1,080
Alcohol Abuse/Alcoholism (NIAAA)	462	458	-3	469
Nursing Research (NINR)	145	144	-1	148
Human Genome Research (NHGRI)	524	511	-13	525
Biomedical Imaging/Bioengineering (NIBIB)	316	314	-2	322
Minority Health/Health Disparities (NIMHD)[g]	211	210	-1	215
Research Resources (NCRR)	1,267	1,258	-9	1,298
Complementary/Alternative Medicine (NCCAM)	129	128	-1	131
Fogarty International Center (FIC)	70	69	-1	71
National Library of Medicine (NLM)	349	345	-4	395
Office of Director (OD)	1,177	1,167	-10	1,298
Buildings & Facilities (B&F)	100	50	-50	126
Total, Program Level	**31,243**	**30,926**	**-317**	**31,987**
Less Funds From Other Sources				
PHS Evaluation Set-Aside Funds (NLM)	8	8	0	8
Type 1 Diabetes Research (NIDDK)[h]	150	150	0	150
Total, Budget Authority	**31,084**	**30,767**	**-317**	**31,829**

Sources: Funding amounts for FY2010 and FY2011 are taken from the NIH FY2011 Operating Plan, available at http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html. The amounts for FY2012 are taken from the NIH FY2012 congressional budget justification, available at http://www.hhs.gov/about/hhsbudget.html.

Notes: Individual amounts may not add to totals due to rounding. The amounts for FY2011 reflect the 0.2% across-the-board rescission in P.L. 112-10.

a. FY2010 level reflects real transfer of $1 million from HHS Office of the Secretary to NIMH, $4.6 million transfer to HRSA Ryan White program (Secretary's authority), and transfers among ICs for the Genes, Environment, and Health Initiative (NIH Director's authority).

b. FY2011 reflects real transfer of almost $1 million from HHS Office of the Secretary to NIMH for the Interagency Autism Coordinating Committee.

c. A zero in the FY2011/FY2010 change column indicates that the funding change, if any, is less than $500,000.

d. FY2010 and FY2011 are non-comparable with respect to FY2012 for various transfers among ICs and to NLM.

e. Includes funds for transfer to the Global Fund for HIV/AIDS, Tuberculosis, and Malaria ($300 million in FY2010, $297 million in FY2011, and $300 million in FY2012). BioShield transfer of $304 million provided in FY2010 was not provided under the FY2011 appropriation.

f. Separate account in the Interior/Environment appropriations act for NIEHS research activities related to Superfund.

g. PPACA Sec. 10334(c) redesignated the Center as an Institute.

h. Funds available to NIDDK for diabetes research under PHSA Sec. 330B (provided by P.L. 110-275 and P.L. 111-309). Funds have been appropriated through FY2013.

FY2011 Funding

Compared to the funding level originally enacted for FY2010, the FY2011 full-year CR (P.L. 112-10) reduced NIH funding by $50 million in the Buildings and Facilities account, by $210 million taken as a pro rata reduction in all other NIH accounts for ICs and the Office of the Director, and by the 0.2% across-the-board rescission. Overall, total NIH funding in FY2011, at $30.926 billion, is $317 million (1%) lower than FY2010. Most institutes and centers are down by about 1% compared with their FY2010 program levels; the B&F account is 50% lower.

FY2012 Budget Highlights

For FY2012, the Obama Administration has requested $31.987 billion for NIH, an increase of $745 million (2.4%) over the FY2010 program level and $1.062 billion (3.4%) over FY2011. In FY2012, the agency will focus on implementing a new translational medicine program. NIH is proposing to establish a new center, the National Center for Advancing Translational Sciences (NCATS), to catalyze the development of new diagnostics and therapeutics. NIH plans to abolish the existing National Center for Research Resources (NCRR) and transfer its programs to either NCATS or other ICs. Another component of NCATS will be the Therapeutics for Rare and Neglected Diseases (TRND) program.

