Discretionary Spending in the Patient Protection and Affordable Care Act (ACA)

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Summary

The Patient Protection and Affordable Care Act (ACA) reauthorized funding for numerous existing discretionary grant programs and other activities. ACA also created multiple new discretionary grant programs and provided for each an authorization of appropriations. Funding for all these discretionary programs is subject to action by congressional appropriators. This report summarizes all the discretionary spending provisions in ACA. A companion product, CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA)*, summarizes all the mandatory appropriations in the law.

Among the provisions that are intended to strengthen the nation's health care safety net and improve access to care, ACA permanently reauthorized the federal health centers 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, 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. 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, 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 the quality of health care, 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, patient navigators, and the co-location of primary health care and mental health services. Additionally, 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 Congressional Budget Office estimated that ACA's discretionary spending provisions, if fully funded by appropriations acts, would result in appropriations of approximately $100 billion over the 10-year period FY2012-FY2021. Much of that funding would be for discretionary programs that existed prior to, and whose funding was reauthorized by, ACA. While most of those existing discretionary programs continue to receive an annual discretionary appropriation, few of the new grant programs authorized under ACA have received any discretionary funding. However, several of the new programs have received mandatory funds from ACA's Prevention and Public Health Fund. This report is periodically revised and updated to reflect important legislative and other developments.

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Introduction

The Patient Protection and Affordable Care Act (ACA)[1] makes significant changes to the way health care is financed, organized, and delivered in the United States. Among its many provisions, ACA restructures the private health insurance market, sets minimum standards for health coverage, and, beginning in 2014, mandates that most U.S. residents obtain health insurance coverage or pay a penalty. The law provides for the establishment by 2014 of state-based health insurance exchanges for the purchase of private health insurance. Qualifying individuals and families will be able to receive federal subsidies to reduce the cost of purchasing coverage through the exchanges.

In addition to expanding private health insurance coverage, ACA, as enacted, requires state Medicaid programs to expand coverage to all eligible nonelderly, non-pregnant individuals under age 65 with incomes up to 133% of the federal poverty level (FPL). States that elect not to expand their Medicaid programs risk losing their existing federal Medicaid matching funds. Under ACA, the federal government will initially cover 100% of the expansion costs, phasing down to 90% of the costs by 2020. On June 28, 2012, the U.S. Supreme Court, in *National Federation of Independent Business v. Sebelius*, found that the Medicaid expansion violated the Constitution by threatening states with the loss of their existing federal Medicaid matching funds.[2] The Court precluded the Secretary of Health and Human Services (HHS) from penalizing states that choose not to participate in the Medicaid expansion (see text box). ACA also amends the Medicare program in an effort to reduce the rate of its projected growth; imposes an excise tax on insurance plans found to have high premiums; and makes many other changes to the tax code, Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), and other federal programs.

Implementation of ACA is projected to have a significant impact on federal revenues and direct (also referred to as mandatory) spending.[3] The law includes direct spending to subsidize the purchase of health insurance coverage through the exchanges, as well as increased outlays for the expansion of the Medicaid program. ACA also includes numerous mandatory appropriations to fund temporary programs to increase access to health care for targeted groups, provide funding to states to plan and establish exchanges, and support many other research and demonstration programs and activities (see discussion below under "Mandatory Appropriations in ACA"). The costs of expanding public and private health insurance coverage and other mandatory spending are offset by revenues from new taxes and industry fees, and by savings from payment and health care delivery system reforms designed to slow the growth in spending on Medicare and other federal health care programs.[4]

[1] 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 ACA. Several other bills that were subsequently enacted made more targeted changes to specific ACA provisions. All references to ACA in this report refer to the law as amended.

[2] *NFIB v. Sebelius*, No. 11-393, slip op. (June 28, 2012), available at http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

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

[4] For more information on ACA's provisions and its projected impact on federal revenues and direct spending, see CRS (continued...)

