Discretionary Spending Under the Affordable Care Act (ACA)

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Summary

The Affordable Care Act (ACA) authorized many new discretionary grant programs and provided each one with an authorization of appropriations—typically through FY2014 or FY2015—to carry them out. The ACA also reauthorized funding for numerous existing programs with expired authorizations of appropriations, most of which were still receiving annual funding.

The Congressional Budget Office (CBO) estimated that fully funding the discretionary grant programs authorized (or reauthorized) by the ACA, based on the amounts specified in the authorizations of appropriations, would result in appropriations of almost $100 billion over the period FY2012-FY2021. However, the total amount of discretionary funding provided to date falls well below CBO's estimate for two reasons. First, few of the new grant programs authorized by the ACA have received any discretionary appropriations. Second, programs that were reauthorized by the ACA generally have received discretionary appropriations at levels well below the amounts authorized in the law.

The ACA included provisions intended to strengthen the health care safety net and improve access to care. For example, it permanently reauthorized the federal health center program and the National Health Service Corps (NHSC). The NHSC provides scholarships and student loan repayments to individuals who agree to a period of service as a primary care provider in a federally designated Health Professional Shortage Area. In addition, the ACA addressed concerns about the current size, specialty mix, and geographic distribution of the health care workforce. It reauthorized and expanded existing health workforce education and training programs under Titles VII and VIII of the Public Health Service Act (PHSA). Title VII supports the education and training of physicians, dentists, physician assistants, and public health workers through grants, scholarships, and loan repayment. The ACA created several new programs to increase training experiences in primary care, in rural areas, and in community-based settings, and provided training opportunities to increase the supply of pediatric subspecialists and geriatricians. It also expanded the nursing workforce development programs authorized under PHSA Title VIII.

As part of a comprehensive framework for federal community-based public health activities, including a national strategy and a national education and outreach campaign, the ACA authorized several new grant programs with a focus on preventable or modifiable risk factors for disease (e.g., sedentary lifestyle, tobacco use). The new law also leveraged a number of mechanisms to improve health care quality, including new requirements for quality measure development, collection, analysis, and public reporting; programs to develop and disseminate innovative strategies for improving the quality of health care delivery; and support for care coordination programs such as medical homes and the co-location of primary health care and mental health services. Additionally, the ACA authorized funding for programs to prevent elder abuse, neglect, and exploitation; grants to expand trauma care services and improve regional coordination of emergency services; and demonstration projects to implement alternatives to current tort litigation for resolving medical malpractice claims, among other provisions.

The two agencies primarily responsible for implementing the ACA's expansion of insurance coverage and its revenue provisions—the Centers for Medicare & Medicaid Services (CMS) and the Internal Revenue Service (IRS)—have requested an increase in their annual appropriations in each of the past five years (i.e., FY2013-FY2017) to help cover these costs. But Congress has not provided the agencies with any additional discretionary funding for ACA implementation. CMS, in particular, has relied on funding from a variety of other sources to support these activities.

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Introduction

Implementation of the Affordable Care Act (ACA)[1] is having a substantial impact on federal mandatory spending.[2] Most of the mandatory spending under the law is for expanding health insurance coverage. This includes premium tax credits and cost-sharing subsidies for individuals and families who purchase private insurance coverage through the ACA health insurance exchanges, as well as federal matching funds for states that choose to expand their Medicaid programs.

In addition, the ACA authorized new Medicare spending and appropriated billions of dollars in mandatory funds to support numerous other activities and programs. For example, it provided a permanent appropriation—available for 10-year periods—for a Center for Medicare & Medicaid Innovation to test and implement innovative health care payment and service delivery models. Furthermore, the ACA established four special funds—and appropriated amounts to each one—to support primary care, public health, and comparative effectiveness research, and help pay for the administrative costs of the law's implementation.[3]

The ACA is having a more modest impact on federal discretionary spending, which is subject to the annual appropriations process.[4] Discretionary spending under the ACA falls into two broad categories. First, there are the amounts provided in appropriations acts for specific grant and other programs pursuant to explicit authorizations of appropriations in the ACA. Second, there are the costs incurred by federal agencies to administer and enforce the health insurance reforms and other core requirements of the law. The two agencies primarily responsible for the ACA's implementation are the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), and the Internal Revenue Service (IRS), within the Department of the Treasury. Both agencies have requested additional administrative funding in recent years to help cover the costs of implementing the law.

This report examines the ACA's effects on discretionary spending. First, it discusses all the ACA authorizations (and reauthorizations) of appropriations for grant and other programs. This information, along with the appropriation amounts (if any) for each program since FY2010, is summarized in a series of tables. The report then briefly discusses the ACA administrative costs borne by CMS and the IRS. **Appendix A** provides background information on the enforceable discretionary spending limits (caps) and the annual spending reductions under the Budget Control Act of 2011.

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[1] The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010 (P.L. 111-148, 124 Stat. 119). A week later, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029), which amended multiple health care and revenue provisions in the ACA and added several new provisions. Since then, Congress and the President have enacted other bills that have made more targeted changes to specific ACA provisions. All references to the ACA in this report refer collectively to the ACA, as amended, and to other related provisions in HCERA.

[2] Mandatory, or direct, spending generally refers to outlays from budget authority (i.e., the authority to incur financial obligations that result in government expenditures such as paying salaries, purchasing services, or awarding grants) that is provided in authorizing laws, as opposed to annual appropriations acts. Mandatory spending includes spending on entitlement programs (e.g., Medicare, Social Security).

[3] While a detailed examination of the ACA is beyond the scope of this report, numerous CRS products that provide more in-depth information on the many new programs and activities authorized and funded by the law are available at http://www.crs.loc.gov (see under "Issues Before Congress: Health").

[4] Discretionary spending refers to outlays from budget authority that is provided in and controlled by annual appropriations acts. It typically covers the routine costs of running federal agencies, including wages and salaries.

This report is periodically revised and updated to reflect important legislative and administrative developments. The next update will occur after Congress completes its work on the FY2017 appropriations acts and the President releases the FY2018 budget.[5] A companion CRS report summarizes all the ACA's mandatory appropriations and the obligation of these funds.[6]

ACA Authorizations of Appropriations

The ACA authorized numerous *new* discretionary grant programs and provided for each an authorization of appropriations, typically through FY2014 or FY2015. Many of these provisions authorize annual appropriations of specified amounts for one or more fiscal years to carry out the program. Other provisions authorize the appropriation of specified amounts for FY2010 or FY2011, and unspecified amounts—such sums as may be necessary, or SSAN—for later years. A few provisions authorize multi-year appropriations, available for obligation for a period in excess of one fiscal year (e.g., for the period FY2011 through FY2014). Numerous other provisions simply authorize the appropriation of SSAN, in a few cases without specifying any fiscal years.

The ACA also was a convenient legislative vehicle to reauthorize funding—in most instances through FY2014 or FY2015—for many *existing* discretionary grant programs, primarily ones authorized under the Public Health Service Act (PHSA). They include most, but not all, of the health workforce education and training programs administered by the Health Resources and Services Administration (HRSA). The authorizations of appropriations for many of these established programs had expired prior to the ACA, though most of them were continuing to receive annual funding. Importantly, the ACA permanently reauthorized appropriations for the federal health centers program, the National Health Service Corp (NHSC), and many programs and services provided by the Indian Health Service (IHS).[7]

All the ACA's discretionary spending provisions that include authorizations of appropriations are summarized in a series of tables below. The provisions are organized by general topic under the following headings: Health Centers and Clinics (**Table 2**); Health Care Workforce (**Table 3**); Prevention and Wellness (**Table 4**); Maternal and Child Health (**Table 5**); Health Care Quality (**Table 6**); Nursing Homes (**Table 7**); Health Disparities Data Collection (**Table 8**); Emergency Care (**Table 9**); Elder Justice (**Table 10**); Biomedical Research (**Table 11**); Biologics (**Table 12**); 340B Drug Pricing (**Table 13**); Medical Malpractice (**Table 14**); Pain Care Management (**Table 15**); Medicaid (**Table 16**); Medicare (**Table 17**); and Private Health Insurance (**Table 18**).

Each table row provides information on a specific ACA provision, organized across four columns. The first column shows the ACA section or subsection number. The second column indicates whether the provision is *freestanding* (i.e., new statutory authority that is not amending an existing statute) or *amendatory* (i.e., amends an existing statute such as the PHSA). Amendatory provisions either add a new program to the statute or modify an existing one. The name of the administering agency or office within HHS is also included, if known. The third column provides

[5] Most of the federal government is currently operating under a FY2017 continuing appropriations act (P.L. 114-254, Division A), which provides funding through April 28, 2017, generally at the levels of—and under the terms and conditions of—the FY2016 appropriations acts, minus an across-the-board reduction of 0.1901%.

[6] CRS Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA)*, by C. Stephen Redhead.

[7] The ACA reauthorized the Indian Health Care Improvement Act (IHCIA), which includes many discretionary Indian Health Service (IHS) programs and services, and it extended indefinitely the authorizations of appropriations for these programs and services. For more information on ACA's Indian health provisions, which are not included in this report, see CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*, by Elayne J. Heisler.

a brief description of the program, including the types of entities and/or individuals eligible for funding,[8] and gives details of the authorization of appropriations.

Finally, the fourth column shows the program's actual funding levels for FY2010 through FY2016 if it received any discretionary appropriations (or other funding) during that period.[9] Many of the programs have seen their discretionary funding remain flat or decrease since FY2010. Funding from sources other than annual discretionary appropriations (e.g., ACA mandatory funds) is shown in parentheses. Unless otherwise noted, the funding figures represent final amounts reflecting sequestration and other adjustments. The FY2017 funding request, if applicable, is also provided.[10]

Acronyms Used in the Tables in This Report

Agency for Healthcare Research and Quality (AHRQ)
Centers for Disease Control and Prevention (CDC)
Centers for Medicare and Medicaid Services (CMS)
Community Health Center Fund (CHCF)
Federal Food, Drug, and Cosmetic Act (FFDCA)
Food and Drug Administration (FDA)
Health Resources and Services Administration (HRSA)
Indian Health Service (IHS)
National Institutes of Health (NIH)
Office of Personnel Management (OPM)
Office of the Secretary (OS)
Prevention and Public Health Fund (PPHF)
Public Health Service Act (PHSA)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Social Security Act (SSA)

All the discretionary funding listed in the tables in this report is provided by the Departments of Labor, Health and Human Services, and Education, and Related Agencies (L-HHS-ED) annual appropriations act. If CRS was unable to identify specific appropriations for a program, then that is indicated by the phrase "No appropriations identified." In some instances a program may be supported with funds from another budget account.

In each of the larger tables with multiple entries (i.e., **Tables 2, 3, 4, 6** and **9**), the ACA provisions are grouped based on whether they reauthorize funding for existing programs or authorize funding for new programs. Where available, the table entry includes the Catalog of Federal Domestic Assistance (CFDA) number for the grant program.[11] Unless otherwise stated, all references in the tables to the Secretary refer to the HHS Secretary.

Annual Appropriation Amounts to Date

The Congressional Budget Office (CBO) estimated that fully funding the discretionary grant programs authorized (or reauthorized) by the ACA, based on the amounts specified in the authorizations of appropriations, would result in appropriations of almost $100 billion over the period FY2012-FY2021.[12] Three programs—the health centers program, the NHSC, and the

[8] Not applicable if the funding is to support programs and activities carried out by the federal agency.

[9] The funding amounts in the tables are taken from HHS agency budget documents available at http://www.hhs.gov/budget/.

[10] The President released the FY2017 budget on February 9, 2016.

[11] CFDA is a government-wide compendium of federal grant and other assistance programs. Each program is assigned a unique five-digit number, XX.XXX, where the first two digits represent the funding agency and the second three digits represent the program. Programs funded by the Department of Health and Human Services begin with the number 93. For more information, see https://www.cfda.gov.

[12] U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," Statement of Douglas W. Elmendorf, Director, 112th Cong., 1st sess., March 30, 2011. Available at http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf. See p. 16. CBO's estimate of ACA discretionary spending includes (1) amounts specified in ACA, plus estimated (continued...)

IHS—account for about $85 billion of that total amount. These programs were in existence prior to the ACA and were permanently reauthorized by the law.

An examination of the tables in this report, however, shows that the total amount of discretionary funding provided to date falls well below CBO's estimate. There are two reasons for this discrepancy. The first reason is that few of the new grant programs authorized by the ACA have received any discretionary appropriations,[13] though a handful have received mandatory funds from the ACA's Prevention and Public Health Fund (PPHF).[14] In most instances, the Administration has not requested discretionary funding for these programs, nor have the appropriators provided any funds. Under the current statutory limits (caps) on discretionary spending (see **Appendix A**), appropriators may find it difficult to fund new programs if they wish to maintain funding levels for long-standing programs with an established appropriations history.

