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

C. Stephen Redhead, Coordinator
Specialist in Health Policy

Pamela W. Smith, Coordinator
Analyst in Biomedical Policy

March 31, 2011

Congressional Research Service
7-5700
www.crs.gov
R41737

CRS Report for Congress
Prepared for Members and Committees of Congress

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 briefly reviews each agency's statutory authority and principal activities and examines its funding for FY2010, FY2011, and FY2012.

The PHS agencies are currently operating under an interim FY2011 continuing resolution. On February 19, 2011, the House passed H.R. 1, the Full-Year Continuing Appropriations Act, 2011, which would make a number of significant cuts to PHS agency funding. Each agency's total (i.e., program level) funding includes its budget authority (i.e., funding provided in the agency's annual appropriations act) plus additional funding from other sources such as user fees, PHS evaluation set-side funds, or amounts provided by the Patient Protection and Affordable Care Act.

AHRQ and NIH are primarily research agencies. AHRQ conducts and supports health services research to improve the quality of health care. It generally receives its entire budget of about $400 million from the PHS evaluation set-aside. H.R. 1 would cut AHRQ's budget by $25 million (6%). The FY2012 budget proposes a $13 million (3%) reduction. NIH conducts and supports basic, clinical, and translational biomedical and behavioral research. H.R. 1 would provide NIH with budget authority of $29.44 billion for FY2011, a reduction of more than $1.6 billion (5%) below the FY2010 level of $31.08 billion. The FY2012 budget requests $31.83 billion for NIH, an increase of $745 million (2.4%) over 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. H.R. 1 would provide $4.14 billion for IHS, an increase of $87 million (2%) over the FY2010 level. The FY2012 budget proposes to increase IHS's budget authority by 12% from the FY2010 level. HRSA funds programs and systems to improve access to health care among the uninsured and medically underserved. H.R. 1 would provide HRSA with FY2011 budget authority of $5.31 billion, which represents a $2.16 billion (29%) decrease compared to the FY2010 level. The FY2012 budget requests $6.81 billion, a cut of about $684 million (9%) from FY2010. SAMHSA funds mental health and substance abuse prevention and treatment services. H.R. 1 would provide SAMHSA with total FY2011 budget authority of $3.20 billion, down $229 million (7%) from the FY2010 level. The FY2012 budget requests $3.39 billion, a 1% reduction compared to FY2010.

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. H.R. 1 would provide CDC with $4.99 billion in budget authority for FY2011, which is about $1.4 billion (22%) below the FY2010 level. The FY2012 budget requests $5.82 billion, a 9% reduction from the FY2010 level. FDA, which regulates drugs, medical devices, food, and tobacco products, receives a significant portion of its funding from industry user fees. The FY2012 budget requests a program level of $4.36 billion for FDA, which is 33% above the FY2010 level of $3.29 billion and includes $1.62 billion in user fees. H.R. 1 would provide $3.31 billion for FY2011.

Contents

Tables

Appendixes

Contacts

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).[1] 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). The Agency for Toxic Substances and Disease Registry 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 primarily authorized under the Public Health Service Act (PHSA).[2] While some of FDA's regulatory activities are 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. 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 such as bioterrorism. While the agencies above have limited regulatory responsibilities, if any, the FDA's 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). ATSDR and IHS funds are provided through the Interior, Environment, and Related Agencies (Interior/Environment) appropriations act, and FDA receives 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 the agency's funding for FY2010, FY2011, and FY2012. The FY2010 amounts reflect the funding provided in their respective appropriations acts, with minor adjustments.[6] The FY2011 amounts represent the funding levels in the Continuing Appropriations Act, 2011, which was the first of several interim continuing resolutions (CRs) to provide funding for the federal government while Congress completes action on FY2011 appropriations. The initial FY2011 CR provided funding generally at FY2010 discretionary spending levels, with a few modifications.[7] The FY2012 amounts represent the funding levels requested in the President's FY2012 budget.[8] All the amounts presented in the agency funding tables are taken from the HHS FY2012 Budget in Brief.[9]

The funding tables show the agency's *budget authority* and *program level* for each fiscal year. Budget authority represents the funding provided in the annual Labor-HHS-ED (or other applicable) appropriations act.[10] Program level indicates the total amount of funding available to the agency, which includes the budget authority provided in appropriations plus additional funding from other sources such as user fees, PHS evaluation set-side funds, or amounts provided by the health reform law (see discussion below under "PPACA Funding").

[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] The Continuing Appropriations Act, 2011, which extended appropriations from October 1, 2010, through December 3, 2010, was signed into law on September 30, 2010 (P.L. 111-242, 124 Stat. 2607). Three subsequent interim CRs sequentially extended that funding through March 4, 2011 (P.L. 111-290, 124 Stat. 3063; P.L. 111-317, 124 Stat. 3454; and P.L. 111-322, 124 Stat. 3518), while maintaining funding generally at FY2010 discretionary spending levels. A fifth interim CR, which extended funding through March 18, 2011, reduced the total annualized non-emergency discretionary spending level provided in FY2010 by $4 billion (P.L. 112-4, 125 Stat. 6). A sixth interim CR, which extended funding through April 8, 2011, further reduced the total annualized non-emergency discretionary spending level by an additional $6 billion (P.L. 112-6). 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] Information on the President's FY2012 HHS budget is available at http://www.hhs.gov/about/hhsbudget.html.

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

[10] 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 awarding grants, that will result in immediate or future expenditures, or outlays, of federal government funds.

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.[11] 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%.[12] The FY2012 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.[13] The set-aside funds that an agency receives are not included in its 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

Beginning in FY2010, the appropriations mandated by the Patient Protection and Affordable Care Act (PPACA) provide an additional source of PHS agency funding.[14] Multiple PPACA provisions appropriate funds for FY2010, FY2011, and FY2012 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.

PPACA also established three multi-billion dollar trust funds, which are providing an additional source of funds to some of the PHS agencies. First, the Community Health Center Fund (CHCF) will provide a total of $11 billion over the five-year period FY2011 through FY2015 for HRSA's health centers program and the National Health Service Corps. Second, 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 trust funds. A portion of the PCORTF funding is allocated for AHRQ. Finally, the Prevention and Public Health Fund (PPHF), which is funded in perpetuity, is to support prevention, wellness, and other public health-related programs and activities authorized under the

[11] 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.

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

[13] 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 spring 2011, available at http://aspe.hhs.gov/rcc/sar.shtml.

[14] P.L. 111-148, 124 Stat. 119; as amended by P.L. 111-152, 124 Stat. 1029.