U.S. Supreme Court Decision on ACA (June 28, 2012)

In *National Federation of Independent Business v. Sebelius (NFIB)* the Court ruled on the constitutionality of both the individual mandate, which requires most U.S. residents (beginning in 2014) to carry health insurance or pay a penalty, and the Medicaid expansion. The Court upheld the individual mandate as a constitutional exercise of Congress's authority to levy taxes. The penalty is to be paid by taxpayers when they file their tax returns and enforced by the Internal Revenue Service.

In a separate opinion, the Court found that compelling states to participate in the ACA Medicaid expansion—which the Court determined to be essentially a new program—or risk losing their existing federal Medicaid matching funds was coercive and unconstitutional under the Spending Clause of the Constitution and the Tenth Amendment. The Court's remedy for this constitutional violation was to prohibit HHS from penalizing states that choose not to participate in the expansion by withholding any federal matching funds for their existing Medicaid program. However, if a state accepts the new ACA expansion funds (initially a 100% federal match), it must abide by all the expansion coverage rules.

Under *NFIB*, all other provisions of ACA remain fully intact and operative. For more information, see CRS Report R42698, *NFIB v. Sebelius: Constitutionality of the Individual Mandate*, by Erika K. Lunder and Jennifer Staman, and CRS Report R42367, *Medicaid and Federal Grant Conditions After NFIB v. Sebelius: Constitutional Issues and Analysis*, by Kenneth R. Thomas.

ACA implementation affects not only direct spending and revenues but also discretionary spending, which is subject to the annual appropriations process.[5] The law includes numerous discretionary spending provisions that authorize the appropriation of funds to implement grant programs and other activities. These provisions are of two kinds:

- Authorizations of appropriations for **new** discretionary grant and other programs created by ACA.
- Authorizations of appropriations for **existing** programs, primarily ones authorized under the Public Health Service Act (PHSA). In most instances, the appropriation authorizations for these established programs expired prior to their reauthorization by ACA. However, almost all of them continued to receive an annual appropriation.[6]

Many of the ACA discretionary spending provisions authorize annual appropriations of specified amounts for one or more fiscal years to carry out the program or activity. 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.

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Report R42051, *Budget Control Act: Potential Impact of Sequestration on Health Reform Spending*, by C. Stephen Redhead.

[5] Discretionary spending refers to outlays from budget authority that is provided in and controlled by annual appropriations acts.

[6] ACA also 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.

Funding for all discretionary programs in ACA depends on actions taken by congressional appropriators, a process that may lead to greater or smaller amounts than the sums authorized by the law. With Congress now operating under enforceable discretionary spending limits (i.e., caps) set by the Budget Control Act (BCA),[7] as amended, it may prove difficult to secure funding for new programs and activities. Even maintaining current funding levels for existing programs with broad support and an established appropriations history can be a challenge when there is pressure to reduce federal discretionary spending.

This report, which is periodically revised and updated to reflect important legislative and other developments, summarizes all the discretionary spending provisions in ACA that authorize (or reauthorize) appropriations for grant programs and other activities. It also includes a brief discussion of two trust funds that were created and funded by ACA, and that are helping support several discretionary programs summarized in the tables below. Finally, the report provides some analysis of the impact of the March 1, 2013 sequestration on ACA-related discretionary spending in FY2013.

Discretionary Spending in ACA

The law's discretionary spending provisions are organized by general topic in a series of tables with the following headings: Health Centers and Clinics (**Table 1**); Health Care Workforce (**Table 2**); Prevention and Wellness (**Table 3**); Maternal and Child Health (**Table 4**); Health Care Quality (**Table 5**); Nursing Homes (**Table 6**); Health Data Collection (**Table 7**); Emergency Care (**Table 8**); Elder Justice (**Table 9**); Biomedical Research (**Table 10**); Biologics (**Table 11**); 340B Drug Pricing (**Table 12**); Medical Malpractice (**Table 13**); Pain Care Management (**Table 14**); Medicaid (**Table 15**); Medicare (**Table 16**); and Private Health Insurance (**Table 17**).