The second reason is that programs that were reauthorized by the ACA generally have received discretionary appropriations at levels well below the amounts authorized in the law. The federal health center program (see **Table 2**) and the NHSC (see **Table 3**) are particularly noteworthy in this regard. These programs have seen a significant reduction in their discretionary appropriations since FY2010, despite the fact that the ACA authorized the appropriation of steadily increasing amounts during this period. Both programs also are receiving substantial mandatory funding from the ACA's Community Health Center Fund (CHCF). CHCF funds have become the sole source of funding for the NHSC, which has not received an annual discretionary appropriation since FY2011. In addition, PPHF funds have supplemented, and in some cases replaced, annual discretionary appropriations for a number of established programs, including ones that were reauthorized by the ACA.[15]

Expired Authorizations of Appropriations

It was noted earlier that the ACA generally authorized (or reauthorized) discretionary appropriations through FY2014 or FY2015. As a result, most of the programs discussed in this report now have expired authorizations of appropriations; four programs have been reauthorized.[16] One ACA program, which never received any funding, has been repealed.[17] A list of all the currently expired programs is provided in **Table B-1** in **Appendix B**.

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amounts for subsequent years (adjusted for anticipated inflation) where ACA specified an amount for the first year (FY2010 or FY2011) and authorized SSAN for subsequent years; and (2) estimated amounts for subsequent years (adjusted for anticipated inflation) where there is an appropriation for FY2010 under prior law and ACA authorized the appropriation of SSAN for later years. The CBO estimate *does not* include new ACA programs for which the law provided only an authorization for the appropriation of SSAN.

[13] Examples of programs that have received discretionary funding include CDC's congenital heart disease and breast health awareness programs (see **Table 4**) and the Cures Acceleration Network (CAN) program at NIH (see **Table 11**).

[14] These programs include (1) Sec. 5208, Nurse-Managed Health Clinics, see **Table 2**; (2) Sec. 5306, Mental and Behavioral Health Education and Training Grants, see **Table 3**; (3) Sec. 5102, State Health Care Workforce Development Grants, see **Table 3**; (4) Sec. 4201, Community Transformation Grants, see **Table 4**; (5) Sec. 10408, Small Business Workplace Wellness Grants, see **Table 4**; and (6) Sec. 10501(g), National Diabetes Prevention Program, see **Table 4**.

[15] These programs include (1) Sec. 5301, Primary Care Training and Enhancement Program, see **Table 3**; (2) Sec. 10501(m)(2), Public Health and Preventive Medicine Programs, see **Table 3**; (3) Sec. 4003, Clinical and Community Preventive Services Task Forces, see **Table 4**; and (4) Sec. 4204, Immunizations Programs, see **Table 4**.

[16] These programs are (1) Sec. 5306, Mental and Behavioral Health Education and Training Grants, see **Table 3**; (2) Sec. 10413, Young Women's Breast Health Awareness, see **Table 4**; (3) Sec. 5604, Co-locating Primary and Specialty Care in Community-Based Mental Health Settings, see **Table 6**; and (4) Sec. 5603, Children's Emergency Medical (continued...)

ACA Administrative Spending

CMS and the IRS are incurring significant administrative costs to implement the ACA. Both agencies have requested an increase in their annual appropriations in each of the past five years (i.e., FY2013-FY2017) to help cover those costs. But Congress has repeatedly denied their requests for additional discretionary funding for ACA implementation.

CMS has instead relied on funding from a variety of sources to support the development and operation of the federally facilitated exchange (FFE). **Table 1** shows total funding for FFE operations since FY2010.

Prior to FY2013, CMS used discretionary funding from its Program Management account—supplemented by a small amount of discretionary funding from the HHS Departmental Management account—for FFE development. The agency also used mandatory funds from the Health Insurance Reform Implementation Fund (HIRIF), which is administered by the HHS Secretary. The ACA established the HIRIF and appropriated $1 billion to it to help pay for administration of the law.

Table 1. CMS Funding for Federally Facilitated Exchange Operations

Dollars in Millions, by Fiscal Year

Funding Source	2010	2011	2012	2013	2014	2015	2016 Est.	2017 Est.
All Sources	5	125	325	1,543	2,032	2,145	1,998	2,145
User Fees (non-add)					*252*	*888*	*1,225*	*1,604*

Source: Table prepared by CRS based on data presented in CMS's Justification of Estimates for Appropriations Committees, FY2017, p. 361, available at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2017-CJ-Final.pdf.

In the FY2013 budget, CMS requested an increase of $1.001 billion for its Program Management account for FFE operations and other activities. Congress did not provide CMS with any additional discretionary funding that year, so the HHS Secretary tapped funds from other sources. They included (1) discretionary funds transferred from other HHS accounts under the Secretary's transfer authority;[18] (2) expired discretionary funds from the Nonrecurring Expenses Fund (NEF);[19] (3) mandatory funds from the HIRIF; and (4) mandatory funds from the PPHF.

In the FY2014 budget, CMS requested an increase of $1.397 billion for its Program Management account for FFE operations and other activities. Once again, Congress did not give CMS any additional funding. The agency relied on transferred departmental funds as well as NEF and

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Services Demonstration Grants, see **Table 9**.

[17] A grant program to establish centers of excellence for depression (ACA Sec. 10410) was repealed by P.L. 114-255; see **Table 6**.

[18] The L-HHS-ED Appropriations Act provides the HHS Secretary with limited authority to transfer funds between appropriations accounts. No more than 1% of the funds in any given account may be transferred, and recipient accounts may not be increased by more than 3%. Congressional appropriators must be notified in advance of any transfer.

[19] The Nonrecurring Expenses Fund is an account within the Department of the Treasury. The HHS Secretary is authorized to transfer to the NEF unobligated balances of expired discretionary funds. NEF funds are available until expended for use by the HHS Secretary for capital acquisitions including facility and information technology infrastructure. Congressional appropriators must be notified in advance of any planned use of NEF funds.

HIRIF funding to help support the FFE. However, Congress prevented—and continues to prevent—the use of PPHF funds by CMS. FY2014 was the first year in which CMS collected FFE user fees; a total of $252 million (see **Table 1**). Under the ACA, exchanges are permitted to charge participating insurance companies an assessment or user fee to support their operations.

In the FY2015 budget, CMS requested an increase of $227 million for its Program Management account to fund FFE operations and other activities. As in the previous two years, Congress denied the agency's request for additional funding. CMS collected $888 million in FFE user fees in FY2015 (see **Table 1**) to help support FFE operations. But with most of the HIRIF funds already obligated, and PPHF funds off limits, CMS appears to have relied largely on discretionary sources for the rest of the funding it needed for FFE operations.[20]

In the FY2016 budget, CMS requested an increase of $270 million for its Program Management account for FFE operations and other activities, none of which was provided by Congress. The agency collected an estimated $1.225 billion in FFE user fees, accounting for 61% of the agency's total funding for FFE operations (see **Table 1**).

CMS requested an increase of $135 million for its Program Management account in FY2017 for FFE operations and other activities.[21] The agency anticipates collecting approximately $1.604 billion in FFE user fees in FY2017, which will cover about cover about three-quarters of the estimated funding for FFE operations (see **Table 1**).

There are fewer details about the IRS's funding for ACA implementation. The IRS is responsible for administering the law's tax provisions, including the premium tax credit and other subsidies. However, the agency has not provided—or been instructed by Congress to provide—a breakdown of its spending on ACA implementation. Like CMS, the IRS requested additional funding for ACA implementation in each of the past five years: $360 million for FY2013, $440 million for FY2014, $436 million for FY2015, $474 million for FY2016, and $195 million for FY2017.[22] But, as with CMS, Congress has not given the IRS any additional funding. According to the HHS budget office, the department transferred to the IRS a total of $543 million in HIRIF funds over the FY2010-FY2016 period to help support ACA implementation.[23]

[20] CMS provided a table showing the various sources of funding for FFE operations, by fiscal year, in its Justification of Estimates for Appropriations Committees, FY2015, at http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2015-CJ-Final.pdf; see p. 349.

[21] Congress has yet to complete legislative action on the FY2017 appropriations bills.

[22] Details of the IRS's funding requests for ACA implementation are provided in the agency's budget documents for FY2013-FY2017 at http://www.treasury.gov/about/budget-performance/Pages/cj-index.aspx.

[23] Email from Claire Perkins, Office of the Secretary, HHS, January 17, 2017.

Table 2. ACA Discretionary Funding: Health Centers and Clinics

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
Health Centers: Existing Program			
5601	Reauthorizes PHSA Sec. 330 (HRSA)	**Health centers.** Permanently reauthorizes funding for the program that provides operating grants to health centers serving federally designated medically underserved populations and furnishing comprehensive primary care services, referrals, and other services needed to facilitate access to such care, regardless of ability to pay. Eligible grantees include community, migrant, public housing, and homeless health centers that meet the statutory requirements of PHSA Sec. 330. Authorizes the appropriation of $2,989 million for FY2010, $3,862 million for FY2011, $4,991 million for FY2012, $6,449 million for FY2013, $7,333 million for FY2014, $8,333 million for FY2015, and, for each subsequent fiscal year, an amount equal to the previous year's funding adjusted for any increase in the number of patients served and the per-patient costs. [CFDA 93.224, 93.527] Note: The ACA appropriated a total of $9.5 billion to the CHCF over the period FY2011-FY2015 for health center operations. It also appropriated $1.5 billion for health center construction and renovation. The Medicare Access and CHIP Reauthorization Act of 2017 (MACRA; P.L. 114-10) appropriated two years of additional CHCF funding (FY2016-FY2017) for health center operations. See CRS Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA).*	FY2010 = $2,185 million[a] FY2011 = $1,581 million[a] (+ $1,000 million CHCF) FY2012 = $1,567 million[a] (+ $1,200 million CHCF) FY2013 = $1,479 million[a] (+ $1,465 million CHCF) FY2014 = $1,492 million[a] (+ $2,145 million CHCF) FY2015 = $1,492 million[a] (+ $3,509 million CHCF) FY2016 = $1,492 million[a] (+ $3,600 million CHCF) FY2017 req. = $1,342 million[a] (+ $3,600 million CHCF)
Health Centers and Clinics: New Programs			
4101(b)	New PHSA Sec. 399Z-1 (HRSA)	**School-based health centers (SBHCs).** Requires the Secretary to award grants to fund the management and operation of SBHCs that provide comprehensive physical and behavioral health services to children and adolescents, subject to parental consent. SBHCs must meet certain specified criteria and match 20% of the grant amount with non-federal funds (unless waived). Preference may be given to SBHCs serving children and adolescents who have limited access to or difficulty accessing health care. Authorizes the appropriation of SSAN for each of FY2010 through FY2014.	No appropriations identified. Note: The ACA appropriated a total of $200 million for SBHC construction and renovation. For more information on the ACA's mandatory appropriations, see CRS Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA)*.
5208	New PHSA Sec. 330A-1 (HRSA)	**Nurse-managed health clinics (NMHCs).** Requires the Secretary to award grants to fund the operation of NMHCs—associated with schools, colleges, federally qualified health centers (FQHCs), or nonprofit health/social services agencies—that provide comprehensive primary health care and wellness services to vulnerable or underserved populations regardless of income or insurance status. At least one advanced practice nurse must hold an executive management position in the NMHC. Authorizes the appropriation of $50 million for FY2010, and SSAN for each of FY2011 through FY2014. [CFDA 93.515]	FY2010 = $15 million (all PPHF) No appropriations identified for FY2011-FY2017.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
10504	New freestanding authority (HRSA)	**Access to affordable care demonstration program.** Within six months of enactment, requires the Secretary to establish a three-year demonstration project in up to 10 states—each state may receive up to $2 million—to provide access to comprehensive health care services to the uninsured. Eligible grantees must be state-based, nonprofit, public-private partnerships that provide access to comprehensive health care services to the uninsured at reduced fees. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.

Sources: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from HRSA's budget documents, available at http://www.hrsa.gov/about/budget/index.html.

Note: For more information on health centers, see CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

a. Annual appropriations for health centers include the following amounts for the Federal Tort Claims Act (FTCA) program: FY2010 = $44 million; FY2011 = $100 million; FY2012 = $95 million; FY2013 = $89 million; FY2014 = $95 million; FY2015 = $100 million; FY2016 = $100 million; FY2017 req. = $100 million. Under the FTCA, health center employees and contractors are considered federal employees and are immune from medical malpractice lawsuits while acting within the scope of their employment. The federal government assumes responsibility for such malpractice claims.