PHSA. 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. A table summarizing the allocation of PPHF funds for FY2010, FY2011, and FY2012 and additional information about the fund are provided in the **Appendix**.[15]

Current Action on FY2011 Appropriations

As noted in the introduction, Congress has yet to complete its work on FY2011 appropriations. The FY2011 amounts in the funding tables below reflect the initial CR, which provided *budget authority* generally at FY2010 levels, with a few modifications. Note, however, that the FY2011 *program levels* are higher than the FY2010 program levels because of additional user fees, PPACA appropriations and transfers, and other funds, as specified in the tables. On February 19, 2011, the House passed the Full-Year Continuing Appropriations Act, 2011 (H.R. 1), which would reduce the annualized FY2011 total discretionary spending level provided in the initial CR, as amended, by $61 billion in budget authority. The measure included several amendments that would prohibit the use of any funds appropriated in H.R. 1 to implement the provisions of PPACA. On March 9, 2011, the Senate rejected H.R. 1, and then rejected an amendment in the nature of a substitute (S.Amdt. 149) offered by Appropriations Committee Chairman Inouye, which would have made smaller spending cuts to discretionary spending than those included in H.R. 1. The Senate amendment would have reduced discretionary spending for FY2011 at a rate of $51 billion below the President's FY2011 request.[16]

Each agency's funding table is accompanied by a description of the changes (mostly reductions) to the agency's budget that were included in H.R. 1, as well as a brief comment on the changes in S.Amdt. 149. For five of the agencies—CDC, HRSA, IHS, NIH, and SAMHSA—a second table itemizing the H.R. 1 changes is included. Each section of the report concludes with an overview of the President's FY2012 budget request for the agency. This report will be updated and revised as legislative events warrant and as additional HHS budget data become available.

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, to increase the efficiency of its delivery, and to broaden access to the most essential health services. To accomplish these goals, it funds, conducts, and disseminates research aimed at reducing the costs of care, promoting patient safety, and increasing the effectiveness of health care services.[17]

[15] For more information on the appropriations and other funds in PPACA, see CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*, by C. Stephen Redhead.

[16] For more information on the FY2011 CRs, see CRS Report RL30343, *Continuing Resolutions: Latest Action and Brief Overview of Recent Practices*, by Sandy Streeter.

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

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.

Table 1 presents funding levels for AHRQ program areas for FY2010 through the FY2012 request. The AHRQ budget is organized according to program areas, including (1) Healthcare Costs, Quality and Outcomes (HQCO) Research; (2) the Medical Expenditure Panel Surveys; and (3) program support. HCQO research focuses on six priority areas, described in more detail 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 budget authority shows up as zero in the table. For FY2010-FY2012 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 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.

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

(dollars in millions)

Program or Activity	FY2010 Actual	FY2011 Initial CR	FY2012 Request
Health Costs, Quality and Outcomes (HCQO) Research			
Health Information Technology	28	28	28
General Patient Safety Research	91	91	65
Patient-Centered Health Research	21	29	46
PCORTF transfer (non-add)	*0*	*8*	*24*
Crosscutting Activities	112	112	92
Value	4	4	4
Prevention/Care Management	21	28	23

Program or Activity	FY2010 Actual	FY2011 Initial CR	FY2012 Request
PPHF transfer (non-add)	*6*	*12*	*0*
Subtotal, HCQO Research	***276***	***291***	***257***
Medical Expenditure Panel Surveys (MEPS)	59	59	59
Program Support	68	68	74
Total, Program Level	**403**	**417**	**390**
Less Funds From Other Sources			
PHS Evaluation Set-Aside Funds	-397	-397	-366
PCORTF Transfer	0	-8	-24
PPHF Transfer	-6	-12	0
Total, Budget Authority	**0**	**0**	**0**

Source: Adapted by CRS from the Department of Health and Human Services, FY2012 Budget in Brief, available at http://www.hhs.gov/about/hhsbudget.html.

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

House FY2011 Full-Year CR (H.R. 1)

H.R. 1 would reduce evaluation set-aside funding available for AHRQ by $25 million from $397 million, as provided in FY2010, to $372 million, a 6% reduction. It would also eliminate the $12 million PPHF transfer (see discussion below under "Centers for Disease Control and Prevention").

Senate Substitute Amendment (S.Amdt. 149 to H.R. 1)

The Senate amendment to H.R. 1 would have maintained AHRQ's funding at the FY2010 level.

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."[18] 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).[19]

Often CDC's activities are not specifically authorized but are based in broad, permanent authorities in the PHSA.[20] 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.[21] 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. As already mentioned, ATSDR was established in the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA, the "Superfund" law).[22]

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.

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 mentioned above, amounts for each year include three mandatory appropriations: (1) for the Vaccines for Children (VFC) program; (2) for activities to support the Energy Employee Occupational Illness Compensation Program (EEOICPA); and (3) appropriations provided under PPACA.[23] CDC also receives annual funds through the PHS evaluation set-aside and through authorized user fees, and may also receive funding through supplemental appropriations.

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

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

[20] For example, PHSA Section 301 authorizes the Secretary of HHS to conduct research and investigations as necessary to control disease; Section 307 authorizes the Secretary to cooperate with and provide assistance to foreign nations; and Section 317 authorizes the Secretary to award grants to states for preventive health programs.

[21] 29 U.S.C. § 671.

[22] 42 U.S.C. § 9604(i). Appropriations authorities for NCBDDD, NCHS, and ATSDR have expired, but the programs continue to receive annual appropriations.

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

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 Actual[a]	FY2011 Initial CR	FY2012 Request
Immunization and Respiratory Diseases	721	821	722
PPHF transfer (non-add)	*0*	*100*	*62*
Vaccines for Children (VFC)[b]	3,761	3,899	4,031
HIV/AIDS, Viral Hepatitis, STDs and Tuberculosis Prevention	1,119	1,089	1,188
PPHF transfer (non-add)	*30*	*0*	*30*
Emerging and Zoonotic Infectious Diseases	281	313	349
PPHF transfer (non-add)	*20*	*52*	*60*
Chronic Disease Prevention and Health Promotion	949	1,167	1,186
PPHF transfer (non-add)	*59*	*301*	*460*
Childhood Obesity Demonstration (PPACA Sec. 4306; non-add)	*25*	*0*	*0*
Birth Defects, Developmental Disabilities, Disability and Health[c]	144	144	144
Environmental Health	181	216	138
PPHF transfer (non-add)	*0*	*35*	*9*
Injury Prevention and Control	149	149	168
PPHF transfer (non-add)	*0*	*0*	*20*
Preventive Health and Health Services Block Grant	100	100	0
Public Health Scientific Services	441	490	494
PPHF transfer (non-add)	*32*	*82*	*70*
Occupational Safety and Health	430	430	315
EEOICPA (mandatory; non-add)[d]	*55*	*55*	*55*
World Trade Center Program (non-add)[e]	*71*	*71*	*0*
Global Health	354	354	381
Public Health Leadership and Support	194	185	163
PPHF transfer (non-add)	*50*	*41*	*41*
Buildings & Facilities	69	69	30
Business Services Support	367	367	417
Public Health Preparedness and Response	1,522	1,523	1,453
State and Local Preparedness Grants (non-add)	*761*	*761*	*651*
CDC Preparedness and Response Capability (non-add)	*166*	*166*	*147*
Strategic National Stockpile (non-add)	*596*	*596*	*655*
PHSSEF (balance from P.L. 111-32; non-add)[f]	*0*	*0*	*30*
ATSDR (from Interior/Environment Appropriations)	100[g]	77	76
Medical Monitoring (PPACA Sec. 10323(b); non-add)[h]	*23*	*0*	*0*
Total, Program Level	**10,884**	**11,395**	**11,255**