NCATS may also incorporate the new Cures Acceleration Network (CAN), authorized under PPACA, for which $100 million is requested in FY2012. PPACA did not fund CAN and specified that other funds appropriated under the PHSA may not be allocated to CAN. The purpose of CAN is to support the development of high-need cures (i.e., drugs, biologics, and devices to diagnose or treat rare diseases, and for which market incentives are inadequate) and facilitate their FDA review. If CAN receives funding, NIH would determine which medical products are high-need cures, and then make awards to research entities or companies in order to accelerate the development of such high-need cures.

In addition to the new translational medicine program, NIH will emphasize three other broad scientific areas in FY2012 including advanced technologies, comparative effectiveness research, and support of young investigators.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Agency Overview

SAMHSA is the lead federal agency for increasing access to behavioral health services.[59] It supports community-based mental health and substance abuse treatment and prevention services through formula grants to the states and U.S. territories and through numerous competitive grant programs to states, territories, tribal organizations, local communities, and private entities. Under

[59] Unless otherwise noted, information in this section is summarized from CRS Report R41477, *Substance Abuse and Mental Health Services Administration (SAMHSA): Agency Overview and Reauthorization Issues*, by Bonnie L. Norton and C. Stephen Redhead.

SAMHSA' s charitable choice provisions, religious organizations are eligible to receive funding in order to provide substance abuse services without altering their religious character. The agency also collects information on the incidence and prevalence of mental illness and substance abuse at the national and state levels.

SAMHSA and most of its programs and activities are authorized under PHSA Title V. However, the agency's two largest programs, the Substance Abuse Prevention and Treatment (SAPT) block grant and the Community Mental Health Services (CMHS) block grant, which together accounted for more than 60% of the agency's budget in FY2010, are separately authorized under PHSA Title XIX Part B.

Under PHSA Title V, SAMHSA is organized into three centers: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT), and the Center for Substance Abuse Prevention (CSAP). Each center has general statutory authority, called Programs of Regional and National Significance (PRNS), under which it has established grant programs for states and communities to address their important substance abuse and mental health needs. PRNS authorizes each center to fund projects that (1) translate promising new research findings to community-based prevention and treatment services; (2) provide training and technical assistance; and (3) target resources to increase service capacity where it is most needed. In addition, PHSA Title V authorizes a number of specific grant programs, referred to as categorical grants. The PHSA also directs SAMHSA to conduct data collection and analysis activities related to mental health and substance abuse.

Most SAMHSA programs are administered by one of the three centers and focus on mental health, substance abuse prevention, or substance abuse treatment. Several cross-cutting programs receive support separately from all three centers, including the National Registry of Evidence-based Programs and Practices, the SAMHSA Health Information Network, the Minority AIDS Program, and the Minority Fellowship Program. To better address cross-cutting issues, SAMHSA has also created connections between centers for programs with both mental health and substance abuse components. For instance, the co-occurring state incentive grant, which supports improvements to infrastructure and capacity for treating individuals with both mental health and substance abuse conditions, is administered by both CMHS and CSAT.

SAMHSA and its programs were last reauthorized in 2000, as part of the Children's Health Act.[60] Funding authority for most of SAMHSA's grant programs expired at the end of FY2003, though many of them continue to receive annual appropriations. Congress has not taken up comprehensive reauthorization legislation since 2000, though it has added some new authorities to Title V and otherwise expanded the agency's programs and activities in the past decade.

Table 7 shows SAMHSA's funding for FY2010 and FY2011, the change between those years, and the FY2012 budget request. Several non-add programs have been included in the table as examples; these do not represent a complete list. While PHS evaluation set-aside funds are incorporated in the funding amounts for certain programs and activities, the PPHF transfers are included as their own separate row. Both the set-aside funds and the PPHF transfers are subtracted from the SAMHSA program level at the bottom of the table to give the agency's total discretionary budget authority. As discussed in more detail below, SAMHSA's FY2012 budget request proposes a restructuring of its programs and activities. To the extent possible, the table

[60] P.L. 106-310, Titles XXXI-XXXIV.

reflects the existing structure, consistent with FY2010 and FY2011 appropriations. The new SAMHSA-wide programs in the FY2012 request are listed separately with the FY2010 and FY2011 columns left blank (see discussion below under "FY2012 Budget Highlights").