Table 3. ACA Discretionary Funding: Health Care Workforce

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
National Health Service Corps (NHSC)			
5207	Reauthorizes PHSA Title III, Part D, Subpart III (HRSA)	**NHSC scholarships and loan repayments.** Permanently reauthorizes funding for the NHSC program. In exchange for a commitment to work in a federally designated Health Professional Shortage Area (HPSA), the program provides (1) scholarships to students training in a primary care discipline to cover tuition, fees, other educational costs, and a stipend; and (2) student loan repayments of up to $50,000 a year to primary care and mental health clinicians. To be eligible for a scholarship, a student must be accepted or enrolled in a training program for medicine, dentistry, family nurse practitioner, nurse midwife, or physician assistant, and agree to two to four years of service in an NHSC-approved site in a HPSA. Loan repayments are for primary care, dental, and mental health clinicians who agree to at least two years of service in an NHSC-approved site in a HPSA. Authorizes the appropriation of $320 million for FY2010, $414 million for FY2011, $535 million for FY2012, $691 million for FY2013, $893 million for FY2014, and $1,155 billion for FY2015; amounts in subsequent years based on previous year's funding, subject to adjustment. [CFDA 93.162, 93.288, 93.547] Note: The ACA appropriated a total of $1.5 billion to the CHCF over the period FY2011-FY2015 for the NHSC. MACRA (P.L. 114-10) appropriated two years of additional CHCF funding (FY2016-FY2017) for the NHSC. See CRS Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA).*	FY2010 = $141 million FY2011 = $25 million (+ $290 million CHCF) FY2012 = $295 million (all CHCF) FY2013 = $285 million (all CHCF) FY2014 = $283 million (all CHCF) FY2015 = $287 million (all CHCF) FY2016 = $310 million (all CHCF) FY2017 req. = $20 million (+ $310 million CHCF + $50 million in proposed new mandatory funds)
Physicians: Existing Program			
5301	Amends and reauthorizes PHSA Sec. 747 (HRSA)	**Primary care training and enhancement program.** (1) Authorizes five-year grants to public and nonprofit private hospitals, medical schools, academically affiliated physician assistant training programs, and other public and nonprofit private entities to support training programs in primary care fields. (2) Authorizes five-year grants to medical schools for primary care capacity building. Funds are to be used to create academic units or programs that improve clinical teaching in the primary care fields, and (in a separate authorization) to integrate academic units to enhance interdisciplinary recruitment, training, and faculty development. Funding priority given to entities proposing innovative approaches to primary care training, among other things. For both grant programs, authorizes the appropriation of $125 million for FY2010, and SSAN for each of FY2011 through FY2014. Note: 15% of the amount appropriated must be used for physician assistant training programs. Separately, authorizes the appropriation of $750,000 for each of FY2010 through FY2014 for capacity building grants to integrate academic units. [CFDA 93.510, 93.514, 93.884]	FY2010 = $39 million (+ $198 million PPHF) FY2011 = $39 million FY2012 = $39 million FY2013 = $37 million FY2014 = $37 million FY2015 = $39 million FY2016 = $39 million FY2017 req. = $39 million

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
Physicians: New Programs			
5203	New PHSA Sec. 775 (HRSA)	**Pediatric specialist loan repayment program.** Requires the Secretary to implement a loan repayment program that pays up to $35,000 for each year of service (for a maximum of three years) to practicing or in-training pediatric specialists and surgeons, as well as child and adolescent mental health specialists, who agree to at least two years of service in a HPSA. Authorizes the appropriation of $30 million for each of FY2010 through FY2014 for loan repayments to pediatric specialists and surgeons, and $20 million for each of FY2010 through FY2013 for loan repayments to mental health providers.	No appropriations identified.
5508(a)	New PHSA Sec. 749A (HRSA)	**Teaching health centers development grants.** Authorizes three-year grants of up to $500,000 to FQHCs, rural health clinics, Indian health centers, and entities receiving PHSA Title X (family planning) funds that establish or expand a primary care residency training program. Authorizes the appropriation of $25 million for FY2010, $50 million for each of FY2011 and FY2012, and SSAN for each fiscal year thereafter.	No appropriations identified.
10501(l)	New PHSA Sec. 749B (HRSA)	**Rural physician training grants.** Requires the Secretary to (1) award grants to medical schools for recruiting students most likely to practice in underserved rural communities and for providing rural-focused training and experience; and (2) within 60 days of enactment, by regulation, define underserved rural communities. Priority is given to entities that train students to practice in rural communities, that have established partnerships with rural community health centers, or who submit a long-term plan for tracking where graduates practice. Note: HRSA published an interim final rule on May 26, 2010 (75 *Federal Register* 29447). Authorizes the appropriation of $4 million for each of FY2010 through FY2013.	No appropriations identified.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
Dentistry: Existing Program			
5303	New PHSA Sec. 748; authority previously part of Sec. 747 (HRSA)	**General, pediatric, and public health dentistry training.** Authorizes grants or contracts to dental and dental hygiene schools, as well as approved residency or advanced education programs in general, pediatric, or public health dentistry, for dental training activities including faculty development, financial assistance, faculty loan repayment programs, technical assistance for pediatric dental programs, and pre- and post-doctoral training programs in dental primary care. Gives priority to entities that train individuals from disadvantaged backgrounds, who have a record of placing graduates in facilities that provide care to the underserved, or whose programs focus on providing care to the underserved through demonstrated partnerships with FQHCs, rural health clinics, or through having programs focused on specific topics, such as HIV/AIDs. Authorizes the appropriation of $30 million for FY2010, and SSAN for each of FY2011 through FY2015. Permits grantees to carry over funds for up to three fiscal years. [CFDA 93.059, 93.884]	FY2010 = $15 million FY2011 = $17 million FY2012 = $20 million FY2013 = $20 million FY2014 = $21 million FY2015 = $21 million FY2016 = $22 million FY2017 req. = $22 million Note: HRSA also administers a state oral health workforce grant program (PHSA Sec. 340G): FY2010 = $17 million; FY2011 = $16 million; FY2012 = $12 million; FY2013 = $11 million; FY2014 = $11 million; FY2015 = $13 million; FY2016 = $14 million; FY2017 req. = $14 million. CFDA 93.236
Dentistry: New Program			
5304	New PHSA Sec. 340G-1 (HRSA)	**Alternative dental health care provider demonstration program.** Authorizes the Secretary to award 15 five-year grants of not less than $4 million to train or employ alternative dental health care providers (e.g., community dental health coordinators, dental health aides) to increase access to dental health care services in rural and other underserved communities. Eligible grantees include institutions of higher education; public-private entities; FQHCs; facilities operated by the IHS or by Indian tribes or organizations; state or county public health clinics; public hospitals or health systems; and accredited dental education programs. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified. Note: A provision in the L-HHS-ED appropriations act for each of the six most recent fiscal years (i.e., FY2011-FY2016) prohibits HRSA from funding this new demonstration program. The prohibition remains in effect under the Continuing Appropriations Act, 2017.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
Nursing: Existing Programs			
5309(a)	Amends and reauthorizes PHSA Sec. 831 (HRSA)	**Nurse education, practice, quality, and retention program.** Authorizes grants or contracts to expand enrollment in baccalaureate nursing programs; provide training in new technologies; develop cultural competencies; expand nursing practice arrangements in non-institutional settings; and support nurse retention programs that offer career advancement for nursing personnel, enhance collaboration among nurses and other health professionals, and promote nurse involvement in clinical decisionmaking. Eligible grantees include nursing schools, health care facilities (including NMHCs), or partnerships of the two. Authorizes the appropriation of SSAN for each of FY2010 through FY2014. See also ACA Sec. 5312 below, which authorizes appropriations for several Title VIII nursing education programs including Sec. 831. [CFDA 93.359, 93.503]	FY2010 = $40 million FY2011 = $40 million FY2012 = $40 million FY2013 = $37 million FY2014 = $38 million FY2015 = $40 million FY2016 = $40 million FY2017 req. = $40 million
5311(a)	Amends and reauthorizes PHSA Sec. 846A (HRSA)	**Nursing faculty loan program.** Authorizes loans to nursing school students pursuing advanced degrees to become qualified nursing faculty. Sets the annual loan limit at $35,500 for FY2010 and FY2011; for subsequent fiscal years, the loan limit is subject to a cost-of-attendance adjustment. Students who go on to serve as nursing school faculty may have up to 85% of their loan repayment cancelled. Authorizes the appropriation of SSAN for each of FY2010 through FY2014. [CFDA 93.264]	FY2010 = $25 million FY2011 = $25 million FY2012 = $25 million FY2013 = $23 million FY2014 = $25 million FY2015 = $27 million FY2016 = $27 million FY2017 req. = $27 million

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
5312	Amends PHSA Sec. 871; previously Sec. 841 (HRSA)	**Authorization of appropriations.** Authorizes the appropriation of $338 million for FY2010, and SSAN for each of FY2011 through FY2016, for the nursing workforce programs authorized under PHSA Secs. 811, 821, 831, and new 831A (see ACA Sec. 5309(b) below: • Sec. 811: Advanced nursing education—grants to accredited programs for advanced nurse education including combined registered nurse master's degree programs, authorized nurse practitioner programs, accredited nurse midwifery programs, and accredited nurse anesthesia programs. [CFDA 93.124, 93.247, 93.358, 93.513] • Sec. 821: Nursing workforce diversity—grants to nursing schools, academic health centers, state or local governments, and other appropriate public or private nonprofit entities for stipends and scholarships so as to increase nursing education opportunities for disadvantaged individuals. [CFDA 93.178] • Sec. 831: Nurse education, practice, quality, and retention—see ACA Sec. 5309(a) above. Note: ACA did not reauthorize funding for the nursing education loan repayment and scholarship programs authorized under PHSA Sec. 846.[a]	Funding for Sec. 811: FY2010 = $64 million FY2011 = $64 million FY2012 = $63 million FY2013 = $60 million FY2014 = $61 million FY2015 = $64 million FY2016 = $65 million FY2017 req. = $65 million Funding for Sec. 821: FY2010 = $16 million FY2011 = $16 million FY2012 = $16 million FY2013 = $15 million FY2014 = $16 million FY2015 = $15 million FY2016 = $15 million FY2017 req. = $15 million See ACA Sec. 5309(a) above for funding for the Sec. 831 program.
Nursing: New Programs			
5309(b)	New PHSA Sec. 831A (HRSA)	**Nurse retention program.** New authority that largely duplicates the nurse retention grant program authorized under PHSA Sec. 831; see ACA Sec. 5309(a) above. Authorizes the appropriation of SSAN for each of FY2010 through FY2012. Note: ACA Sec. 5312 also authorizes appropriations for this new program; see above.	No appropriations identified.
5311(b)	New PHSA Sec. 847 (HRSA)	**Nursing faculty loan repayment program.** Authorizes a loan repayment program for qualified nursing students or graduates who agree to serve as nursing faculty for four to six years. Sets the annual loan limit for FY2010 and FY2011 at $10,000 for individuals with a master's or equivalent degree in nursing ($20,000 for those with a doctorate or equivalent degree in nursing), and an aggregate loan limit of $40,000 for individuals with a master's or equivalent degree in nursing ($80,000 for those with a doctorate or equivalent degree in nursing). Thereafter, the annual and aggregate loan limits are subject to a cost-of-attendance adjustment. Authorizes the appropriation of SSAN for each of FY2010 through FY2014.	No appropriations identified.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
5316	New freestanding authority	**Family nurse practitioner demonstration program.** Requires the Secretary to award three-year demonstration grants to FQHCs and NMHCs, not to exceed $600,000 a year, for programs to train nurse practitioners as primary care providers (as defined in ACA Sec. 5208). Preference given to bilingual individuals. Authorizes the appropriation of SSAN for each of FY2011 through FY2014.	No appropriations identified.
Geriatrics and Long-Term Care: Existing Program			
5305(c)	Amends and reauthorizes PHSA Sec. 865; previously Sec. 855 (HRSA)	**Comprehensive geriatric education program.** Provides grants for traineeships for individuals preparing for advanced degrees in geriatric nursing or other nursing areas that specialize in elder care. Eligible grantees include nursing schools, health care facilities, programs leading to certification as a certified nurse assistant, and partnerships of such schools, facilities, and programs. Authorizes the appropriation of SSAN for each of FY2010 through FY2014. [CFDA 93.265]	FY2010 = $5 million FY2011 = $5 million FY2012 = $4 million FY2013 = $4 million FY2014 = $4 million FY2015 = $5 million Note: In FY2015, HRSA combined the Comprehensive Geriatric Education Program with the other existing geriatric education and training programs authorized by PHSA Sec. 753; see below.
Geriatrics and Long-Term Care (LTC): New Programs			
5302	New PHSA Sec. 747A (HRSA)	**Direct care worker training.** Requires the Secretary to establish a grant program to provide new training opportunities, such as tuition and fee assistance, for direct care workers employed in LTC settings. Individuals who receive assistance are required to work in the field of geriatrics, disability services, LTC services and supports, or chronic care management for a minimum of two years. Eligible grantees include institutions of higher education that have an established partnership with an LTC entity, as specified. Authorizes the appropriation of $10 million for the period FY2011 through FY2013.	No appropriations identified.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
5305(a)	Amends PHSA Sec. 753 by adding new subsections (d)-(e) (HRSA)	**Geriatric workforce development; geriatric career incentive awards.** Sec. 753(d) requires the Secretary to award no more than 24 grants or contracts for $150,000 to entities that operate geriatric education centers to support short-term intensive courses on geriatrics and LTC, and support training for family caregivers and direct care workers. Eligible grantees include accredited schools of allied health, medicine, nursing, dentistry, osteopathic medicine, optometry, podiatric medicine, veterinary medicine, public health, or chiropractic care; accredited graduate programs in clinical psychology, clinical social work, health administration, marriage and family therapy, and counseling; and physician assistant programs. Sec. 753(e) requires the Secretary to award grants or contracts to advance practice nurses, clinical social workers, pharmacists, and psychologists pursuing an advanced degree in geriatrics or a related field, in return for agreeing to teach or practice in the field of geriatrics, LTC, or chronic care management for a minimum of five years upon completion of the degree. Authorizes the appropriation of $10.8 million for the period FY2011 through FY2014 for Sec. 753(d), and $10 million for the period FY2011 through FY2013 for Sec. 753(e). [CFDA 93.156, 93.250, 93.969]	No appropriations identified. Note: The three existing geriatric education and training programs authorized under PHSA Sec. 753(a)-(c) (i.e., Geriatric Education Centers, the Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals Program, and the Geriatric Academic Career Awards Program), which support activities that are broadly comparable to the new programs authorized by the ACA, have received the following amounts: FY2010 = $34 million; FY2011 = $34 million; FY2012 = $31 million (+ $2 million PPHF), FY2013 = $29 million (+ $2 million PPHF); FY2014 = $33 million; FY2015 = $34 million; FY2016 = $39 million; FY2017 req. = $39 million. In FY2015, HRSA combined these three programs and the Comprehensive Geriatric Education Program (see above) into one new program, the Geriatric Workforce Enhancement Program.
Pain Care: New Program			
4305(c)	New PHSA Sec. 759 (HRSA)	**Education and training in pain care.** Authorizes a grant program to train health professionals in pain care. Eligible grantees include health professions schools, hospices, and other public and private entities. Applicants must agree to include training and education on recognizing the signs and symptoms of pain; applicable laws and policies on controlled substances; interdisciplinary approaches to pain care delivery; barriers to care in underserved populations; and recent developments in pain care. Authorizes the appropriation of SSAN for each of FY2010 through FY2012, to remain available until expended. [See also **Table 15**.]	No appropriations identified.
Public Health: Existing Programs			
10501(m)(2)	Amends PHSA Sec. 770 (HRSA)	**Public health and preventive medicine programs.** Reauthorizes funding for the public health workforce programs authorized under PHSA Secs. 765-769. They include grants for public health training centers; tuition, fees, and stipends for traineeships in public health and in health administration; and residency programs in preventive medicine and dental public health. Several programs mention preference for underserved communities or underrepresented minorities. Eligible grantees include accredited academic institutions, as well as state, local, and tribal public health departments. Authorizes the appropriation of $43 million for FY2011, and SSAN for each of FY2012 through FY2015. [CFDA 93.117, 93.249, 93.516, 93.964]	FY2010 = $10 million (+ $15 million PPHF) FY2011 = $10 million (+ $20 million PPHF) FY2012 = $8 million (+ $25 million PPHF) FY2013 = $8 million FY2014 = $18 million FY2015 = $21 million FY2016 = $21 million FY2017 req. = $17 million