Program or Activity	FY2010 Actual[a]	FY2011 Initial CR	FY2012 Request
Less Funds From Other Sources			
Vaccines for Children (VFC)	-3,761	-3,899	-4,031
EEOICPA	-55	-55	-55
PHS Evaluation Funds	-352[i]	-352[i]	-490[i]
PHSSEF	0	0	-30
PPHF Transfers	-192	-611	-753
Other PPACA Funds	-48	0	0
User Fees	-2	-2	-2
Total, CDC/ATSDR Budget Authority	**6,474**	**6,475**	**5,894**
Less ATSDR Budget Authority	-77	-77	-76
Total, CDC Budget Authority	**6,397**	**6,398**	**5,818**

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 Centers for Disease Control and Prevention, FY2012 congressional budget justification, available at http://www.cdc.gov/fmo/topic/Budget%20Information/index.html. Other sources are noted below.

Notes: Individual amounts may not add to subtotals or totals due to rounding.

a. Generally pursuant to P.L. 111-117, Consolidated Appropriations Act, 2010, except when otherwise noted.

b. 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.

c. This budget line is referred to in the HHS Budget in Brief as "Child Health, Disabilities, and Blood Disorders."

d. 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.

e. Beginning July 1, 2011 (i.e., for the final quarter of FY2011), the World Trade Center Program currently funded through discretionary appropriations will be 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.

f. P.L. 111-32, the Supplemental Appropriations Act, 2009, provided $7.7 billion for the response to the H1N1 influenza pandemic to the Public Health and Social Services Emergency Fund (PHSSEF), a fund administered by the HHS Secretary that appropriators have typically used for one-time or short-term project funding. The FY2012 request proposes to use $30 million in unexpended funds from the PHSSEF for Strategic National Stockpile purchases.

g. Pursuant to P.L. 111-88, Interior Department and Further Continuing Appropriations for FY2010.

h. 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.

i. Pursuant to P.L. 111-117, Consolidated Appropriations Act, 2010, this amount includes $13 million for Immunization and Respiratory Diseases, $248 million for Public Health Scientific Services, and $92 million for Occupational Safety and Health.

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

House FY2011 Full-Year CR (H.R. 1)

H.R. 1 would provide CDC with $5.742 billion in budget authority through Labor-HHS-ED appropriations, which represents a decrease of about $650 million compared to the FY2010 level. However, the amount proposed for CDC includes the entire $750 million that was appropriated to the PPHF for FY2011, effectively eliminating the $120 million in FY2011 PPHF funds that had been allocated to AHRQ, HRSA, and SAMHSA (see **Table A-1** in the **Appendix**, and the respective agency's funding tables). Thus, the overall reduction in budget authority from the FY2010 level is $1.4 billion (22%). **Table 3** summarizes the reductions in specific programs, which include the elimination of funding for building and facilities and for congressionally directed projects (i.e., earmarks). H.R. 1 would, by reference, provide CDC with $352 million in evaluation set-aside funds (same as FY2010). It would not affect the availability of mandatory funds from VFC and EEOICPA, or user fee revenue.

H.R. 1 also would provide ATSDR with $77 million in budget authority through Interior/Environment appropriations, the same level as in FY2010.

An amendment to H.R. 1 offered by Representative Alcee Hastings, H.Amdt. 99, would reallocate $14 million from the FY2011 administrative budget of CDC (and NIH and HRSA) to provide $42 million for the Ryan White AIDS Drug Assistance Program (ADAP). The amendment, which was adopted by voice vote, is not reflected in **Table 3**.

Table 3. H.R. 1 Proposed Changes to CDC Programs and Activities

(dollars in millions)

Program or Activity	Compared to FY2010
Immunization and Respiratory Diseases	-156 (22%)
Global Health	-32 (9%)
Buildings & Facilities	-69 (100%)
Public Health Preparedness and Response	-269 (18%)
Congressionally Directed Projects	-21 (100%)
General CDC-wide Reduction	-850
Total	**-1,397 (22%)**

Source: Adapted by CRS from information provided by the House Committee on Appropriations on H.R. 1 as introduced (Feb. 11, 2011), available at http://republicans.appropriations.house.gov/_files/ProgramCutsFY2011ContinuingResolution.pdf.

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

Senate Substitute Amendment (S.Amdt. 149 to H.R. 1)

The Senate amendment to H.R. 1 would have provided $6.038 billion in CDC budget authority through Labor-HHS-ED appropriations, and $77 million (the FY2010 level) for ATSDR through Interior/Environment appropriations. The CDC amount included $12 million for buildings and facilities; not less than $382 million for Business Support Services; $527 million for the Strategic National Stockpile; and $211 million for NIOSH. The amendment would have provided to CDC an additional $352 million in evaluation set-aside funds (same as FY2010). It would not have affected the $611 million in FY2011 PPHF funding allocated to CDC (see **Table 2**), nor would it have affected the availability of mandatory funds from VFC and EEOICPA, or user fee revenue.

FY2012 Budget Highlights

The Administration requests $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 requests $490 million in PHS evaluation set-aside funds, and proposes to transfer $753 million in FY2012 PPHF funds to various CDC activities.

The Administration proposes to eliminate the Preventive Health and Health Services block grant, saying that state health departments receive substantial CDC funding through other existing activities.[24] It also proposes 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 merging the existing budget lines for Nutrition, Physical Activity and Obesity; Health Promotion; Heart Disease and Stroke; School Health, Diabetes; Cancer Prevention and Control; Prevention Centers; and Arthritis and Other Chronic Diseases.[25] 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 proposes to use $221 million from the PPHF to implement Community Transformation Grants authorized in PPACA Section 4201. This program would award competitive grants to state, local and tribal governments and non-profit entities to implement evidence-based community preventive health activities.

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

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

[25] 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.

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.[26]

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 authority.[27] FDA is also responsible for certain provisions in other laws, most notably the PHSA.[28] 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 within 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[29] has two funding streams: direct appropriations (budget authority) and industry user fees. 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 ($922 million in FY2010) 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. Combining direct appropriations and user fees, FDA had a total FY2010 budget of nearly $3.286 billion. **Table 4** displays FDA funding levels for FY2010 through the FY2012 request.

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

[27] 21 U.S.C. §§ 301 et seq.