Table 7. Substance Abuse and Mental Health Services Administration (SAMHSA)

(Dollars in Millions)

Program or Activity	FY2010	FY2011	FY11/FY10 Change[a]	FY2012 Request
Mental Health				
Mental Health PRNS[b]	361	350	-11	273
Youth Violence Prevention (non-add)	*(94)*	*(94)*	*(0)*	*(94)*
National Traumatic Stress Network (non-add)	*(41)*	*(41)*	*(0)*	*(11)*
MH System Transformation (non-add)	*(29)*	*(29)*	*(0)*	*(11)*
GLS Youth Suicide Prevention (non-add)	*(35)*	*(34)*	*(1)*	*(36)*
Project LAUNCH (non-add)	*(25)*	*(25)*	*(0)*	*(0)*
Children's Mental Health Services	121	118	-4	121
Protection & Advocacy	36	36	0	36
PATH Homeless Formula Grant	65	65	0	65
Mental Health Block Grant	421	420	-1	435
Subtotal, Mental Health	***1,005***	***989***	***-16***	***931***
Substance Abuse				
Substance Abuse Prevention PRNS[b]	202	196	-6	75
Strategic Prevention Framework (non-add)	*(112)*	*(110)*	*(-2)*	*(0)*
Substance Abuse Treatment PRNS[b]	452	442	-10	402
Access to Recovery (non-add)	*(99)*	*(99)*	*(0)*	*(98)*
Prescription Drug Monitoring (NASPER)	2	0	-2	2
Substance Abuse Block Grant	1,799	1,783	-16	1,494
Subtotal, Substance Abuse	***2,455***	***2,420***	***-35***	***1,973***
SAMHSA-Wide Programs (FY2012 Request)				
Substance Abuse: State Prevention Grant	—	—	—	395
Behavioral Health: Tribal Prevention Grant	—	—	—	—[c]
Mental Health: State Prevention Grant	—	—	—	90
Other Initiatives (Military Families, Health IT)	—	—	—	14
Performance, Quality, Public Awareness & Support	—	—	—	27
Subtotal, SAMHSA-Wide Programs	—	—	—	***526***
Health Surveillance and Program Support	102	102	0	128
PPHF Transfers[d]	20	88	68	93
St. Elizabeths Hospital	1	0	-1	0
Total, Program Level	**3,583**	**3,599**	**16**	**3,649**

Program or Activity	FY2010	FY2011	FY11/FY10 Change[a]	FY2012 Request
Less Funds From Other Sources				
PHS Evaluation Set-Aside Funds	132	132	0	170
PPHF Transfers	20	88	68	93
Total, Budget Authority	**3,431**	**3,380**	**-52**	**3,387**

Sources: Funding amounts for FY2010 and FY2011 are taken from the SAMHSA FY2011 Operating Plan, available at http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html. The amounts for FY2012 are taken from the SAMHSA FY2012 congressional budget justification, available at http://www.hhs.gov/about/hhsbudget.html.

Notes: Individual amounts may not add to subtotals or totals due to rounding. The amounts for FY2011 reflect the 0.2% across-the-board rescission in P.L. 112-10.

a. A zero in the FY2011/FY2010 change column indicates that the funding change, if any, is less than $500,000.

b. This budget line includes funding for competitive grant programs created under general authority for CMHS, CSAP, and CSAT (i.e., Programs of Regional and National Significance, or PRNS) and funding for categorical programs that each have their own specific PHSA authorization.

c. The FY2012 budget proposes funding a new tribal grant program for preventing substance abuse and suicide with $50 million of the $93 million in FY2012 PPHF funds that are intended for transfer to SAMHSA (see the following table note and also **Table B-1** in **Appendix B**).

d. The FY2010 PPHF funds were used to supplement funding for the Primary and Behavioral Health Care Integration (PBHCI) program. For FY2011, PPHF funds are being used to supplement funding for the PBHCI and GLS Youth Suicide Prevention programs, among others. The FY2012 PPHF funds include $50 million for a new tribal behavioral health prevention grant program (see **Table B-1** in **Appendix B**).