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
Public Health: New Programs			
5204	New PHSA Sec. 776 (HRSA)	**Public health workforce loan repayment program.** Requires the Secretary to establish a student loan repayment program that pays up to $35,000 a year, or one-third of total debt, whichever is less, to increase the supply of public health professionals. Eligible individuals must agree to work for at last three years in a public health agency or related training fellowship. Authorizes the appropriation of $195 million for FY2010, and SSAN for each of FY2011 through FY2015.	No appropriations identified.
5206(b)	New PHSA Sec. 777 (HRSA)	**Public health and allied health scholarship program.** Authorizes grants to accredited institutions for scholarships to help support the training of mid-career professionals in public health and allied health. Available grant funds are to be divided 50:50 between supporting public health and allied health professionals. Authorizes the appropriation of $60 million for FY2010, and SSAN for each of FY2011 through FY2015.	No appropriations identified.
5313	New PHSA Sec. 399V (CDC)	**Community health worker (CHW) program.** Requires CDC to award grants to promote healthy behaviors and outcomes for populations in medically underserved communities through programs of training and supervision of CHWs. Eligible grantees include states and subdivisions, health departments, free clinics, hospitals, and FQHCs. Priority is to be given to applicants that target areas with a high proportion of uninsured or underinsured individuals, or with high rates of chronic illness or infant mortality. Authorizes the appropriation of SSAN for each of FY2010 through FY2014.	No appropriations identified.
5314	New PHSA Sec. 778 (CDC)	**CDC training fellowships.** Authorizes the Secretary to expand existing CDC training fellowships in epidemiology, laboratory science, and informatics; the Epidemic Intelligence Service (EIS); and other training programs that meet similar objectives. Participants may be placed in state and local health agencies, and states can receive federal assistance for loan repayment programs for such participants. Authorizes the appropriation of $39.5 million for each of FY2010 through FY2013 ($24.5 million for EIS, and $5 million each for epidemiology, laboratory science, and informatics). [CFDA 93.065]	Funding for CDC's public health workforce and career development programs: FY2010 = $38 million (+ $7 million PPHF) FY2011 = $36 million (+ $25 million PPHF) FY2012 = $36 million (+ $25 million PPHF) FY2013 = $48 million (+ $16 million PPHF) FY2014 = $52 million FY2015 = $52 million FY2016 = $52 million FY2017 req. = $21 million (+ $36 million PPHF)

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
5315	New PHSA Title II, Part D—Secs. 271-274 (U.S. Surgeon General)	**United States Public Health Sciences Track.** Authorizes the establishment of a science track at academic sites selected by the Secretary to award degrees that emphasize team-based service, public health, epidemiology, and emergency preparedness/response. Funds may be used for program development and for tuition and stipends for students who meet a service obligation, including in the United States Public Health Service (USPHS) Commissioned Corps. Requires the Secretary to transfer SSAN from the Public Health and Social Services Emergency Fund for FY2010 and each fiscal year thereafter. Note: P.L. 112-10 prohibited any such transfer of funds.[b]	No appropriations identified.
5210	Amends PHSA Sec. 203 (U.S. Surgeon General)	**USPHS Commissioned Corps.** Establishes a Ready Reserve Corps of officers who are subject to involuntary call to active duty (and training) by the Surgeon General, in order to bolster the available workforce for both routine and emergency public health missions. Authorizes the appropriation of $17.5 million for each of FY2010 through FY2014 ($5 million for recruitment and training, $12.5 million for the Ready Reserve Corps).	No appropriations identified.
Workforce Diversity, Health Disparities, Cultural Competency: Existing Programs			
5307(a)	Amends and reauthorizes PHSA Sec. 741 (HRSA)	**Cultural competency, prevention, public health, disparities, and individuals with disability training.** Authorizes grants, contracts, or cooperative agreements for the development and evaluation of research, demonstration projects, and model curricula that provide training in cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities. Requires the Secretary to coordinate this program with the one authorized under PHSA Sec. 807 (see below). Authorizes the appropriation of SSAN for each of FY2010 through FY2015.	No appropriations identified.
5307(b)	Amends and reauthorizes PHSA Sec. 807 (HRSA)	**Cultural competency, prevention, public health, disparities, and individuals with disability training.** Authorizes grants, contracts, or cooperative agreements for the development and evaluation of research, demonstration projects, and model curricula that provide training in cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities. The Secretary is required to coordinate this program with the one authorized under PHSA Sec. 741 (see above). Authorizes the appropriation of SSAN for each of FY2010 through FY2015.	No appropriations identified.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
5401	Amends and reauthorizes PHSA Sec. 736 (HRSA)	**Centers of excellence (COE).** Requires the Secretary to fund COEs at health professions schools that recruit, enroll, and graduate underrepresented minorities or that recruit underrepresented minorities serving in faculty or administrative positions. Authorizes the appropriation of $50 million for each of FY2010 through FY2015, and SSAN for each subsequent fiscal year. [CFDA 93.157]	FY2010 = $25 million FY2011 = $24 million FY2012 = $23 million FY2013 = $21 million FY2014 = $22 million FY2015 = $22 million FY2016 = $22 million FY2017 req. = $22 million
5402	Amends PHSA Sec. 740 (HRSA)	**Authorization of appropriations.** Authorizes appropriations for the workforce diversity programs authorized under PHSA Secs. 737, 738, and 739: • Authorizes the appropriation of $51 million for FY2010, and SSAN for each of FY2011 through FY2014, for Sec. 737, Scholarships for Disadvantaged Students, which provides grants to health professions schools for awarding scholarships to students from disadvantaged backgrounds with financial need. [CFDA 93.925] • Authorizes the appropriation of $5 million for each of FY2010 through FY2014 for Sec. 738, Faculty Loan Repayment Program, which helps repay loans for health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college for at least two years. [CFDA 93.923] • Authorizes the appropriation of $60 million for FY2010, and SSAN for each of FY2011 through FY2014 for Sec. 739, Health Careers Opportunity Program, which provides grants to health professions schools and other educational institutions to improve recruitment and academic preparation of students from disadvantaged backgrounds. [CFDA 93.822]	Funding for Sec. 737: FY2010 = $49 million FY2011 = $49 million FY2012 = $47 million FY2013 = $44 million FY2014 = $45 million FY2015 = $46 million FY2016 = $46 million FY2017 req. = $49 million Funding for Sec. 738: FY2010 = $1 million FY2011 = $1 million FY2012 = $1 million FY2013 = $1 million FY2014 = $1 million FY2015 = $1 million FY2016 = $1 million FY2017 req. = $1 million Funding for Sec. 739: FY2010 = $22 million FY2011 = $22 million FY2012 = $15 million FY2013 = $14 million FY2014 = $14 million FY2015 = $14 million FY2016 = $14 million FY2017 req. = $14 million

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
5403(a)	Amends and reauthorizes PHSA Sec. 751 (HRSA)	**Area Health Education Centers (AHECs).** Requires the Secretary to award grants (with a matching requirement) to medical and nursing schools of at least $250,000 to (1) plan, develop, and operate AHEC programs; and (2) to maintain and improve the effectiveness of existing AHEC programs. AHECs recruit, train, and prepare individuals from minority populations or from disadvantaged or rural backgrounds to work in medically underserved areas. Authorizes the appropriation of $125 million for each of FY2010 through FY2014; funds may be carried over for up to three fiscal years. [CFDA 93.107, 93.824]	Funding for AHECs: FY2010 = $33 million FY2011 = $33 million FY2012 = $27 million FY2013 = $28 million FY2014 = $30 million FY2015 = $30 million FY2016 = $30 million FY2017 req. = $0
Workforce Diversity, Health Disparities, Cultural Competency: New Program			
5403(b)	New PHSA Sec. 752 (HRSA)	**Continuing educational support for health professionals serving in underserved communities.** Requires the Secretary to award grants to enhance education through distance learning, continuing education, collaborative conferences, and telehealth, with a focus on primary care. Eligible grantees include health professions schools, academic health centers, state or local governments, or other public or nonprofit entities participating in training activities. Authorizes the appropriation of $5 million for each of FY2010 through FY2014, and SSAN for each subsequent fiscal year. [CFDA 93.189]	No appropriations identified.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
Mental and Behavioral Health: New Program			
5306	Redesignates PHSA Sec. 756 as Sec. 757, and adds a new Sec. 756 (HRSA)	**Mental and behavioral health education and training grants.** Authorizes grants for the recruitment and education of students in social work, interdisciplinary psychology training, and internships or other field placement programs related to child and adolescent mental health. Priority for social work grants given to schools of social work meeting certain criteria such as recruiting from and placing graduates into areas with a high-need/high-demand population. Priority for psychology grants given to institutions focusing on the needs of specified vulnerable groups. Priority for grants to train professional and paraprofessional child/adolescent mental health workers given to programs designed to increase the number of such workers serving high-priority populations. Authorizes the appropriation of $35 million for the period of FY2010 through FY2013 (i.e., $8 million for training in social work, $12 million for training in graduate psychology, $10 million for training in professional child and adolescent mental health, and $5 million for training in paraprofessional child and adolescent mental health). [CFDA 93.732] Note: Section 9021 of the Helping Families in Mental Health Crisis Reform Act of 2016 (P.L. 114-255, Division B) amended PHSA Sec. 756 and authorized the appropriation of $50 million for each of FY2018 through FY2022; i.e., $10 million for training in social work, $15 million for training in graduate psychology, $15 million for training in professional mental health (incl. child and adolescent mental health), and $10 million for training in paraprofessional mental health (incl. child and adolescent mental health).	FY2012 = $10 million (all PPHF) No appropriations identified since FY2012. Note: (1) HRSA's mental and behavioral health education and training programs, which predate the ACA, received the following amounts: FY2010 = $3 million; FY2011 = $3 million; FY2012 = $3 million; FY2013 = $3 million; FY2014 = $8 million; FY2015 = $9 million; FY2016 = $10 million; FY2017 req. = $10 million. (2) SAMHSA received $35 million in FY2014 and in FY2015, and $50 million in FY2016, for the Behavioral Health Workforce Education and Training (BHWET) Program, a partnership with HRSA to expand the mental and behavioral health workforce. The FY2017 budget requests $56 million for BHWET, to be appropriated directly to HRSA.
Policy and Planning: Existing Program			
5103	Amends and reauthorizes PHSA Sec. 761 (HRSA)	**Health care workforce program assessment.** Requires the Secretary to establish a National Center for Health Care Workforce Analysis, award grants to support state and regional centers for health workforce analysis, and increase funding for longitudinal evaluations of specified individuals who have received education, training, or financial assistance from programs under PHSA Title VII. Authorizes the appropriation of the following amounts: $7.5 million for each of FY2010 through FY2014 for the National Center; $4.5 million for each of FY2010 through FY2014 for state and regional centers; and SSAN for FY2010 through FY2014 for the longitudinal evaluations. [CFDA 93.300]	FY2010 = $3 million FY2011 = $3 million FY2012 = $3 million FY2013 = $3 million FY2014 = $5 million FY2015 = $5 million FY2016 = $5 million FY2017 req. = $5 million Note: These amounts also include funding for PHSA Sec. 792 (health professions data) and Sec. 806 (nursing grant program data).