[28] 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.

[29] 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 4. Food and Drug Administration (FDA)

(dollars in millions)

Program Area	FY2010 Actual	FY2011 Initial CR	FY2012 Request
Foods	783	781	1,035
Human Drugs	877	941	1,152
Biologics	304	318	368
Animal Drugs and Feeds	155	155	176
Devices and Radiological Health	367	367	395
Toxicological Research (NCTR)	59	59	60
Tobacco Products	217	217	455
Headquarters and Office of the Commissioner	198	203	289
GSA Rent	171	173	214
Other Rent and Rent-Related Activities (including White Oak consolidation)	129	133	193
Export and Color Certification	10	10	10
Buildings & Facilities (B&F)	12	12	13
National Center for Natural Products Research	3	3	0
Total Program Level	**3,286**	**3,373**	**4,360**
Less Funds from User Fees	922	1,011	1,616[a]
Total Budget Authority	**2,364**	**2,362**	**2,744**

Source: Adapted by CRS from the Department of Health and Human Services, FY2012 Budget in Brief, available at http://www.hhs.gov/about/hhsbudget.html.

Notes: Individual amounts may not add to totals due to rounding.

a. The President's FY2012 request includes $1,557 million in user fees from currently authorized programs plus $60 million in proposed user fees that would require authorizing legislation to implement.

House FY2011 Full-Year CR (H.R. 1)

H.R. 1 would provide the FDA with a total program level of $3.307 billion, less than 1% above its FY2010 level. This small increase masks a more significant change in the agency's two main budget components. Compared to the FY2010 appropriations for salaries and expenses,[30] H.R. 1 would provide a 10% decrease in budget authority and a 31% increase in user fees. Almost three-quarters of the increase in user fees, however, is for the FDA's tobacco program, which receives no appropriated funds and is entirely supported by fees. Calculating the change in FDA's budget outside of the tobacco program, the budget authority would decrease by 10%, user fees would increase 10%, and the total (minus tobacco program) program level would decrease 6% compared to the FY2010 level.

[30] H.R. 1 does not explicitly include a Building & Facilities (B&F) amount.

Senate Substitute Amendment (S.Amdt. 149 to H.R. 1)

The Senate amendment would have provided FDA with $401 million (19%) more than H.R. 1 in budget authority for salaries and expenses. Specified user fees did not differ between H.R. 1 and S.Amdt. 149. The proposed increases were distributed among the FDA program areas (except the tobacco products program, whose budget derives solely from user fees). Of note was a 74% increase, relative to H.R. 1, for the National Center for Toxicological Research, which would restore that program to its FY2010 funding. FDA-wide, the Senate total would have increased budget authority 7% over the FY2010 level.

FY2012 Budget Highlights

The President requested a total program level of $4.360 billion for FDA. This is 33% more than FY2010, and 32% more than H.R. 1. 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 31% more than H.R. 1. The requested user fees are 75% more than FY2010 and 34% more than H.R. 1. The requested user fee total for FY2012 includes $1.457 billion for ongoing user fee programs (for prescription drugs, medical devices, animal drugs, animal generic drugs, tobacco, mammography screening, and drug export and certification fees); $99 million for new fee categories authorized in the Food Safety Modernization Act (food export certification, voluntary qualified importer program, food reinspection, and recall fees);[31] and $60 million for proposed, as yet unauthorized, fees (generic drugs, medical products reinspection, and international courier fees).

FDA's FY2012 budget highlights four areas of requested increased funds.[32] These are an additional $218 million for the Transforming Food Safety and Nutrition Initiative to implement the Food Safety Modernization Act; an additional $70 million for the Advancing Medical Countermeasures Initiative to develop products to respond to terrorist threats and naturally emerging diseases; 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 an additional $49 million for the FDA Regulatory Science and Facilities Initiative to both 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.

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

[32] 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 live in rural and urban areas, and 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.[33]

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 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.

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, poison control, and other areas.

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

Table 5 shows funding levels for HRSA's programs and activities for FY2010 through the FY2012 request, including transfers from the PPACA Community Health Center Fund (CHCF) and the PPHF. The table also includes programs that received direct appropriations from PPACA.[34] Program level funding for other major programs is also shown.

Table 5. Health Resources and Services Administration (HRSA)

(dollars in millions)

Program or Activity	FY2010 Actual	FY2011 Initial CR	FY2012 Request
Primary Care			
Health Centers	2,141	3,146	3,222
CHCF transfer (non-add)	*0*	*1,000*	*1,200*
Health Center Tort Claims	44	44	96
School-Based Health Centers (PPACA Sec. 4101(a))	50	50	50
Health Center Construction (PPACA Sec. 10503(c))	0	1,500[a]	0
Other Primary Care[b]	18	18	18
Subtotal, Primary Care	***2,253***	***4,758***	***3,386***
Health Workforce			
National Health Service Corps	141	432	418
CHCF transfer (non-add)	*0*	*290*	*295*
Training for Diversity	97	97	108
Primary Care Training and Enhancement	237	39	140
PPHF transfer (non-add)	*200*	*0*	*0*
Interdisciplinary, Community-Based Linkages	72	72	97
State Health Workforce Development Grants	6	0	51
PPHF transfer (non-add)	*5*	*0*	*0*
Public Health Workforce Development	24	30	25
PPHF transfer (non-add)	*15*	*20*	*15*
Nursing Workforce Development	290	244	333
PPHF transfer (non-add)	*45*	*0*	*0*
Home Health Aide Demonstration (PPACA Sec. 5507(a))	5	5	5
Children's Hospital GME Payments	317	318	0
Teaching Health Ctrs GME Payments (PPACA Sec. 5508(c))	0	230	0
Other Workforce Programs[c]	41	41	80
Subtotal Health Workforce	***1,230***	***1,507***	***1,257***
Maternal and Child Health			

[34] 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 Actual	FY2011 Initial CR	FY2012 Request
Maternal and Child Health Block Grant	661	662	654
Healthy Start	105	105	105
Home Visiting Grants (PPACA Sec. 2951)	100	250	350
Family to Family Health Information Ctrs (PPACA Sec. 5507)	5	5	5
Other Maternal and Child Health Programs[d]	114	115	121
Subtotal, Maternal and Child Health	***984***	***1,136***	***1,235***
Health Care Systems			
Medical School Development (PPACA Sec. 10502)	100	0	0
Other Health Care Systems Programs[e]	167	168	101
Subtotal, Health Care Systems	***267***	***168***	***101***
Subtotal, HIV/AIDS	***2,315***	***2,291***	***2,401***
Subtotal, Rural Health	***185***	***186***	***124***
Other Activities			
Congressional Projects	337	338	0
Family Planning	317	317	327
Healthy Weight Collaborative (PPHF transfer)	5	0	5
Other Activities[f]	178	178	205
Subtotal, Other Activities	***837***	***833***	***537***
Total, Program Level	**8,072**	**10,879**	**9,046**
Less Funds From Other Sources			
PHS Evaluation Funds	-25	-25	-280
User Fees	-24	-24	-33
PPHF Transfers	-271	-20	-20
CHCF Transfers	0	-1290	-1495
Other PPACA Funds	-260	-2040	-410
Total, Budget Authority	**7,492**	**7,480**	**6,808**

Source: Adapted by CRS from the Department of Health and Human Services, FY2012 Budget in Brief, available at http://www.hhs.gov/about/hhsbudget.html.