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, either by adding a new program or amending an existing one). The name of the administering agency or office within HHS is also included, if known. The third column provides a brief description of the program or activity, including the types of entities and/or individuals eligible for funding.[8] The fourth column gives details of the authorization of appropriations and shows the FY2011, FY2012, and FY2013 funding levels for those programs and activities that received funding during that period. The FY2013 levels reflect the March 1, 2013, sequestration (see discussion under "Automatic Annual Spending Reductions Under the Budget Control Act"). The FY2014 funding request, if applicable, is also provided.[9]

Note that in several of the larger tables with multiple entries (i.e., **Tables 1, 2, 3, 5** and **8**), 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

[7] P.L. 112-25, 125 Stat. 240.

[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, including the FY2013 sequestration operating plans, available at http://www.hhs.gov/budget/.

Federal Domestic Assistance (CFDA) number for the grant program.[10] Unless otherwise stated, all references in the tables to the Secretary refer to the HHS Secretary.

The Congressional Budget Office (CBO) estimated that ACA's discretionary spending provisions, if fully funded by future appropriations acts, would result in appropriations of almost $100 billion over the period FY2012-FY2021.[11] However, much of that funding—about $85 billion—would be for three programs that were in existence prior to, and whose funding was reauthorized by, ACA; namely, the National Health Service Corps, the federal health centers program, and the Indian Health Service (IHS).

Most, though not all, of the existing grant programs that were reauthorized under ACA received a discretionary appropriation for FY2011, FY2012, and FY2013, as well as a FY2014 request for continued funding. In contrast, few of the new grant programs authorized under ACA have received annual discretionary appropriations.[12] However, several of the new programs have received mandatory funds from ACA's Prevention and Public Health Fund (see discussion below under "Mandatory Appropriations in ACA").

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)

ACA Administrative Costs and Funding

In addition to the costs of fully funding ACA's discretionary grant programs and other activities, CBO projected that both HHS and the Internal Revenue Service (IRS) will incur substantial administrative costs to implement the law's private health insurance reforms and its changes to

[10] 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.

[11] 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 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.

[12] Examples include CDC's congenital heart disease and breast health awareness programs (see **Table 3**) and the Cures Acceleration Network (CAN) program at NIH (see **Table 10**).

the federal health care programs. CBO estimated that the costs to the IRS of implementing the eligibility determination, documentation, and verification processes for the health insurance subsidies will probably total between $5 billion and $10 billion over 10 years. It further estimated that the costs to HHS of implementing the changes in Medicare, Medicaid, and CHIP, as well as some of the reforms to the private insurance market, will require similar amounts over 10 years.[13]

The Health Care and Education Reconciliation Act (HCERA) established, and appropriated $1 billion to, the Health Insurance Reform Implementation Fund (HIRIF) to help cover the initial administrative costs of implementation. The HIRIF is one of many sources of mandatory funding provided by ACA to support various new and existing HHS programs and activities (see discussion below under "Mandatory Appropriations in ACA"). The Administration's FY2013 budget projected that all the HIRIF funds would be obligated by the end of FY2012 and so requested more than $1 billion in new discretionary funding for CMS and the IRS to pay for ongoing administrative costs of ACA implementation. However, Congress did not provide any new discretionary funds for FY2013 for ACA implementation.[14]

In FY2013, CMS reportedly will spend about $1.5 billion on ACA implementation, primarily to establish federally facilitated insurance exchanges in states that elect not to run their own exchanges and to engage in consumer education and outreach.[15] HHS officials have stated that, in the absence of any new FY2013 discretionary funding for ACA implementation, the department will use funds from the following sources:[16]

- $235 million in unobligated HIRIF funds carried over from FY2012;
- $454 million from the Prevention and Public Health Fund (see discussion below under "Mandatory Appropriations in ACA");
- $450 million from the non-recurring expenses fund;[17] and
- $116 million from the Secretary's authority to transfer funds from other HHS accounts.[18]

[13] CBO, March 30, 2011, see footnote 11.