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
Policy and Planning: New Programs			
5101	New freestanding authority	**National Health Care Workforce Commission.** Establishes a 15-member commission focused on evaluating and meeting the need for health care workers in the United States. The commission is required to conduct studies, produce annual reports beginning in 2011, and make recommendations on high-priority topics related to the health care workforce. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.
5102	New freestanding authority (HRSA)	**State health care workforce development grants.** Establishes a matching grants program for state partnerships to plan and implement activities leading to coherent and comprehensive health care workforce development strategies at the state and local levels. Planning grants of up to $150,000 are for up to one year and require a 15% match. Implementation grants are for up to two years (with up to one additional year of funding) and require a 25% match. Authorizes the appropriation of $8 million for FY2010, and SSAN for each subsequent fiscal year, for planning grants; and $150 million for FY2010, and SSAN for each subsequent fiscal year, for implementation grants. [CFDA 93.509]	FY2010 = $6 million (all PPHF) No appropriations identified since FY2012.

Sources: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from HRSA's budget documents, available at http://www.hrsa.gov/about/budget/index.html.

a. The nursing education loan repayment program repays 60% of a registered nurse's educational loans in return for a two-year commitment to work in a health care facility with a critical shortage of nurses. Participants may have an additional 25% of their loan repaid in exchange for one more year of service. The nurse scholarship program offers scholarships to individuals attending nursing school in exchange for at least two years working in a health care facility with a critical shortage of nurses. Together the two programs, which are authorized under PHSA Sec. 846 and collectively known as NURSE Corps, received $94 million in FY2010, $93 million in FY2011, $83 million in FY2012, $78 million in FY2013, $80 million in FY2014, $82 million in FY2015, and $83 million in FY2016. The FY2017 request is for $83 million. The authorization of appropriations for Sec. 846 expired at the end of FY2007 and was not reauthorized by ACA or by any subsequent legislation.

b. The Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10, Div. B, Sec. 1828) prohibited the transfer of funds from the Public Health and Social Services Emergency Fund (PHSSEF) to support the U.S. Public Health Sciences Track. The PHSSEF is an HHS account administered by the Secretary. Congress has historically used the PHSSEF to provide one-time funding for non-routine activities. Each fiscal year, Congress appropriates amounts to the PHSSEF for specified purposes. ACA did not authorize or appropriate funds to the PHSSEF.

Table 4. ACA Discretionary Funding: Prevention and Wellness

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
Community-Based Prevention: Existing Programs			
3509/3511	New PHSA Secs. 229 (OS), 310A (CDC), 925 (AHRQ); new SSA Sec. 713 (HRSA); and new FFDCA Sec. 1011 (FDA). Amends PHSA Secs. 486(a) (NIH) and 501(f) (SAMHSA).	**Offices on Women's Health.** Establishes within OS an Office on Women's Health, headed by a Deputy Assistant Secretary for Women's Health, and transfers all functions and personnel from the existing Office on Women's Health of the Public Health Service to the new office. Requires the OS Office on Women's Health to establish an HHS Coordinating Committee on Women's Health and a National Women's Health Information Center, among other things. Authorizes the appropriation of SSAN for each of FY2010 through FY2014. Amends the existing authorities for NIH's Office of Research on Women's Health (ORWH) and SAMHSA's Associate Administrator for Women's Services by specifying that the ORWH director and the Associate Administrator are to report directly to the NIH Director and the SAMHSA Administrator, respectively. Authorizes the appropriation of SSAN (no years specified). Establishes Offices of Women's Health at CDC, AHRQ, and HRSA (and codifies the existing Office of Women's Health at FDA) to make recommendations regarding grant-making through other agency accounts. Authorizes the appropriation of SSAN for each of FY2010 through FY2014.	Funding for OS Office on Women's Health: FY2010 = $34 million FY2011 = $34 million FY2012 = $34 million FY2013 = $33 million FY2014 = $34 million FY2015 = $32 million FY2016 = $32 million FY2017 req. = $32 million Funding for NIH Office of Research on Women's Health: FY2010 = $43 million FY2011 = $42 million FY2012 = $42 million FY2013 = $40 million FY2014 = $41 million FY2015 = $41 million FY2016 = $42 million FY2017 req. = $42 million

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
4003	Amends PHSA Sec. 915(a) (AHRQ). New PHSA Sec. 399U (CDC).	**Clinical and community preventive services task forces.** Reauthorizes and expands the authority for the U.S. Preventive Services Task Force (USPSTF) to review and recommend effective clinical preventive services. Provides explicit statutory authority for the existing Task Force on Community Preventive Services (TFCPS) to review and recommend effective community-based interventions. Authorizes the appropriation of SSAN for each fiscal year to carry out the activities of the USPSTF and the TFCPS.	AHRQ funding for USPSTF: FY2010 = $4 million (+ $5 million PPHF) FY2011 = $4 million (+ $7 million PPHF) FY2012 = $4 million (+ $7 million PPHF) FY2013 = $5 million (+ $6 million PPHF) FY2014 = $4 million (+ $7 million PPHF) FY2015 = $12 million FY2016 = $12 million FY2017 req. = $12 million CDC funding for TFCPS: FY2010 = $5 million (all PPHF) FY2011 = $7 million (all PPHF) FY2012 = $10 million (all PPHF) FY2013 = $7 million (all PPHF) FY2014 amount not specified FY2015 amount not specified FY2016 amount not specified FY2017 request amount not specified
4102(b)	Amends PHSA Sec. 317M(c) (CDC, HRSA)	**School-based dental sealant program.** Amends the existing school-based dental sealant grant program, which was discretionary, by requiring the Secretary to award grants to the 50 states and to Indian tribes for school-based dental sealant programs. Note: The authorization of appropriations for the school-based dental sealant program expired at the end of FY2005. ACA did not reauthorize appropriations for the program.	Funding for all of CDC's existing oral health programs under PHSA Sec. 317M: FY2010 = $15 million FY2011 = $15 million FY2012 = $16 million FY2013 = $15 million FY2014 = $16 million FY2015 = $16 million FY2016 = $18 million FY2017 req. = $18 million [Note: Amounts below the line reflect realignment for the CDC Working Capital Fund (WCF) and are not comparable to amounts above the line.]

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
4204	Amends PHSA Sec. 317 and adds a new subsection (m) (CDC)	**Immunization programs.** Provides explicit authority for states to purchase vaccines at prices negotiated by Secretary. Authorizes the appropriation of SSAN (no years specified) for state immunization grants. Establishes a new immunization demonstration grant, for which is authorized the appropriation of SSAN for each of FY2010 through FY2014. [CFDA 93.185, 93.268, 93.533, 93.539]	Funding for the Sec. 317 immunization program (including program implementation and accountability): FY2010 = $561 million FY2011 = $361 million (+ $100 million PPHF) FY2012 = $452 million (+ $190 million PPHF) FY2013 = $461 million (+ $91 million PPHF) FY2014 = $451 million (+ $160 million PPHF) FY2015 = $401 million (+ $210 million PPHF) FY2016 = $286 million (+ $324 million PPHF) FY2017 req. = $224 million (+ $336 PPHF) [Note: Amounts below the line reflect realignment for the CDC WCF and are not comparable to amounts above the line.]
10334	Amends PHSA Sec. 1707 (OS) and PHSA Title IV (NIH), and adds new PHSA Sec. 1707A (AHRQ, CDC, CMS, FDA, HRSA, SAMHSA)	**Offices of Minority Health.** Establishes within OS an Office of Minority Health, headed by a Deputy Assistant Secretary for Minority Health, and transfers all functions and personnel from the existing Office of Minority Health of the Public Health Service to the new office. Authorizes the appropriation of SSAN for each of FY2011 through FY2016. Renames NIH's National Center on Minority Health and Health Disparities (NCMHD) as the National Institute on Minority Health and Health Disparities (NIMHD). Specifies that the NIMHD Director is responsible for the coordination of all NIH research on minority health and health disparities. Establishes an Office of Minority Health in AHRQ, CDC, CMS, FDA, HRSA, and SAMHSA. Requires the Secretary to designate an appropriate amount of each agency's funding to support the activities of its Office of Minority Health.	Funding for OS Office of Minority Health: FY2010 = $56 million FY2011 = $56 million FY2012 = $56 million FY2013 = $40 million FY2014 = $57 million FY2015 = $57 million FY2016 = $57 million FY2017 req. = $57 million Funding for NIH/NIMHD: FY2010 = $212 million FY2011 = $210 million FY2012 = $276 million FY2013 = $262 million FY2014 = $268 million FY2015 = $269 million FY2016 = $280 million FY2017 req. = $281 million

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
10412	Reauthorizes PHSA Sec. 312 (HRSA)	**Rural access to emergency devices.** Authorizes the appropriation of $25 million for each of FY2003 through FY2014 for a program of grants to community partnerships to purchase and distribute automatic external defibrillators (AEDs) in rural communities, and to provide AED training for first responders. [CFDA 93.259]	FY2010 = $3 million FY2011 = $0.2 million FY2012 = $1 million FY2013 = $2 million FY2014 = $3 million FY2015 = $5 million FY2016 = $0 FY2017 req. = $0
Community-Based Prevention: New Programs			
4004	New freestanding authority	**Education and outreach regarding prevention.** Requires the Secretary to carry out various specified communications activities regarding health promotion and disease prevention, for common and serious chronic health problems. They include establishing, within one year of enactment, a national media campaign on health promotion and disease prevention. Authorizes the appropriation of SSAN for each fiscal year; no more than $500 million total.	Note: Education and outreach for health promotion are core public health activities and a part of many HHS programs, authorized in broad language in the PHSA. Thus, it is not possible to identify total funding for Sec. 4004 implementation. HHS has reported using a portion of PPHF funds each year for various prevention, education and outreach activities targeting, for example, tobacco use and Alzheimer's disease.
4102(a)	New PHSA Secs. 399LL, 399LL-1, and 399LL-2 (CDC)	**Oral health activities.** Requires CDC, subject to appropriations, to fund a five-year national oral health education campaign, and award grants to community-based providers of dental services for dental caries disease management programs, among other things. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.
4102(c)	Amends PHSA Sec. 317M by adding a new subsection (d) (CDC)	**Oral health infrastructure.** Requires the Secretary to enter into cooperative agreements with states and tribal entities to establish oral health leadership and programs to improve oral health. Authorizes the appropriation of SSAN for FY2010 through FY2014.	No appropriations identified.
4102(d)	New freestanding authority (CDC, AHRQ)	**Oral health surveillance.** Requires the Secretary to expand the following surveillance systems to include more information on oral health: Pregnancy Risk Assessment Monitoring System (PRAMS); National Health and Nutrition Examination Survey (NHANES); National Oral Health Surveillance System (NOHSS); and Medical Expenditure Panel Survey (MEPS). Authorizes the appropriation of SSAN (no years specified) for PRAMS, and SSAN for each of FY2010 through FY2014 for NOHSS; no explicit authorization of appropriations for NHANES/MEPS expansion.	No appropriations identified.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
4201	New freestanding authority (CDC)	**Community transformation grants.** Requires CDC to fund competitive grants for the implementation, evaluation, and dissemination of evidence-based community preventive health activities. Authorizes the appropriation of SSAN for each of FY2010 through FY2014. [CFDA 93.531]	FY2011 = $146 million (all PPHF) FY2012 = $226 million (all PPHF) FY2013 = $146 million (all PPHF) Funding for community transformation grants, supported entirely with PPHF funds, ended in FY2013. A related initiative, the Partnerships to Improve Community Health Program, was funded for FY2014 and FY2015.
4202(a)	New freestanding authority (CDC)	**Community wellness pilot program.** Requires CDC to award grants to state and local health departments, and to Indian tribes, for five-year pilot programs to provide community prevention interventions, screenings, and clinical referrals for individuals between 55 and 64 years of age. Authorizes the appropriation of SSAN for each of FY2010 through FY2014.	No appropriations identified.
4206	Amends PHSA Sec. 330 by adding a new subsection (s)	**Individualized wellness plan demonstration program.** Requires the Secretary to establish a pilot program in not more than 10 community health centers to test the impact of providing at-risk individuals who use the centers with individualized wellness plans. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.
4304	New PHSA Sec. 2821 (CDC)	**Epidemiology and laboratory capacity grants.** Codifies existing grant programs to strengthen national epidemiology, laboratory, and information management capacity for the response to infectious diseases and other conditions of public health importance. Authorizes the appropriation of $190 million for each of FY2010 through FY2013. Note: ACA requires a specific distribution of funds among epidemiology, information management, and laboratory grants. A provision in annual appropriations acts nullifies this distribution directive.	Funding for CDC's Epidemiology and Laboratory Capacity (ELC) program and Emerging Infections Program (EIP) grants: FY2010 = $20 million (all PPHF) FY2011 = $40 million (all PPHF) FY2012 = $40 million (all PPHF) FY2013 = $40 million (PPHF + transfers) FY2014 = $40 million (all PPHF) FY2015 = $40 million (all PPHF) FY2016 = $40 million (all PPHF) FY2017 req. = $40 million (all PPHF)
10407	New freestanding authority (CDC)	**Diabetes activities.** Requires CDC to conduct various diabetes prevention activities and fund an Institute of Medicine (IOM) report. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
10411	New PHSA Secs. 399V-2 (CDC) and 425 (NIH)	**Congenital heart disease programs.** Authorizes CDC to establish a National Congenital Heart Disease Surveillance System (NCHDSS), or to award one grant to establish such a system. Authorizes NIH to expand and coordinate research on congenital heart disease. Authorizes the appropriation of SSAN for each of FY2011 through FY2015 for both the surveillance system and the expanded research program.	FY2012 = $2 million FY2013 = $2 million FY2014 = $3 million FY2015 = $4 million FY2016 = $4 million FY2017 req. = $0 [CDC proposed using $4 million in FY2017 PPHF funds, but this was not provided in the Continuing Appropriations Act, 2017.]
10413	New PHSA Sec. 399NN (OS, CDC)	**Young women's breast health awareness.** Among other things, requires CDC to conduct an education campaign and award grants for a media campaign regarding breast health in young women, and to conduct prevention research; requires the Secretary to award grants to provide education and assistance to young women diagnosed with breast disease. Authorizes the appropriation of $9 million for each of FY2010 through FY2014. Note: Section 2 of the EARLY Act Reauthorization of 2014 (P.L. 113-265) authorized the appropriation of $4.9 million for each of FY2015 through FY2019.	FY2010 = $5 million FY2011 = $5 million FY2012 = $5 million FY2013 = $5 million FY2014 = $5 million FY2015 = $5 million FY2016 = $5 million FY2017 request amount not specified
10501(g)	New PHSA Sec. 399V-3 (CDC)	**National diabetes prevention program (NDPP).** Among other things, requires the Secretary to award grants for community-based diabetes prevention program model sites. Authorizes the appropriation of SSAN for each of FY2010 through FY2014.	FY2010 = $0 FY2011 = $0 FY2012 = $10 million (all PPHF) FY2013 = $3 million* FY2014 = $10 million FY2015 = $10 million FY2016 = $20 million FY2017 req. = $20 million * NDPP received funds from internal agency transfers.
Workplace Wellness: New Program			
10408	New freestanding authority (CDC)	**Small business wellness program.** Requires the Secretary to award grants to employers to provide their employees with access to comprehensive workplace wellness programs. Eligible employers are those with fewer than 100 employees, who work at least 25 hours per week. Authorizes the appropriation of $200 million for the period of FY2011 through FY2015, to remain available until expended.	FY2011 = $10 million (all PPHF) FY2012 = $10 million (all PPHF) FY2013 = $0 FY2014 = $10 (all PPHF) FY2015 = $10 (all PPHF) FY2016 = $0 FY2017 req. = $0