Notes: Individual amounts may not add to subtotals or totals due to rounding.

a. PPACA Sec. 10503(c) specifies that this amount be available for the period FY2011 through FY2015. HHS includes the entire appropriation in FY2011.

b. Other primary care programs are: Free Clinics Medical Malpractice, and Hansen's Disease Programs.

c. Other workforce programs are: Health Workforce Information and Analysis, Oral Health Training, Teaching Health Centers Planning Grants, and Patient Navigator.

d. 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.

e. Other health care systems programs are: Organ Transplantation, Cord Blood Stem Cell Bank, C.W. Bill Young Cell Transplantation Program, Poison Control Centers, 340B Drug Pricing Program, and State Health Access Grants.

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

House FY2011 Full-Year CR (H.R. 1)

H.R. 1 would provide HRSA with a total FY2011 budget authority of $5.313 billion, which represents a $2.2 billion, or 29%, decrease compared to the FY2010 level. **Table 6** itemizes the proposed cuts to HRSA programs in H.R. 1. These cuts include a $1 billion reduction in funding for the Health Centers Program, and the elimination of Labor-HHS-ED funding for the National Health Service Corps (NHSC). Both programs received transfers from the CHCF for FY2011, as shown in **Table 5**; $1 billion for the Health Centers Program, and $290 million for the NHSC. H.R. 1 would eliminate the $20 million PPHF transfer (see earlier discussion under "Centers for Disease Control and Prevention").

H.R. 1 also would eliminate funding for the Title X family planning program and reduce funding for the Maternal and Child Health Block Grant by $50 million. An amendment to the bill would prohibit the use of any funds appropriated in H.R. 1 for Planned Parenthood or its affiliates. Another provision would allow the PPACA funds for the new Maternal, Infant, and Early Childhood Home Visiting Program to supplant HRSA funds for similar programs and initiatives.

Funding for congressionally directed health facility construction and renovation is eliminated, as is funding for various programs that support specific regional healthcare needs including Native Hawaiians, Alaska residents (through the Denali Commission), and residents of the Mississippi Delta region (through the Delta Health Initiative). Finally, H.R. 1 would decrease funding for poison control centers by $27 million, from $29 million in FY2010, and eliminate funding for the congenital disabilities program.

An amendment to H.R. 1 offered by Representative Alcee Hastings, H.Amdt. 99, provides an additional $42 million for the Ryan White AIDS Drug Assistance Program (ADAP) by reallocating $14 million from each of the FY2011 administrative budgets of CDC, HRSA, and NIH. The amendment, which was adopted by voice vote, is not reflected in **Table 6**.

Table 6. H.R. 1 Proposed Changes to HRSA Programs and Activities

(dollars in millions)

Program or Activity	Compared to FY2010
Health Centers	-1,000 (46%)
National Health Service Corps	-142 (100%)
Health Professions[a]	-145 (29%)
Patient Navigator	-5 (100%)
Maternal and Child Health Block Grant	-50 (8%)
Congenital Disabilities	-1 (100%)
Organ Transplantation	-1 (4%)

Program or Activity	Compared to FY2010
Poison Control Centers	-27 (93%)
State Health Access Grant Program	-75 (100%)
Delta Health	-35 (100%)
Denali Commission	-10 (100%)
Native Hawaiian Healthcare	-14 (100%)
Congressionally Directed Projects	-338 (100%)
Family Planning (Title X)	-318 (100%)
Total	**-2,160 (29%)**

Source: Adapted by CRS from information provided by the House Committee on Appropriations on H.R. 1 as introduced (Feb. 11, 2011), available at http://republicans.appropriations.house.gov/_files/ProgramCutsFY2011ContinuingResolution.pdf.

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

a. Health Professions programs include diversity training programs, training in primary care medicine, interdisciplinary community-based linkages programs, certain nursing programs, and programs in public health and preventive medicine.

Senate Substitute Amendment (S.Amdt. 149 to H.R. 1)

The Senate amendment would have provided HRSA with total FY2011 budget authority of $7.178 billion, a $314 million (4%) decrease from the FY2010 level. The bill contained provisions to maintain minimum budget authority for state AIDS Drug Assistance Programs, oral health programs, and health centers tort claims. As in H.R. 1 and the President's FY2012 budget, the Senate amendment would have eliminated funding for the Denali Commission and the Delta Health Initiative.

FY2012 Budget Highlights

The President's FY2012 budget request includes total budget authority of $6.808 billion for HRSA, which represents a decrease of $684 million (9%) from FY2010 (see **Table 5**). The President's budget proposes to eliminate funding for a number of HRSA programs.[35] Several of these cuts are consistent with the funding proposed in H.R. 1. These include funding for earmark projects such as health facility construction and renovation, the Denali Commission, and the Delta Health Initiative. The President's budget also would eliminate funding for certain rural health projects,[36] and for the Children's Hospital GME program.[37]

[35] 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.

[36] Including funding for rural access to emergency devices, rural hospitals, and for rural utility, sanitation, and other infrastructure projects.

[37] This program provides funding to Children's Hospitals to support medical residency training in general pediatric medicine and pediatric specialties.

The President's budget request provides $1 billion for health workforce programs, a net decrease of $27 million (2%) from the FY2010 program level. The budget seeks to expand the primary care workforce capacity, team-based health care services, and geriatric education. The FY2012 budget would direct the majority of health workforce funds to Nursing Workforce Development, Primary Care Training and Enhancement, and the NHSC. The budget would increase funding for certain other health workforce programs and would fund grants to develop Teaching Health Centers and provide graduate medical education (GME) payments for these centers.[38]

The FY2012 budget request proposes a 26% increase in funding for Maternal and Child Health programs over the FY2010 level, which largely reflects an increase in PPACA funding for the Maternal, Infant, and Early Childhood Home Visiting Program.

The FY2012 request would provide a total of $2.4 billion for the Ryan White program, an increase of $85 million over FY2010; $80 million for the ADAP, bringing its total to $940 million, and an additional $5 million for Early Intervention programs.

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.[39] 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.[40]

The Snyder Act of 1921[41] provides general statutory authority for IHS.[42] In addition, specific IHS programs are authorized by two acts: the Indian Sanitation Facilities Act of 1959[43] and the Indian Health Care Improvement Act (IHCIA).[44] The Indian Sanitation Facilities Act authorizes the PHS to construct sanitation facilities for Indian communities and homes, and IHCIA authorizes

[38] 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.