[14] The Continuing Appropriations Resolution, 2013 (P.L. 112-175, 126 Stat. 1313), enacted on September 28, 2012, provided temporary funding for the first six months of FY2013. It increased funding for most discretionary programs by 0.612% over the FY2012 levels. Congress completed action on FY2013 appropriations when it passed the Consolidated and Further Continuing Appropriations Act, 2013 (P.L. 113-6, 127 Stat. 198), which was signed into law on March 26, 2013. P.L. 113-6 funded most HHS discretionary programs at their FY2012 levels minus an across-the-board rescission of 0.2%, with some anomalies (i.e., provisions that specify alternative amounts for particular programs or activities).

[15] John Reichard, "HHS Using Several Sources to Fund Federal Health Insurance Exchange," *CQ Roll Call*, April 10, 2013.

[16] Ibid.

[17] The non-recurring expenses fund, within the Department of the Treasury, was established by Division G, Section 223 of the Consolidated Appropriations Act, 2008 (P.L. 110-161, 121 Stat. 2188). The HHS Secretary may transfer to the fund unobligated balances of expired annual discretionary funds up to five years after the fiscal year in which those funds were available for obligation. The amounts transferred to the fund are available until expended for use by HHS for various specified purposes. Congressional appropriators must be notified in advance of any planned use of funds.

[18] Each year, the HHS Secretary is provided with authority to transfer funds between appropriation 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.

Mandatory Appropriations in ACA

Separate from the discretionary spending authorizations summarized in the tables in this report, ACA included numerous mandatory appropriations that provide billions of dollars to fund new and existing grant programs and activities within HHS.[19]

Of particular note, ACA established two multi-billion dollar funds that are providing amounts to several of the discretionary grant programs authorized (or reauthorized) under ACA:

- The **Community Health Center Fund (CHCF)**, to which ACA provided a total of $11 billion in annual appropriations over a five-year period (i.e., FY2011-FY2015), is helping support the federal health centers program and the National Health Service Corps (NHSC).[20] While CHCF funding may have been intended to supplement annual discretionary appropriations for health centers and the NHSC program, the funds have partially supplanted discretionary health center appropriations and have become the sole source of funding for the NHSC program, which received no discretionary funds in FY2012 or FY2013 (see **Table 1** and **Table 2**). Note: A separate ACA appropriation provided $1.5 billion for health center construction and renovation (see **Table 1**).[21]
- The **Prevention and Public Health Fund (PPHF)**, for which ACA provided a permanent annual appropriation, is intended to fund prevention, wellness, and other public health-related programs and activities authorized under the PHSA.[22] PPHF funds have been used to support several new discretionary grant programs authorized by ACA.[23] In addition, PPHF funds have supplemented, and in some cases supplanted, annual discretionary appropriations for a number of established programs, including ones that were reauthorized by ACA (see **Table 2**, **Table 3**, and **Table 5**).

[19] All the appropriations provided in ACA, as well as details of the obligation of these funds, are summarized in a companion product, CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA)*, by C. Stephen Redhead.

[20] ACA Section 10503(a)-(b). The law appropriated the following amounts to the CHCF for health center operating grants: FY2011 = $1 billion; FY2012 = $1.2 billion; FY2013 = $1.5 billion; FY2014 = $2.2 billion; and FY2015 = $3.6 billion. It also appropriated the following amounts to the CHCF for the National Health Service Corps: FY2011 = $290 million; FY2012 = $295 million; FY2013 = $300 million; FY2014 = $305 million; and FY2015 = $310 million.

[21] ACA Section 10503(c). See also CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

[22] ACA Section 4002. As originally enacted, ACA appropriated the following amounts to the PPHF: FY2010 = $500 million; FY2011 = $750 million; FY2012 = $1 billion; FY2013 = $1.25 billion; FY2014 = $1.5 billion; and FY2015 and each fiscal year thereafter = $2 billion. The Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96, Sec. 3205) amended Section 4002 and reduced the amounts appropriated over the period FY2013-FY2021 by a total of $6.25 billion. The reduced appropriations for each of those fiscal years are as follows: FY2013 = $1 billion; FY2014 = $1 billion; FY2015 = $1 billion; FY2016 = $1 billion; FY2017 = $1 billion; FY2018 = $1.25 billion; FY2019 = $1.25 billion; FY2020 = $1.5 billion; and FY2021 = $1.5 billion.