Sources: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from agency budget documents, including operating plans for certain fiscal years, available at http://www.hhs.gov/budget/, and communications with the CDC Washington Office.

Table 5. ACA Discretionary Funding: Maternal and Child Health

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
2952(b)	New SSA Sec. 512 (HRSA)	**Services to individuals with a postpartum condition.** Authorizes grants to establish, operate and coordinate effective and cost-efficient systems for the delivery of essential services to individuals with, or at risk of, postpartum depression and their families. Eligible grantees include public or nonprofit private entities, state or local government public-private partnerships, recipients of Healthy Start grants, public or nonprofit private hospitals, community-based organizations, hospices, ambulatory care facilities, community health centers, and primary care centers. Authorizes the appropriation of $3 million for FY2010, and SSAN for each of FY2011 and FY2012. Note: Section 10005 of the Helping Families in Mental Health Crisis Reform Act of 2016 (P.L. 114-255, Division B) established a new grant program for maternal depression screening, assessment, and treatment services, and authorized the appropriation of $5 million for each of FY2018 through FY2022 to carry it out.	No appropriations identified.

Source: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 6. ACA Discretionary Funding: Health Care Quality

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
Quality Measure Development, Analysis, and Public Reporting: New Programs			
3013(a)&(c)	New PHSA 931 (AHRQ)	**Quality measure development.** Requires the Secretary, in consultation with AHRQ and CMS, to (1) identify gaps where no quality measures exist or where existing measures need improvement, updating or expansion consistent with the National Strategy for Quality Improvement; and (2) fund or enter into agreements with eligible entities that have demonstrated expertise in measure development to develop, improve, update, or expand quality measures in areas identified as gap areas. Authorizes the appropriation of $75 million for each of FY2010 through FY2014, to remain available until expended. At least 50% of the amounts appropriated must be used pursuant to SSA Sec. 1890A(e), as added by ACA Sec. 3013(b). See below.	Although no appropriations have been made pursuant to this authorization, quality measure development is being carried out with other programmatic and agency funding.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
3013(b)	Amends new SSA Sec. 1890A, as added by ACA Sec. 3014(b), by adding a new subsection (e) (CMS)	**Quality and efficiency measures development.** Requires CMS, in consultation with AHRQ, through contracts, to develop quality and efficiency measures as determined appropriate for use under the SSA.	Although no appropriations have been made pursuant to this authorization, quality measure development is being carried out with other programmatic and agency funding.
3015	New PHSA Sec. 399II	**Collection and analysis of data for quality and resource use measures.** Requires the Secretary to establish and implement an overall strategic framework to carry out the public reporting of performance information. Requires the Secretary to collect and aggregate consistent data on quality and resource use measures, and authorizes the Secretary to award grants or contracts for this purpose. Authorizes the Secretary to award grants or contracts to multi-stakeholder entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures. Authorizes the appropriation of SSAN for each of FY2010 through FY2014.	No appropriations identified.
3015	New PHSA Sec. 399JJ	**Public reporting of performance information.** Requires the Secretary to make available to the public, through standardized websites, performance information summarizing data on quality measures. The information must include clinical conditions to the extent such data are available and, where appropriate, be provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions. Authorizes the appropriation of SSAN for each of FY2010 through FY2014.	No appropriations identified.
Quality Improvement Research, Training, and Implementation: New Programs			
3501	New PHSA Sec. 933 (AHRQ)	**Health care delivery system research.** Requires AHRQ to (1) identify, develop, evaluate, and disseminate innovative strategies for quality improvement practices in the delivery of health care services that represent best practice; (2) support research on health care delivery improvement and facilitate adoption of best practices; and (3) make the research findings available to the public; among other specified functions. Authorizes the appropriation of $20 million for FY2010 through FY2014.	FY2014 = $5 million No other appropriations identified.
3501/3511	New PHSA Sec. 934 (AHRQ)	**Quality improvement technical assistance and implementation.** Requires AHRQ to award grants (with a matching requirement) to eligible entities for providing technical support to health care providers in order to help them understand, adapt, and implement the models and practices identified by the research conducted by the agency. Grantees must have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
3508/3511	New freestanding authority	**Quality and patient safety training.** Authorizes the Secretary to award demonstration grants (with a matching requirement) to eligible health professions schools or consortia to develop and implement academic curricula that integrate quality improvement and patient safety into clinical education of health professionals. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.
Health Care Coordination: Existing Program			
3510	Amends and reauthorizes PHSA Sec. 340A (HRSA)	**Patient navigator program.** Prohibits the Secretary from awarding a grant to an entity under this section unless the entity provides assurances that patient navigators recruited, assigned, trained, or employed using these grant funds meet certain minimum core proficiencies. Eligible grantees include public or nonprofit private health centers (including FQHCs), IHS facilities, hospitals, cancer centers, rural health clinics, academic health centers, and nonprofit entities that partner or coordinate referrals with such a facility to provide patient navigator services. Authorizes the appropriation of $3.5 million for FY2010, and SSAN for each of FY2011 through FY2015. [CFDA 93.191]	FY2010 = $5 million FY2011 = $5 million No appropriations identified since FY2011.
Health Care Coordination: New Programs			
3502/3511	New freestanding authority	**Community health team grants to support medical homes.** Requires the Secretary to award grants to or enter into contracts with states, state-designated entities, and tribal organizations to support community-based interdisciplinary, interprofessional health teams in assisting primary care practices. Funding must be used to establish the health teams and to provide capitated payments to the providers. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.
3503/3511	New PHSA Sec. 935 (AHRQ)	**Medication therapy management (MTM) grants.** Requires the Secretary, not later than May 1, 2010, to provide grants to support MTM services provided by licensed pharmacists that are targeted at patients who take four or more prescribed medications, take high-risk medications, have two or more chronic diseases, or have undergone a transition of care or other factors that are likely to create a high risk for medication-related problems. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
3506	New PHSA Sec. 936 (AHRQ)	**Program to facilitate shared decisionmaking.** Requires the Secretary, through a contract, to develop and identify standards for patient decision aids, to review patient decision aids, and develop a certification process for determining whether patient decision aids meet those standards. The contract is to be awarded to the entity that holds the contract under SSA Sec. 1890 (currently the National Quality Forum). Further requires the Secretary to (1) award grants or contracts to develop, update, and produce patient decision aids, to test such materials to ensure they are balanced and evidence-based, and to educate providers on their use; and (2) to award grants for establishing Shared Decision Making Resource Centers to develop and disseminate best practices to speed adoption and effective use of patient decision aids and shared decisionmaking. Also requires the Secretary to award grants to providers for the development and implementation of shared decision-making techniques. Authorizes the appropriation of SSAN for FY2010 and each subsequent fiscal year.	No appropriations identified.
5405	New PHSA Sec. 399V-1 (AHRQ)	**Primary care extension program.** Requires the Secretary to establish a Primary Care Extension Program to award state planning and implementation grants for Primary Care Extension Program State Hubs, consisting of the state health department and other specified entities. State hubs must contract with and provide grant funds to county and local entities to serve as Primary Care Extension Agencies that assist primary care providers in implementing patient-centered medical homes and develop and support primary care learning communities, among other functions. Authorizes the appropriation of $120 million for each of FY2011 and FY2012, and SSAN for each of FY2013 and FY2014.	No appropriations identified.
5604	New PHSA Sec. 520K (SAMHSA)	**Co-locating primary and specialty care in community-based mental health settings.** Requires the Secretary to fund demonstration projects for providing coordinated and integrated services to individuals with mental illness and co-occurring chronic diseases through the co-location of primary and specialty care services in community-based mental and behavioral health settings. Authorizes the appropriation of $50 million for FY2010, and SSAN for each of FY2011 through FY2014. Note: Section 9003 of the Helping Families in Mental Health Crisis Reform Act of 2016 (P.L. 114-255, Division B) amended PHSA Sec. 520K and authorized the appropriation of $51.9 million for each of FY2018 through FY2022.	Note: SAMHSA's Primary & Behavioral Health Care Integration (PBHCI) program, authorized under PHSA Sec. 520A, predates ACA and has received the following amounts: FY2011 = $28 million (+ $35 million PPHF); FY2012 = $31 million (+ $35 million PPHF); FY2013 = $31 million; FY2014 = $52 million; FY2015 = $52 million; FY2016 = $52 million; FY2017 req. = 26 million.
10333	New PHSA Sec. 340H[a]	**Community-based collaborative care network program.** Authorizes the Secretary to award grants to support community-based collaborative care networks (CCN). An eligible CCN is a consortium of health care providers with a joint governance structure that provides comprehensive coordinated and integrated health care services (as defined by the Secretary) for low-income populations. CCNs must include a safety net hospital and all FQHCs in the community, as specified. Authorizes the appropriation of SSAN for each of FY2011 through FY2015.	No appropriations identified.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
10410	New PHSA Sec. 520B (SAMHSA)	**Centers of excellence for depression.** Requires SAMHSA to award five-year grants (with a matching requirement) on a competitive basis to eligible institutions of higher education or research institutions to establish national centers of excellence for depression. One grantee is to be designated as the coordinating center and required to establish and maintain a national database. Centers of excellence may receive a grant of up to $5 million; the coordinating center may receive a grant of up to $10 million. Authorizes the appropriation of $100 million for each of FY2011 through FY2015, and $150 million for each of FY2016 through FY2020. Note: Section 9017 of the Helping Families in Mental Health Crisis Reform Act of 2016 (P.L. 114-255, Division B) repealed PHSA Sec. 520B.	No appropriations identified.

Sources: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from agency budget documents, available at http://www.hhs.gov/budget/.

a. The ACA established two new programs that were both designated as section 340H of the PHSA: (1) the community-based collaborative care network program, authorized by ACA section 10333 (see above); and (2) graduate medical education (GME) payments to qualified teaching health centers, authorized by ACA section 5508(c).

Table 7. ACA Discretionary Funding: Nursing Homes

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
6112	New freestanding authority	**National independent monitor demonstration program.** Requires the Secretary, within one year of enactment, to implement a two-year demonstration to develop, test, and implement an independent monitoring program to oversee interstate and large intrastate chains of skilled nursing facilities (SNFs) and nursing facilities (NFs). Authorizes the appropriation of SSAN (no years specified); a monitored chain must contribute a portion of costs of the demonstration, as determined by the Secretary.	No appropriations identified.
6114	New freestanding authority	**Culture change and information technology demonstration programs.** Requires the Secretary, within one year of enactment, to award one or more competitive grants to support each of the following three-year demonstration projects for SNFs and NFs: (1) develop best practices for culture change (i.e., patient-centric models of care); and (2) develop best practices for the use of health information technology. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.