[39] 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.

[40] 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.

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

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

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

[44] 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.

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.

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

Table 7 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,[45] 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 7. Indian Health Service (IHS)

(dollars in millions)

Program or Activity	FY2010 Actual	FY2011 CR	FY2012 Request
Clinical Services	3,845	3,861	4,284
Contract Health Services (non-add)[a]	*779*	*779*	*949*
Catastrophic Health Emergency Fund (non-add)[b]	*48*	*48*	*58*
Preventive Health	144	144	157
Special Diabetes Program for Indians[c]	150	150	150
Subtotal, Clinical and Preventive Services	**4,139**	**4,155**	**4,591**
Urban Health Projects	43	43	47
Indian Health Professions	41	41	42
Tribal Management/Self-Governance	9	9	9
Direct Operations	69	69	74
Contract Support Costs	398	398	462
Subtotal, Other Health Services	***560***	***560***	***634***
Maintenance and Improvement	60	60	65
Sanitation Facilities Construction	96	96	80
Health Care Facilities Construction	29	29	85
Facilities/Environmental Health Support	193	193	211
Medical Equipment	23	23	25
Subtotal, Health Facilities	***401***	***401***	***465***
Total, Program Level	**5,100**	**5,116**	**5,689**
Less Funds from Other Sources			
Collections	-891	-908	-908
Rental of Staff Quarters	-6	-6	-8

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

Program or Activity	FY2010 Actual	FY2011 CR	FY2012 Request
Special Diabetes Program for Indians[c]	-150	-150	-150
Total, Budget Authority[d]	**4,052**	**4,052**	**4,624**

Source: Adapted by CRS from the Department of Health and Human Services, FY2012 Budget in Brief, available at http://www.hhs.gov/about/hhsbudget.html.

Notes: Individual amounts may not add to subtotals or totals due to rounding.

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

b. This fund is authorized in Section 202 of the Indian Health Care Improvement Act. For information about appropriations for the Catastrophic Health Emergency Fund, see IHS "Justification of Estimates for Appropriations Committees, FY2012," pp. 91and 93, at http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/FY%202012%20Budget%20Justification.pdf.

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

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

House FY2011 Full-Year CR (H.R. 1)

H.R. 1 would appropriate $4.14 billion to the IHS, an increase of $87 million (2%) over the FY2010 level. It would increase funding for the Indian Health Services account, which funds clinical and preventive services, among other things, by a total of $226 million, of which $133 million would be used to increase funding for specified activities (see **Table 8**). The remaining $93 million would be used to increase unspecified activities funded under the Indian Health Services account. H.R. 1 would decrease funding appropriated to the Indian Health Facilities account, used to support activities such as facility construction, renovation, and maintenance, by $139 million (35%). IHS received one-time funds under the American Recovery and Reinvestment Act (ARRA, P.L. 111-5) for these purposes.[46] HHS reports that IHS also has funds carried over from prior fiscal years for some activities funded under this account.[47]

Table 8. H.R. 1 Proposed Changes to IHS Programs and Activities

(dollars in millions)

Program or Activity	Compared to FY2010
Indian Health Services	+226 (6%)
Contract Health Services (non-add)	*+83 (11%)*
Catastrophic Health Emergency Fund (non-add)	*+5 (10%)*
Contract Support Costs (non-add)	*+45 (11%)*
Indian Health Facilities	-139 (35%)

[46] For discussion, see CRS Report R40181, *Selected Health Funding in the American Recovery and Reinvestment Act of 2009*, coordinated by C. Stephen Redhead.

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

Program or Activity	Compared to FY2010
Total	**+87 (2%)**

Source: Adapted by CRS from information provided by the House Committee on Appropriations on H.R. 1 as introduced (Feb. 11, 2011), available at http://republicans.appropriations.house.gov/_files/ProgramCutsFY2011ContinuingResolution.pdf.

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

Senate Substitute Amendment (S.Amdt. 149 to H.R. 1)

Under the Senate Amendment IHS would have continued to operate at FY2010 levels. However, Section 1755 of the amendment would have required IHS to submit, within 30 days of enactment, "a spending, expenditure, or operating plan for fiscal year 2011." The Senate amendment would have further required that the plan be at the account level (i.e., it would specify funding for the Indian Health Services and Indian Health Facilities accounts).

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.[48] 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.[49]

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."[50] 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

[48] 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.

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

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

24 of the ICs, the Office of the Director (OD), and the Buildings and Facilities account. NIH receives additional funds from the Interior/Environment appropriations act and from a mandatory appropriation for diabetes research.[51]

Table 9 shows funding for NIH for FY2010 through the FY2012 request.

Table 9. National Institutes of Health (NIH)

(dollars in millions)

Institutes and Centers (ICs)	FY2010 Actual[a]	FY2011 Initial CR[b]	FY2012 Request
Cancer (NCI)	5,101	5,099	5,196
Heart/Lung/Blood (NHLBI)	3,095	3,094	3,148
Dental/Craniofacial Research (NIDCR)	413	413	420
Diabetes/Digestive/Kidney (NIDDK)	1,957	1,957	1,988
Neurological Disorders/Stroke (NINDS)	1,635	1,635	1,664
Allergy/Infectious Diseases (NIAID)[c]	4,816	4,510	4,916
General Medical Sciences (NIGMS)	2,051	2,050	2,102
Child Health/Human Development (NICHD)	1,329	1,328	1,352
Eye (NEI)	707	706	719
Environmental Health Sciences (NIEHS), L-HHS appropriation	689	689	701
NIEHS, Interior/Environment appropriation[d]	79	79	81
Aging (NIA)	1,110	1,109	1,130
Arthritis/Musculoskeletal/Skin (NIAMS)	539	539	548
Deafness/Communication Disorders (NIDCD)	419	418	426
Mental Health (NIMH)	1,490	1,489	1,517
Drug Abuse (NIDA)	1,059	1,059	1,080
Alcohol Abuse/Alcoholism (NIAAA)	462	462	469
Nursing Research (NINR)	146	146	148
Human Genome Research (NHGRI)	516	516	525
Biomedical Imaging/Bioengineering (NIBIB)	316	316	322
Minority Health/Health Disparities (NIMHD)[e]	211	211	215
Research Resources (NCRR)	1,268	1,268	1,298
Complementary/Alternative Medicine (NCCAM)	129	129	131
Fogarty International Center (FIC)	70	70	71
National Library of Medicine (NLM)	359	374	395
Office of Director (OD)	1,177	1,176	1,298

[51] 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 Actual[a]	FY2011 Initial CR[b]	FY2012 Request
Buildings & Facilities (B&F)	100	100	126
Total, Program Level	**31,243**	**30,943**	**31,987**
Less Funds From Other Sources			
PHS Evaluation Funds (NLM)	-8	-8	-8
Type 1 Diabetes Research (NIDDK)[f]	-150	-150	-150
Total, Budget Authority	**31,084**	**30,785**	**31,829**

Source: Adapted by CRS from the Department of Health and Human Services, FY2012 Budget in Brief, available at http://www.hhs.gov/about/hhsbudget.html.