FY2011 Funding

The FY2011 full-year CR (P.L. 112-10) slightly reduced SAMHSA's funding below the FY2010 level. With the 0.2% across-the-board rescission, the agency's discretionary budget authority for FY2011 is $3.380 billion, which is $52 million (1.5%) less than the FY2010 amount. However, that reduction was more than offset by a $68 million increase in PPHF transfers. SAMHSA's total program level for FY2011 is $3.599 billion, which is $16 million (0.4%) above the FY2010 program level of $3.583 billion. P.L. 112-10 prohibited the funding of grants for prescription drug monitoring programs originally authorized under the National All Schedules Prescription Electronic Reporting Act of 2005 (NASPER).[61] In FY2010, $2 million was appropriated for the NASPER grants.

FY2012 Budget Highlights

The President's FY2012 budget request includes a total program level of $3.649 billion for SAMHSA, which represents an increase of $66 million (2%) over the FY2010 program level (see **Table 7**). The FY2012 program level includes budget authority of $3.387 billion, down about 1% from the FY2010 budget authority of $3.431 billion, plus $263 million in PHS evaluation set-aside funds and PPHF transfers. Importantly, the FY2012 budget reflects a restructuring of SAMHSA's programs in an effort to focus more resources on prevention of substance abuse and

[61] P.L. 109-60, 119 Stat. 1979.

mental illness, assist Indian tribes in addressing substance abuse and suicide, and support emerging issues such as primary/behavioral health care integration and health information technology.

To accomplish these goals SAMHSA's FY2012 budget request includes funding for three new prevention programs. First, it proposes a new substance abuse prevention state grant program focused on high-risk communities and youth, which will be funded using the SAPT block grant's 20% prevention set-aside. Second, it proposes expanding an existing discretionary mental health prevention program aimed at young children (Project LAUNCH) to create a new state grant program to support comprehensive mental health prevention strategies for children, youth and young adults. Finally, the FY2012 budget proposes a new grant program using PPHF funds to promote behavioral health in Indian tribes by reducing alcohol and substance abuse and preventing suicide.

Among other programmatic changes reflected in its FY2012 budget, SAMHSA has combined most of the existing PRNS grant programs in the three centers into a single account for Innovation and Emerging Issues; consolidated funding for three different data collection systems and the agency's evidence-based practice registry into one Performance and Quality Information Systems budget line; and grouped the seclusion and restraint program, the protection and advocacy and the prescription drug monitoring formula grant programs, and two other regulatory and oversight programs into a single budget line.

Appendix A. Community Health Center Fund

PPACA Section 10503 established a Community Health Center Fund (CHCF) to provide supplemental funding for health center operations and the National Health Service Corps (NHSC). The law provided annual appropriations to the CHCF totaling $11 billion over the five-year period FY2011 through FY2015.

PPACA also included a provision the intent of which is that in order for the CHCF funds to be used, regular appropriations for the health centers program and the NHSC must be maintained at least at the FY2008 funding level. P.L. 112-10 eliminated this requirement for FY2011, thus allowing CHCF funds to be used in FY2011 even though the regular appropriations for health centers and the NHSC for the current fiscal year have been cut well below the FY2008 level. **Table A-1** summarizes the amounts appropriated to the CHCF and the allocation of funds for each of the five fiscal years.

PPACA Section 10503 also included an appropriation of $1.5 billion, available for the period FY2011 through FY2015, for health center construction and renovation. These funds are separate from the CHCF and are not included in **Table A-1**.

Table A-1. Community Health Center Fund, FY2011-FY2015

(Dollars in Millions)

Program	FY2011	FY2012	FY2013	FY2014	FY2015
Health Center Program	1,000	1,200	1,500	2,200	3,600
National Health Service Corps	290	295	300	305	310
Total	**1,290**	**1,495**	**1,800**	**2,505**	**3,910**

Source: Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152).