Source: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 8. ACA Discretionary Funding: Health Disparities Data Collection

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
4302(a)	New PHSA Title XXXI; new Sec. 3101	**Health disparities data collection and analysis.** Not later than two years after enactment, requires federally conducted and supported health programs and surveys, to the extent practicable, to collect and report data on race, ethnicity, sex, primary language, and disability status, as well as other demographic data on health disparities as deemed appropriate by the Secretary. Requires the Secretary to adopt standards for the measurement and collection of such data. Requires the Secretary to analyze the data collected on health disparities; provide for the public reporting and dissemination of the data and analyses; and safeguard the privacy of the information. Authorizes the appropriation of SSAN for each of FY2010 through FY2014; however, data may not be collected unless funds are directly appropriated for such purpose. Note: On October 31, 2011, HHS published final standards for collecting and reporting health disparities data. See http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208.	No appropriations identified.
5605	New freestanding authority	**Key national indicators.** Establishes a Commission on Key National Indicators composed of eight members appointed by Congress. [Note: The commission members were appointed in Dec. 2010. See http://www.stateoftheusa.org/content/commission-on-key-national-ind.php.] Requires the commission to contract with the National Academy of Sciences to review available public and private sector research on key national indicator set selection and determine how best to establish a key national indicator system, among other things. Mandates a Government Accountability Office (GAO) study of previous efforts by public, private, or foreign entities to develop best practices for a key national indicator system. Authorizes the appropriation of $10 million for FY2010, and $7.5 million for each of FY2011 through FY2018, with amounts appropriated to remain available until expended. Note: GAO released its study in March 2011. See http://www.gao.gov/new.items/d11396.pdf.	No appropriations identified.

Source: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 9. ACA Discretionary Funding: Emergency Care and Trauma Services

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
Emergency Care and Trauma Services: Existing Programs			
3505(a)	Amends and reauthorizes PHSA Secs. 1241-1245 (HRSA)	**Trauma care centers.** Requires the Secretary to establish separate grant programs for IHS and tribal trauma care centers to (1) help defray substantial uncompensated care costs, (2) further the core missions of trauma care centers, and (3) provide emergency relief to ensure the continued availability of trauma services. Authorizes the appropriation of $100 million for FY2009, and SSAN for each of FY2010 through FY2015.	No appropriations identified.
5603	Amends and reauthorizes PHSA Sec. 1910 (HRSA)	**Children's emergency medical services demonstration grants.** Expands emergency services for children who need treatment for trauma or critical care by lengthening the period for demonstration grants to four years (with an optional fifth year). Authorizes the appropriation of $25 million for FY2010, $26.3 million for FY2011, $27.6 million for FY2012, $28.9 million for FY2013, and $30.4 million for FY2014. [CFDA 93.127] Note: The Emergency Medical Services for Children Reauthorization Act of 2014 (P.L. 113-180) authorized the appropriation of $20.2 million for each of FY2015 through FY2019.	FY2010 = $21 million FY2011 = $21 million FY2012 = $21 million FY2013 = $20 million FY2014 = $20 million FY2015 = $20 million FY2016 = $20 million FY2017 req. = $20 million
Emergency Care and Trauma Services: New Programs			
3504(a)	New PHSA Sec. 1204 (OS)	**Regional systems for emergency care.** Requires the Assistant Secretary for Preparedness and Response to award at least four multi-year contracts or grants (with matching requirement) to states and Indian tribes for pilot projects to improve regional coordination of emergency services. Priority given to entities serving a medically underserved population. Authorizes the appropriation of $24 million for each of FY2010 through FY2014.	Note: In addition to authorizing funding for the new program, this ACA provision reauthorizes funding for the existing trauma care grant programs in PHSA Title XII Parts A and B (i.e., Secs. 1201-1204 and 1211-1222, respectively). No appropriations identified for any of these programs.
3504(b)	New PHSA Sec. 498D (NIH, AHRQ, HRSA, CDC)	**Emergency medicine research.** Requires the Secretary to expand and accelerate basic, translational, and service delivery research on emergency medicine and care systems, including pediatric emergency medical care. Also requires the Secretary to support research on the economic impact of coordinated emergency care systems. Authorizes the appropriation of SSAN for each of FY2010 through FY2014.	No appropriations identified.
3505(b)	New PHSA Secs. 1281-1282	**Trauma service availability grants.** Requires the Secretary to award grants to states for the purpose of supporting trauma-related physician specialties and broadening access to and availability of trauma care services. States must use at least 40% of the funds for grants to safety net trauma centers. Authorizes the appropriation of $100 million for each of FY2010 through FY2015.	No appropriations identified.

Sources: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from HRSA's and OS's budget documents, available at http://www.hrsa.gov/about/budget/index.html.

Table 10. ACA Discretionary Funding: Elder Justice

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
6703(a)	New SSA Sec. 2021 (OS)	**Elder Justice Coordinating Council.** Establishes an Elder Justice Coordinating Council to include the Secretary as chair and the U.S. Attorney General, as well as the head of each federal department or agency, identified by the chair, as having administrative responsibility or administering programs related to elder abuse, neglect, and exploitation. Authorizes the appropriation of SSAN (no years specified). See also new SSA Sec. 2024 below.	No appropriations identified.
6703(a)	New SSA Sec. 2022	**Advisory Board on Elder Abuse, Neglect, and Exploitation.** Establishes an advisory board to create a short- and long-term multidisciplinary plan for development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council. Authorizes the appropriation of SSAN (no years specified). See also new SSA Sec. 2024 below.	No appropriations identified.
6703(a)	New SSA Sec. 2024	**Authorization of appropriations.** Authorizes funding for new SSA Secs. 2021 (Coordinating Council), 2022 (Advisory Board), and 2023 (human subject protection guidelines for researchers). Authorizes the appropriation of $6.5 million for FY2011, and $7.0 million for each of FY2012 through FY2014.	No appropriations identified.
6703(a)	New SSA Sec. 2031	**Forensic centers and expertise.** Requires the Secretary to award grants to eligible entities to establish and operate stationary and mobile forensic centers and to develop forensic expertise pertaining to elder abuse, neglect, and exploitation. Authorizes the appropriation of $4 million for FY2011, $6 million for FY2012, and $8 million for each of FY2013 and FY2014.	No appropriations identified.
6703(a)	New SSA Sec. 2041(a)	**Incentives for LTC staffing.** Requires the Secretary to award grants to LTC facilities for them to offer continuing training and varying levels of certification to employees providing direct care to residents and to improve management practices so as to promote retention of direct care workers. Authorizes the appropriation of $20 million for FY2011, $17.5 million for FY2012, and $15 million for each of FY2013 and FY2014 for new SSA Sec. 2041.	No appropriations identified.
6703(a)	New SSA Sec. 2041(b)	**Certified EHR technology grant program.** Authorizes grants to LTC facilities for specified activities that would assist such entities in offsetting costs related to purchasing, leasing, developing, and implementing certified electronic health record technology. See above authorization of appropriations for new SSA Sec. 2041.	No appropriations identified.
6703(a)	New SSA Sec. 2041(c)	**Standards for transactions involving clinical data by LTC facilities.** Requires the Secretary to adopt electronic standards for the exchange of clinical data by LTC facilities and, within 10 years, to have in place procedures to accept the optional electronic submission of clinical data by LTC facilities pursuant to such standards. See above authorization of appropriations for new SSA Sec. 2041.	No appropriations identified.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
6703(a)	New SSA Sec. 2042(a)	**Adult protective service functions.** Requires the Secretary to undertake various activities with respect to adult protective services, including providing funding, collecting and disseminating data on elder abuse, disseminating information on best practices and training, conducting research, and providing technical assistance to states and other entities. Authorizes the appropriation of $3 million for FY2011, and $4 million for each of FY2012 through FY2014.	FY2015 = $4 million FY2016 = $8 million FY2017 req. = $10 million No appropriations identified prior to FY2015. For more information, see CRS Report R43707, *The Elder Justice Act: Background and Issues for Congress*, by Kirsten J. Colello.
6703(a)	New SSA Sec. 2042(b)	**Grants to enhance provision of adult protective services.** Requires the Secretary to award formula grants to states to enhance adult protective services programs. Authorizes the appropriation of $100 million for each of FY2011 through FY2014.	No appropriations identified.
6703(a)	New SSA Sec. 2042(c)	**Adult protective services demonstration grants.** Requires the Secretary to fund state demonstration programs for adult protective services that test methods to prevent and detect elder abuse. Authorizes the appropriation of $25 million for each of FY2011 through FY2014.	No appropriations identified.
6703(a)	New SSA Sec. 2043(a)	**Long-term care ombudsman program grants.** Requires the Secretary to award grants to improve the capacity of state LTC ombudsman programs to address abuse and neglect complaints, conduct pilot programs, and provide support for such programs. Authorizes the appropriation of $5 million for FY2011, $7.5 million for FY2012, and $10 million for each of FY2013 and FY2014.	No appropriations identified.
6703(a)	New SSA Sec. 2043(b)	**Ombudsman training programs.** Requires the Secretary to establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and state LTC ombudsman programs. Authorizes the appropriation of $10 million for each of FY2011 through FY2014.	No appropriations identified.
6703(b)	New freestanding authority	**National Training Institute for Surveyors.** Requires that the Secretary enter into a contract with an entity to establish and operate a National Training Institute for Federal and State Surveyors to train surveyors who investigate allegations of abuse in programs and LTC facilities that receive payments under Medicare or Medicaid. Authorizes the appropriation of $12 million for the period of FY2011 through FY2014.	No appropriations identified.
6703(b)	New freestanding authority	**Grants to state survey agencies.** Requires the Secretary to award grants to state survey agencies that perform surveys of Medicare or Medicaid participating nursing facilities to design and implement complaint investigation systems. Authorizes the appropriation of $5 million for each of FY2011 through FY2014.	No appropriations identified.
6703(c)	New freestanding authority	**National nurse aide registry study and report.** Requires the Secretary, in consultation with appropriate government agencies and private sector organizations, to conduct a study on establishing a national nurse aide registry and report on its findings. Authorizes the appropriation of SSAN (no years specified) to carry out these activities, with funding not to exceed $500,000.	No appropriations identified.

Source: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 11. ACA Discretionary Funding: Biomedical Research

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
10409	Amends PHSA Secs. 402(b) and 499(c); new PHSA Sec. 402C[a] (NIH)	**Cures Acceleration Network (CAN).** Establishes a CAN program within the Office of the NIH Director[a] to award grants, contracts, or cooperative agreements to support the development of treatments for diseases or conditions that are rare, and for which market incentives are inadequate. Eligible grantees include public or private entities, which may include private or public research institutions, institutions of higher education, medical centers, biotechnology companies, pharmaceutical companies, disease advocacy organizations, patient advocacy organizations, and academic research institutions. Authorizes the appropriation of $500 million for FY2010, and SSAN for subsequent fiscal years. Other funds appropriated under the PHSA may not be allocated to CAN.	FY2012 = $10 million FY2013 = $9 million FY2014 = $10 million FY2015 = $10 million FY2016 = $26 million FY2017 req. = $26 million

Sources: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from NIH's budget documents, available at http://officeofbudget.od.nih.gov/br.html.

a. P.L. 112-74 created the National Center for Advancing Translational Sciences (NCATS) within NIH and transferred the CAN program from the Office of the NIH Director to NCATS. It also redesignated PHSA Sec. 402C as Sec. 480.

Table 12. ACA Discretionary Funding: Biologics

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
7002	Amends PHSA Sec. 351 (FDA)	**FDA approval of biosimilar biologics.** Creates an abbreviated regulatory pathway for approving biological products that are demonstrated to be biosimilar to, or interchangeable with, an FDA-licensed biological product. Provides for the collection of user fees, subject to congressional authorization, to cover regulatory costs beginning in FY2013. Authorizes the appropriation of SSAN for each of FY2010 through FY2012. For more information on FDA regulation of biosimilar biological products, see http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/default.htm.	No appropriations identified FY2010-FY2012. Appropriators have provided for the following user fees to be assessed: FY2013 = $20 million FY2014 = $21 million FY2015 = $21 million FY2016 = $22 million FY2017 req. = $22 million

Source: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from FDA's budget documents, available at http://www.fda.gov/AboutFDA/ReportsManualsForms/Reports/BudgetReports/default.htm.

Table 13. ACA Discretionary Funding: 340B Drug Pricing

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
7102	Amends PHSA Sec. 340B(d) (HRSA)	**Improvements to 340B program integrity.** Requires the Secretary to develop systems to improve compliance and program integrity to (1) increase transparency and strengthen monitoring, oversight, and investigation of the prices that manufacturers charge covered entities; and (2) ensure covered entities do not divert drugs or obtain multiple discounts. Further requires the Secretary to establish a new administrative dispute resolution process to mediate and resolve covered entity overpayment claims and manufacturer claims against covered entities for drug diversion or multiple discounts. Authorizes the appropriation of SSAN for FY2010 and each succeeding fiscal year.	FY2010 = $2 million FY2011 = $4 million FY2012 = $4 million FY2013 = $4 million FY2014 = $10 million FY2015 = $10 million FY2016 = $10 million FY2017 req. = $26 million (includes $9 million from a proposed new user fee program)

Sources: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from HRSA's budget documents, available at http://www.hrsa.gov/about/budget/index.html.

Table 14. ACA Discretionary Funding: Medical Malpractice

ACA Section	Statutory Authority (Agent)	Summary of Provision	Funding (FY2010-FY2017)
10607	New PHSA Sec. 399V-4 (HRSA)	**Liability reform demonstration program.** Authorizes five-year demonstration grants to states for the implementation and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or organizations. Planning grants of up to $500,000 may be awarded to states for the development of demonstration project applications. To receive a grant, a state must develop an alternative system that allows for the resolution of disputes caused by health care providers or organizations, and reduces medical errors by encouraging the collection and analysis of patient safety data related to the resolved disputes. Authorizes the appropriation of $50 million for the period FY2011 through FY2015.	No appropriations identified.