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

Automatic Annual Spending Reductions Under the Budget Control Act

On March 1, 2013, President Obama ordered the sequestration, or cancellation, of $85.33 billion in FY2013 budgetary resources from nonexempt budget accounts across the federal government. The FY2013 sequestration order was issued pursuant to the Balanced Budget and Emergency Deficit Control Act (BBEDCA), as amended by the Budget Control Act of 2011 (BCA).[24] Under the BCA, the FY2013 sequestration was to be ordered on January 2, 2013. A provision in the American Taxpayer Relief Act of 2012 (ATRA)[25] delayed the order by two months.

The FY2013 sequestration is the first of a series of automatic spending reductions under the BCA, as amended by ATRA, that are required each year through FY2021. These annual spending reductions were triggered by the failure of the Joint Select Committee on Deficit Reduction to propose, and Congress and the President to enact, legislation to reduce the deficit by an amount greater than $1.2 trillion over the period FY2012-FY2021.

BCA's Spending Reduction Procedures

Based on the formula in the BCA, the automatic spending reductions triggered by the failure of the Joint Committee must cut $109.33 billion in each fiscal year over the period FY2013-FY2021. That amount is equally divided between defense and nondefense spending, each of which is subject to a $54.67 billion annual cut. Importantly, ATRA reduced the cuts for FY2013 by $24 billion, which means that both defense and nondefense spending are subject to $12 billion less in cuts in FY2013 (i.e., $42.67 billion, instead of $54.67 billion).[26] The annual spending reduction in each spending category—defense and nondefense—is further divided proportionately between discretionary spending and nonexempt direct (i.e., mandatory) spending.

Direct Spending

Under the BCA, direct spending reductions are to be executed each year by an automatic across-the-board cancellation of budgetary resources—a process known as sequestration—for all nonexempt accounts. The sequestration process is subject to exemptions and to certain rules, which are specified in Sections 255 and 256, respectively, of the BBEDCA.[27] Under the sequestration rules, reductions in Medicare payments to health care providers and health plans (which account for most of Medicare spending) are capped at 2%. Many other federal direct spending programs, accounting for most of the government's entitlement and other direct spending (excluding Medicare), are exempt from sequestration altogether.[28]

[24] P.L. 112-25, 125 Stat. 240. For a more detailed examination of all the provisions in the BCA, see CRS Report R41965, *The Budget Control Act of 2011*, by Bill Heniff Jr., Elizabeth Rybicki, and Shannon M. Mahan.

[25] P.L. 112-240, 126 Stat. 2313.

[26] For more information, see CRS Report R42949, *The American Taxpayer Relief Act of 2012: Modifications to the Budget Enforcement Procedures in the Budget Control Act*, by Bill Heniff Jr.

[27] For an overview of the BBEDCA exemptions and special rules, see CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

[28] Ibid.

Discretionary Spending

Discretionary spending reductions in FY2013 also were achieved through a sequestration of nonexempt discretionary appropriations. The sequestration rules exempt some discretionary spending, notably for veterans' health care and Pell grants.[29] For each of the remaining fiscal years (i.e., FY2014-FY2021), however, discretionary spending reductions will be achieved by lowering the enforceable discretionary spending limits (i.e., caps) established under the BCA, as amended by ATRA, by the total dollar amount of the reduction.[30] Thus, policymakers will get to decide how to apportion the cuts within the lowered spending caps rather than having the cuts applied across-the-board to all nonexempt accounts through sequestration.

FY2013 Sequestration

On September 14, 2012, pursuant to the Sequestration Transparency Act of 2012 (STA),[31] OMB released a report on the potential impact of a BCA-triggered FY2013 sequestration on direct and discretionary spending.[32] The report provided a breakdown of exempt and nonexempt budget accounts, and included estimates of the FY2013 funding reductions in nonexempt accounts. The STA directed OMB to estimate the effects of sequestration based on FY2012 funding levels. The estimates, which OMB emphasized were preliminary and subject to revision, predated ATRA's enactment and thus did not take into account the law's $24 billion reduction in required spending cuts for FY2013.