Appendix B. Prevention and Public Health Fund

PPACA Section 4002 established a Prevention and Public Health Fund (PPHF), appropriated in perpetuity, to be used to support prevention, wellness, and other public health-related programs and activities authorized under the Public Health Service Act (PHSA). PPACA appropriates to the PPHF: $500 million for FY2010; $750 million for FY2011; $1 billion for FY2012; $1.25 billion for FY2013; $1.5 billion for FY2014; and $2 billion for FY2015 and each fiscal year thereafter. Transfers from the PPHF to specific HHS activities for FY2010 and FY2011 have been carried out by the HHS Secretary and are summarized, along with the Administration's proposed transfers for FY2012, in **Table B-1**. PPHF transfers to PHS agencies are also itemized in the funding tables presented earlier in this report. PPACA requires the Secretary, when using PPHF funds to augment existing programs and activities, to maintain at least the FY2008 funding level.

FY2011 appropriations for the PPHF became available on October 1, 2010, at the beginning of the fiscal year. FY2011 operating plans for the recipient agencies show how these funds have been and will continue to be used for this fiscal year. In some cases, PPHF funds appear to be used to replace funds from regular appropriations.[62]

Under current law, PPHF funds are appropriated in perpetuity. As a result, the FY2012 amounts in the table reflect not the Administration's request for the funds, but rather the Administration's intended allocation and use of the funds. Congress may by law (including an appropriations law) direct the Secretary to expend the funds in a manner other than what is proposed, or take any other actions with respect to these funds.

Table B-1. Prevention and Public Health Fund Transfers, FY2010-FY2012

(Dollars in Millions)

Agency	Activity	FY2010	FY2011	FY2012
AHRQ	Prevention/Care Management	6	12	0
AHRQ Subtotal		***6***	***12***	***0***
HRSA	Primary Care Training and Enhancement	198	0	0
HRSA	State Health Workforce Development Grants	6	0	0
HRSA	Public Health Workforce Development	15	20	15
HRSA	Nursing Workforce Development	47	0	0
HRSA	Healthy Weight Collaborative	5	0	5
HRSA Subtotal		***271***	***20***	***20***
CDC	Immunization and Respiratory Diseases	0	100	62
CDC	HIV/AIDS, Viral Hepatitis, STDs and Tuberculosis Prevention	30	0	30
CDC	Emerging and Zoonotic Infectious Diseases	20	52	60

[62] See, for example, CDC's Environmental and Health Outcome Tracking Network. The program received $33 million in regular appropriations for FY2010, and no funding in regular appropriations for FY2011. However, the program received $35 million from the Prevention and Public Health Fund for FY2011. FY2011 CDC operating plan, p. 3, http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html.

Agency	Activity	FY2010	FY2011	FY2012
CDC	Chronic Disease Prevention and Health Promotion	59	301	460
CDC	Environmental Health	0	35	9
CDC	Injury Prevention and Control	0	0	20
CDC	Public Health Scientific Services	32	72	70
CDC	Public Health Leadership and Support	50	41	41
CDC	Public Health Preparedness and Response	0	10	0
CDC Subtotal		***192***	***611***	***753***
SAMHSA	Primary and Behavioral Health Care Integration	20	35	20
SAMHSA	Garrett Lee Smith Youth Suicide Prevention	0	10	0
SAMHSA	Prevention Prepared Communities	0	0	23
SAMHSA	Health Surveillance	0	18	0
SAMHSA	Screening, Brief Intervention, and Referral to Treatment	0	25	0
SAMHSA	Behavioral Health: Tribal Prevention Grants	0	0	50
SAMHSA Subtotal		***20***	***88***	***93***
OS	Obesity Prevention and Fitness	10	9	13
OS	Tobacco	1	10	11
OS	Health Care Surveillance and Planning	1	0	1
OS	Teen Pregnancy Prevention	0	0	110
OS Subtotal		***12***	***19***	***135***
HHS Total		**500**	**750**	**1,000**

Sources: Funding amounts are taken from the FY2011 agency operating plans (AHRQ, HRSA, and CDC for FY2010 and FY2011), available at http://www.hhs.gov/asfr/ob/docbudget/2011operatingplan.html; the HHS FY2012 Budget in Brief (AHRQ, HRSA, and CDC for FY2012), available at http://www.hhs.gov/about/hhsbudget.html; and the FY2012 congressional budget justification (SAMHSA and HHS General Departmental Management for all years), available at http://www.hhs.gov/about/hhsbudget.html.

Note: Individual amounts may not add to subtotals or total due to rounding.

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