Source: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 15. ACA Discretionary Funding: Pain Care Management

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
4305(a)	New freestanding authority	**Conference on pain.** Requires the Secretary, within one year of appropriating funds, to contract with the IOM to convene a Conference on Pain for the purpose of assessing the public health impact of pain, reviewing pain research, care, and education, and identifying barriers to improved pain care. A report summarizing the Conference's findings must be submitted to Congress by June 30, 2011. Authorizes the appropriation of SSAN for each of FY2010 and FY2011. Note: IOM released its report on June 29, 2011. See http://painconsortium.nih.gov/.	No appropriations identified.

Source: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 16. ACA Discretionary Funding: Medicaid

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
2705	New freestanding authority (CMS)	**Global payment system demonstration program.** Requires the Secretary, in coordination with the Center for Medicare and Medicaid Innovation, to fund up to five Medicaid demonstrations during the period FY2010 through FY2012 under which a participating state will adjust payments made to a large safety net hospital system or network from a fee-for-service model to a global capitated payment model. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.
2706	New freestanding authority (CMS)	**Pediatric accountable care organization demonstration program.** Requires the Secretary to conduct a five-year Medicaid demonstration (Jan. 1, 2012, through Dec. 31, 2016) under which a participating state is allowed to recognize pediatric providers as an accountable care organization (ACO) for the purpose of receiving incentive payments. Eligible pediatric providers must meet certain performance guidelines established by the Secretary to be recognized as an ACO, and must achieve a specified minimum level of Medicaid savings to receive an incentive payment. Authorizes the appropriation of SSAN (no years specified).	No appropriations identified.

Source: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 17. ACA Discretionary Funding: Medicare

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
3129	Amends and reauthorizes SSA Sec. 1820 (HRSA)	**Rural hospital flexibility grant program.** Extends authorization of appropriations for the rural hospital flexibility (Flex) grants that support a range of performance and quality improvement activities at small rural hospitals. Permits the funding to be used to help rural hospitals participate in delivery system reform programs authorized under ACA. Authorizes the appropriation of SSAN for each of FY2011 and FY2012, to remain available until expended. [CFDA 93.241]	FY2010 = $41 million FY2011 = $41 million FY2012 = $41 million FY2013 = $38 million FY2014 = $41 million FY2015 = $42 million FY2016 = $42 million FY2017 req. = $26 million

Sources: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from HRSA's budget documents, available at http://www.hrsa.gov/about/budget/index.html.

Table 18. ACA Discretionary Funding: Private Health Insurance

ACA Section	Statutory Authority (Agency)	Summary of Provision	Funding (FY2010-FY2017)
1334	New freestanding authority (OPM)	**Multi-state health plans.** Requires OPM to contract with health insurers to offer at least two multi-state health plans (at least one nonprofit) through exchanges in each state. Authorizes OPM to prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums. Requires multi-state plans to cover essential health benefits and meet all the requirements of a qualified health plan. Authorizes the appropriation of SSAN (no years specified). Note: On March 11, 2013, OPM published a final rule to implement the multi-state plan program (78 *Federal Register* 15560).	No appropriations identified.

Source: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended).

Appendix A. Discretionary Spending and the Budget Control Act of 2011

Congress has taken a number of steps in recent years to limit federal discretionary spending. In April 2011, lawmakers agreed to cuts in discretionary spending for a broad range of agencies and programs as part of negotiations to complete the FY2011 appropriations process and avert a government shutdown. Four months later, as part of negotiations to raise the debt ceiling, Congress and the President enacted the Budget Control Act of 2011 (BCA).[24]

The BCA established enforceable discretionary spending limits, or caps, for defense and nondefense spending for each of FY2012 through FY2021, and provided for further annual spending reductions equally divided between the categories of defense and nondefense spending beginning in FY2013. Within each spending category, those further reductions are allocated proportionately to discretionary spending and mandatory spending, subject to certain exemptions and special rules. All the spending summarized in this report falls within the nondefense category.

Under the BCA, spending reductions are achieved through two different methods: (1) sequestration (i.e., an across-the-board cancellation of budgetary resources) and (2) lowering the BCA-imposed discretionary spending caps. The Office of Management and Budget (OMB) is responsible for calculating the percentages and amounts by which mandatory and discretionary spending are required to be reduced each year, and for applying the relevant exemptions and special rules.

The BCA requires mandatory spending reductions to be executed each year through a sequestration of all nonexempt accounts. Discretionary spending also was reduced through sequestration in FY2013. However, for each of the remaining fiscal years (i.e., FY2014 through FY2021), the annual reductions in discretionary spending required under the BCA are to be achieved by lowering the discretionary spending caps by the total dollar amount of the required reduction. This means that the cuts within the lowered spending cap may be apportioned through the annual appropriations decisionmaking, rather than via an across-the-board reduction through sequestration.

FY2013 Sequestration

Nonexempt nondefense discretionary spending in FY2013 generally was subject to a 5.0% sequestration.[25]

FY2014-FY2017 Nondefense Discretionary Spending Caps

Table A-1 shows the original nondefense discretionary (NDD) spending caps for FY2014-FY2017 established by the BCA. For each of those four fiscal years, the BCA required the caps to be lowered by approximately $37 billion to achieve the necessary reduction in NDD spending.

[24] P.L. 112-25, 125 Stat. 240. The BCA amended the Balance Budget and Emergency Deficit Control Act of 1985 (BBEDCA; P.L. 99-177; Title II, 99 Stat. 1038). For more information, see CRS Report R41965, *The Budget Control Act of 2011*.

[25] This percentage reduction reflects adjustments made by the American Taxpayer Relief Act of 2012 (ATRA; P.L. 112-240, 126 Stat. 2313), which amended the BCA by reducing the overall dollar amount that had to be cut from FY2013 nonexempt discretionary and mandatory spending.

Table A-1. Nondefense Discretionary Spending Limits

Billions of Dollars

	FY2014	FY2015	FY2016	FY2017
Original caps under BCA	510.000	520.000	530.000	541.000
Revised caps under BBA13 and BBA15	491.773	492.356	518.491	518.531

Source: Budget Control Act of 2011 (P.L. 112-25); Bipartisan Budget Act of 2013 (P.L. 113-67, Division A); Bipartisan Budget Act of 2015 (P.L. 114-74).

However, the Bipartisan Budget Act of 2013 (BBA13)[26] amended the BCA by establishing new levels for the FY2014 and FY2015 NDD spending caps, and eliminating the requirement for those caps to be reduced. While the BBA13 caps were set at a level that was lower than the original BCA caps (see **Table A-1**), they were higher than the BCA-lowered caps that they replaced.

The Bipartisan Budget Act of 2015 (BBA15)[27] further amended the BCA by establishing new levels for the FY2016 and FY2017 NDD spending caps, and eliminating the requirement for those caps to be lowered. Once again, the BBA15 caps were set at a level below the original BCA caps for those two fiscal years (see **Table A-1**), but above the BCA-lowered caps that they replace.

The revised NDD caps allowed an additional $26 billion for nondefense programs in FY2016 compared to the previous fiscal year. However, there is a slight increase in NDD appropriations allowed by the FY2017 revised cap level. As shown in Table 19, the revised cap for FY2017 is $40 million above the revised cap for FY2016.

Trends in Nondefense Discretionary Spending Since FY1962

Nondefense discretionary (NDD) spending helps support transportation, education grants, housing assistance, public health programs, biomedical research, veterans' health care, most homeland security activities, the federal justice system, foreign aid, and environmental protection, among other activities.

According to CBO, federal NDD spending has represented a fairly stable share of the economy since FY1962, averaging about 3.8% of gross domestic product (GDP). NDD spending was at its highest between FY1975 and FY1981, when it averaged almost 5% of GDP. It increased again between FY2009 and FY2011 as a result of stimulus spending under the American Recovery and Reinvestment Act (ARRA). During this period NDD outlays represented 4.5% of GDP.[28]

NDD spending as a share of GDP is now declining and has fallen to 3.2%. This is a smaller percentage relative to the size of the economy than at any time since FY1962, which was the first year for which comparable data are available.

CBO projects that NDD spending under current deficit-reduction policies will drop to 2.6% of GDP by 2027.[29]

[26] P.L. 113-67, Division A; 127 Stat. 1165.

[27] P.L. 114-74, 129 Stat. 584.

[28] U.S. Congressional Budget Office, *The Budget and Economic Outlook: 2015 to 2025*, January 2015, p. 79, https://www.cbo.gov/sites/default/files/cbofiles/attachments/49892-Outlook2015.pdf.

[29] U.S. Congressional Budget Office, *The Budget and Economic Outlook: 2017 to 2027*, January 2017, Figure 1-7, https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52370-outlook.pdf.

Appendix B. Expired Authorizations of Appropriations

Table B-1. Programs with Expired Authorizations of Appropriations

Listed by Topic Area, Program Name, and ACA Section Number

Health Centers and Clinics (Table 2)	
School-Based Health Centers (Sec. 4101(b))	*Nurse-Managed Health Clinics (Sec. 5208)*
Health Care Workforce (Table 3)	
Primary Care Training & Enhancement (Sec. 5301)	*Education and Training In Pain Care (Sec. 4305(c))*
Pediatric Specialist Loan Repayment Program (Sec. 5203)	Public Health & Preventive Medicine (Sec. 10501(m)(2))
Rural physician Training Grants (Sec. 10501(l))	*Public Health Workforce Loan Repayment Program (Sec. 5204)*
General and Pediatric Dentistry Training (Sec. 5303)	*Public Health & Allied Health Scholarships (Sec. 5206(b))*
Nurse Faculty Loan Program (Sec. 5311(a))	*Community Health Worker Program (Sec. 5313)*
Advanced Nursing Education (Sec. 5312)	CDC Training Fellowships (Sec. 5314)
Nursing Workforce Diversity (Sec. 5312)	*USPHS Commissioned Corps Ready Reserve (Sec. 5210)*
Nursing Education, Practice, Quality, and Retention (Sec. 5312)	*Cultural Competency, Prevention, Public Health, Disparities, and Individuals with Disability Training (Secs. 5307(a)&(b))*
Nurse Faculty Loan Repayment Program (Sec. 5311(b)	Scholarships for Disadvantaged Students (Sec. 5402)
Family Nurse Practitioner Demonstration (Sec. 5316)	Faculty Loan Repayment Program (Sec. 5402)
Geriatric Nursing Education and Training (Sec. 5305(c))	Health Careers Opportunity Program (Sec. 5402)
Direct Care Worker Training (Sec. 5302)	Area Health Education Centers (Sec. 5403(a))
Geriatric Workforce Development (Sec. 5305(a))	National Center for Health Care Workforce Analysis (Sec. 5103)
Prevention and Wellness (Table 4)	
Offices of Women's Health (Sec. 3509/3511)	*Community Transformation Grants (Sec. 4201)*
School-Based Dental Sealant Program (Sec. 4102(b))	*Community Wellness Pilot Program (Sec. 4202(a))*
Immunization Demonstration Grants (Sec. 4204(b))	Epidemiology & Laboratory Capacity Grants (Sec. 4304)
Office of Minority Health (Sec. 10334)	Congenital Heart Disease Program (Sec. 10411)
Rural Access to Emergency Devices (Sec. 10412)	National Diabetes Prevention Program (Sec. 10501(g))
Oral Health Infrastructure (Sec. 4102(c))	Small Business Wellness Program (Sec. 10408)
Oral Health Surveillance (Sec. 4102(d))	
Maternal and Child Health (Table 5)	
Individuals with Postpartum Depression (Sec. 2952(b))	
Health Care Quality (Table 6)	
Quality and Efficiency Measures Development (Sec. 3013)	Patient Navigator Program (Sec. 3510)
Collection and Analysis of Quality Data (Sec. 3015)	*Primary Care Extension Program (Sec. 5405)*
Public Reporting of Quality Measures (Sec. 3015)	*Community-Based Collaborative Care Network (Sec. 10333)*
Health Care Delivery System Research (Sec. 3501)	

Health Disparities (Table 8)	
Data Collection and Analysis (Sec. 4302(a))	
Emergency Care and Trauma Services (Table 9)	
Trauma Care Centers (Sec. 3505(a))	*Emergency Medicine Research (Sec. 3504(b))*
Regional Systems for Emergency Use (Sec. 3504(a))	*Trauma Service Availability Grants (Sec. 3505(b))*
Elder Justice (Table 10)	
Elder Justice Coordinating Council (Sec. 6703(a))	*LTC Ombudsman Program & Training (Sec. 6703(a))*
Forensic Centers and Expertise (Sec. 6703(a))	*National Training Institute of Surveyors (Sec. 6703(b))*
LTC Facility Staffing & Information Technology (Sec. 6703(a))	*Grants to State Survey Agencies (Sec. 6703(b))*
Adult Protective Services (Sec. 6703(a))	
Medical Malpractice (Table 14)	
Liability Reform Demonstration Program (Sec. 10607)	
Medicare (Table 17)	
Rural Hospital Flexibility Grant Program (Sec. 3129)	

Source: Table prepared by CRS based on the text of the Affordable Care Act (ACA; P.L. 111-148, as amended).

Note: Programs listed in roman type have received annual discretionary appropriations. Programs for which CRS could not identify any specific discretionary appropriations are listed in *italic type*. In some cases a program may receive funding from another budget account; see Tables 2-18 for additional details on program funding.

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