Notes: Individual amounts may not add to totals due to rounding.

a. FY2010 Actual reflects real transfer of $1 million from HHS Office of the Secretary to NIMH, $4.6 million transfer to HRSA Ryan White program, as well as comparable adjustments for transfer of funds from ICs to NLM.

b. FY2011 CR reflects real transfer of $1 million from HHS Office of the Secretary to NIMH. Also assumes a full-year CR at FY2010 enacted levels less $304 million for NIAID due to Bioshield transfer not available in FY2011. NIH, *Justification of Estimates for Appropriations Committees, FY2012, Vol. I, Overview*, p. ST-4, OA-12.

c. Includes funds for transfer to the Global Fund for HIV/AIDS, Tuberculosis, and Malaria ($300 million in each of FY2010, FY2011, and FY2012). Bioshield transfer of $304 million was not provided under FY2011 CR.

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

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

f. 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.

House FY2011 Full-Year CR (H.R. 1)

H.R. 1 would provide NIH with $29.443 billion, a reduction of more than $1.6 billion (5%) below the FY2010 level of $31.084 billion. **Table 10** itemizes the various program cuts that make up the total reduction. They include $260 million from non-competing research grants across all ICs, and $77 million from the NIH Buildings and Facilities account. The bill would impose a general reduction, shared proportionately by the ICs, of $639 million. It also would specify that the average cost of competing research project grants not exceed $400,000 and that at least 9,000 such grants be awarded in FY2011. The current average cost of competing research project grants is about $426,000; NIH was planning on awarding about 8,700 such grants in FY2011.[52]

In addition, H.R. 1 would eliminate two amounts that were part of NIAID's appropriation in FY2010: $300 million normally provided each year to NIH for transfer out to the Global AIDS Fund, and $304 million that in FY2010 was transferred into NIH from the Project Bioshield Special Reserve Fund.[53] Since the bill also removes the requirement for NIH to make the transfer

[52] NIH, *Justification of Estimates for Appropriations Committees, FY2012, Vol. I, Overview*, table on "Research Project Grants: Total Number of Awards and Dollars," p. OA-46.

[53] For more information, see CRS Report R41033, *Project BioShield: Authorities, Appropriations, Acquisitions, and Issues for Congress*, by Frank Gottron.

to the Global Fund, NIH effectively does not lose any resources from elimination of the $300 million from its appropriation. The $304 million not provided from the Bioshield Fund would be an actual loss to NIH that would not be made up with additional budget authority. Instead, H.R. 1 would provide that internal transfers from other ICs to NIAID would make up for $257 million of the $304 million. H.R. 1 would also reduce the appropriation to NIEHS for Superfund-related activities by nearly $2 million.

Table 10 reflects an amendment to H.R. 1 offered by Representative Alcee Hastings, H.Amdt. 99, adopted by voice vote, that would reallocate $14 million from the FY2011 administrative budget of NIH (and CDC and HRSA) to provide $42 million for the Ryan White AIDS Drug Assistance Program (ADAP).

Table 10. H.R. 1 Proposed Changes to NIH Programs and Activities

(dollars in millions)

Program or Activity	Compared to FY2010
Global AIDS Transfer (NIAID)	-300 (100%)
Project BioShield Transfer (NIAID)	-304 (100%)
Buildings & Facilities	-77 (77%)
Non-Competing Grants	-260
Common Fund (OD)	-49 (4%)
General NIH-wide Reduction	-639
Superfund (NIEHS)	-2 (2%)
Administrative Reduction (Hastings Amdt.)	-14
Total	**-1,645 (5%)**

Source: Adapted by CRS from information provided by the House Committee on Appropriations on H.R. 1 as introduced (Feb. 11, 2011), available at http://republicans.appropriations.house.gov/_files/ProgramCutsFY2011ContinuingResolution.pdf.

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

Senate Substitute Amendment (S.Amdt. 149 to H.R. 1)

The Senate amendment would have provided the same level of funding for NIH as in FY2010. The only language pertaining to NIH in the amendment concerned maintaining the funding for the National Institute of Allergy and Infectious Diseases at its FY2010 total, with none of the funds to be derived by transfer from the Bioshield Fund in the Office of the Secretary.

FY2012 Budget Highlights

For FY2012 the Obama Administration has requested $32.0 billion for NIH, an increase of $745 million (2.4%) over FY2010. 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 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. 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 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. These activities are centrally coordinated in the Center for Behavioral Health Statistics and Quality.

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.[54] Funding authority for most of SAMHSA's grant programs expired at the end of FY2003, though many of them continue to receive 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.[55]

Table 11 shows SAMHSA's funding for FY2010 through the FY2012 request, including amounts transferred from the PPHF. As discussed in more detail below, SAMHSA has restructured its programs and activities. The FY2012 column in the table reflects those changes. In order to compare funding across fiscal years, the figures in both the FY2010 and FY2011 columns are organized in the same way.

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

[55] For more information on SAMHSA and its programs and activities, see CRS Report R41477, *Substance Abuse and Mental Health Services Administration (SAMHSA): Agency Overview and Reauthorization Issues*, by Bonnie L. Norton and C. Stephen Redhead.

Table 11. Substance Abuse and Mental Health Services Administration (SAMHSA)

(dollars in millions)

Program or Activity	FY2010 Actual	FY2011 Initial CR	FY2012 Request
Substance Abuse Block Grant	1,455	1,455	1,494
Mental Health Block Grant	421	421	435
Subtotal, Block Grants	***1,875***	***1,875***	***1,929***
Substance abuse: state prevention grants	455	456	395
Mental health: state prevention grants	25	25	90
Behavioral health: tribal prevention grants (PPHF transfer)	0	0	50
Subtotal, State, Tribal & Community Prevention Grants	***480***	***481***	***535***
CMHS Programs[a]	328	328	271
CSAP Programs[a]	75	76	69
CSAT Programs[a]	408	408	393
SAMHSA-wide Initiatives: Military Families, Health IT	0	0	14
Primary & Behavioral Healthcare Integration (PPHF transfer)	20	35	20
Substance Abuse Treatment (PPHF transfer)	0	25	0
Suicide Prevention (PPHF transfer)	0	10	0
Prevention Prepared Communities (PPHF transfer)	0	0	23
Subtotal, Innovation and Emerging Issues	***831***	***881***	***790***
Children's Mental Health Services	121	121	121
PATH Homeless Grants	65	65	65
Regulatory and Oversight Functions	55	55	55
Protection and advocacy (non-add)	*36*	*36*	*36*
Public Awareness and Support	14	14	14
Performance and Quality Information Systems	37	38	13
Program Management	102	102	128
Health surveillance (PPHF transfer)	0	18	0
St. Elizabeths Hospital	1	1	0
Total, Program Level	**3,583**	**3,651**	**3,649**
Less Funds From Other Sources			
PHS Evaluation Set-Aside Funds	-132	-132	-170
PPHF Transfers	-20	-88	-93
Total, Budget Authority	**3,431**	**3,432**	**3,387**

Source: Adapted by CRS from the Department of Health and Human Services, FY2012 Budget in Brief, available at http://www.hhs.gov/about/hhsbudget.html.

Notes: Individual amounts may not add to subtotals or totals due to rounding.

a. This budget line includes funding for competitive grant programs created under general (i.e., PRNS) authority, as well as categorical programs, each with a specific PHSA authorization.

House FY2011 Full-Year CR (H.R. 1)

H.R. 1 would provide SAMHSA with total FY2011 budget authority of $3.202 billion, which represents a decrease of $229 million (7%) compared to the FY2010 level. That amount includes a general agency-wide reduction of $200 million, plus a handful of smaller specified cuts and the elimination of $14 million in congressionally directed projects (see **Table 12**). H.R. 1 would also eliminate the $88 million in PPHF transfers (see earlier discussion under "Centers for Disease Control and Prevention").

Table 12. H.R. 1 Proposed Changes to SAMHSA Programs and Activities

(dollars in millions)

Program or Activity	Compared to FY2010
Mental Health PRNS	-3 (<1%)
Substance Abuse Treatment PRNS	-3 (<1%)
Substance Abuse Prevention PRNS	-8 (4%)
St. Elizabeths Hospital	-1 (100%)
General SAMHSA-wide Reduction	-200 (6%)
Congressionally Directed Projects	-14 (100%)
Total	**-229 (7%)**

Source: Adapted by CRS from information provided by the House Committee on Appropriations on H.R. 1 as introduced (Feb. 11, 2011), available at http://republicans.appropriations.house.gov/_files/ProgramCutsFY2011ContinuingResolution.pdf.

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

Senate Substitute Amendment (S.Amdt. 149 to H.R. 1)

The Senate amendment would have provided SAMHSA with total FY2011 budget authority of $3,416 million, a $15 million (less than 1%) decrease from the FY2010 level.

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 11**). 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 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 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. 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 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 A-1**. PPHF transfers to PHS agencies are itemized in the funding tables presented earlier in this report. PPACA requires the Secretary, if using PPHF funds to augment existing programs and activities, to maintain at least the FY2008 funding level, to which the PPHF amount is added. The Secretary is also permitted to use the PPHF to fund new activities, in which case the FY2008 amount is zero.

FY2011 appropriations for the PPHF became available on October 1, 2010, at the beginning of the fiscal year. Although Congress could redirect these funds through a subsequent law (including an appropriations law), under current law the funds are available to the HHS Secretary to be used consistent with the purposes stated in PPACA.

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 A-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	200	0	0
HRSA	State Health Workforce Development Grants	5	0	0
HRSA	Public Health Workforce Development	15	20	15
HRSA	Nursing Workforce Development	45	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
CDC	Chronic Disease Prevention and Health Promotion	59	301	460
CDC	Environmental Health	0	35	9
CDC	Injury Prevention and Control	0	0	20

Agency	Activity	FY2010	FY2011	FY2012
CDC	Public Health Scientific Services	32	82	70
CDC	Public Health Leadership and Support	50	41	41
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: Adapted by CRS from the Department of Health and Human Services, FY2012 Budget in Brief (AHRQ, HRSA, and CDC); FY2012 congressional budget justification for the Substance Abuse and Mental Health Services Administration (SAMHSA); and FY2012 congressional budget justification for HHS General Departmental Management (OS), p. 163, http://www.hhs.gov/about/hhsbudget.html. For more information about the FY2010 and FY2011 PPHF transfers, see "HHS Announces $750 million Investment in Prevention," press release, February 9, 2011, http://www.hhs.gov/news/press/2011pres/02/20110209b.html.

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

Author Contact Information

C. Stephen Redhead, Coordinator
Specialist in Health Policy
credhead@crs.loc.gov, 7-2261

Pamela W. Smith, Coordinator
Analyst in Biomedical Policy
psmith@crs.loc.gov, 7-7048

Amalia K. Corby-Edwards
Analyst in Public Health and Epidemiology
acorbyedwards@crs.loc.gov, 7-0423

Elayne J. Heisler
Analyst in Health Services
eheisler@crs.loc.gov, 7-4453

Judith A. Johnson
Specialist in Biomedical Policy
jajohnson@crs.loc.gov, 7-7077

Sarah A. Lister
Specialist in Public Health and Epidemiology
slister@crs.loc.gov, 7-7320

Bernice Reyes-Akinbileje
Analyst in Health Resources and Services
breyes@crs.loc.gov, 7-2260

Amanda K. Sarata
Specialist in Health Policy
asarata@crs.loc.gov, 7-7641

Susan Thaul
Specialist in Drug Safety and Effectiveness
sthaul@crs.loc.gov, 7-0562

Key Policy Staff

Area of Expertise	Name	Phone	E-mail
General HHS budget	Pamela W. Smith	7-7048	psmith@crs.loc.gov
AHRQ programs and budget	Amanda K. Sarata	7-7641	asarata@crs.loc.gov
CDC programs and budget	Sarah A. Lister	7-7320	slister@crs.loc.gov
FDA programs and budget	Susan Thaul (budget, drugs)	7-0562	sthaul@crs.loc.gov
	Judith A. Johnson (budget, biologics)	7-7077	jajohnson@crs.loc.gov
	Erin D. Williams (medical devices)	7-4897	ewilliams@crs.loc.gov
	C. Stephen Redhead (tobacco)	7-2261	credhead@crs.loc.gov
	Sarah A. Lister (food, animal drugs & feed)	7-7320	slister@crs.loc.gov
HRSA programs and budget	Amalia K. Corby-Edwards (budget)	7-0423	acorbyedwards@crs.loc.gov
	Elayne J. Heisler (health centers, workforce)	7-4453	eheisler@crs.loc.gov
	Bernice Reyes-Akinbileje (workforce)	7-2260	breyes@crs.loc.gov
	Judith A. Johnson (HIV/AIDS)	7-7077	jajohnson@crs.loc.gov
IHS programs and budget	Elayne J. Heisler	7-4453	eheisler@crs.loc.gov
NIH programs and budget	Pamela W. Smith	7-7048	psmith@crs.loc.gov
	Judith A. Johnson	7-7077	jajohnson@crs.loc.gov
SAMHSA programs and budget	C. Stephen Redhead	7-2261	credhead@crs.loc.gov
	Erin Bagalman	7-5345	ebagalman@crs.loc.gov