On March 1, 2013, the President ordered a sequestration of FY2013 budgetary resources in accordance with OMB's final calculations of the dollar amounts of the reduction to each nonexempt budget account. Those calculations, which take into account ATRA's $24 billion adjustment, were provided in a report submitted to Congress.[33]

OMB calculated that sequestration will reduce nonexempt nondefense discretionary spending by 5.0% and reduce spending on nonexempt nondefense mandatory programs by 5.1%.[34]

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[29] Ibid. Note: All veterans programs, mandatory and discretionary, are exempt from sequestration.

[30] The BCA established annual discretionary spending caps for each of FY2012 through FY2021. For more information, see CRS Report R42051, *Budget Control Act: Potential Impact of Sequestration on Health Reform Spending*, by C. Stephen Redhead.

[31] P.L. 112-155, 126 Stat. 1210.

[32] U.S. Office of Management and Budget, *OMB Report Pursuant to the Sequestration Transparency Act of 2012 (P.L. 112-155)*, http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/stareport.pdf.

[33] U.S. Office of Management and Budget, *OMB Report to the Congress on the Joint Committee Sequestration for Fiscal Year 2013*, http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/fy13ombjcsequestrationreport.pdf.

[34] The March 1, 2013 sequestration was ordered before enactment of full-year appropriations for FY2013. As instructed by the BBEDCA, OMB calculated the percentage reduction for discretionary spending based on annualized funding levels under the six-month FY2013 continuing resolution (P.L. 112-175), which generally funded discretionary programs at their FY2012 levels *plus 0.612%.* OMB then applied that percentage to the funding levels provided in the continuing resolution to determine the dollar amount reduction for each nonexempt account. Congress completed its work on FY2013 appropriations with passage of the Consolidated and Further Continuing Appropriations Act, 2013 (P.L. 113-6), which was signed into law on March 26, 2013. It funds most HHS discretionary programs at their FY2012 levels *minus an across-the-board rescission of 0.2%*, with some anomalies. Thus, final discretionary funding levels in P.L. 113-6 are slightly lower than the annualized funding levels provided in the six-month continuing resolution. Pursuant to the BBEDCA, OMB did not recompute the percentage reduction for discretionary spending, but instead appears to have applied the dollar amount reductions calculated based on the six-month continuing resolution to the (continued...)

In general, ACA-related discretionary spending in FY2013 is fully sequestrable at the 5.0% rate applicable to nonexempt nondefense discretionary spending. Importantly, OMB has concluded that the sequestration rules under BBEDCA Section 256, which include a 2% limit on cuts in spending on community health centers, migrant health centers, and the IHS, apply only to mandatory spending reductions and not to cuts in discretionary spending.[35] Thus, while FY2013 discretionary spending on all health centers is fully sequestrable, cuts in CHCF (mandatory) funding for community health centers and migrant health centers are capped at 2%.[36]

As already noted, discretionary spending reductions for each of the remaining years (i.e., FY2014-FY2021) will be achieved through a downward adjustment of the revised statutory spending caps. In contrast to the automatic spending reductions achieved through sequestration, lowering the annual discretionary spending caps allows Congress and the President to determine through the annual appropriations process which accounts are to be reduced, and by how much, in order to meet those caps.[37] Lowering the annual discretionary spending caps also may make it more difficult to maintain funding levels for existing programs.

Note that the FY2013 funding amounts listed in the tables below reflect the March 1, 2013, sequestration.[38]

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marginally lower final FY2013 levels.

[35] Based on its statutory interpretation of BBEDCA, OMB determined that the March 1, 2013 Joint Committee sequestration order was not an order pursuant to BBEDCA Sec. 254, under which sequestrations may be ordered to enforce the discretionary spending limits (BBEDCA Sec. 251) and the pay-as-you-go, or PAYGO, requirements (BBEDCA Sec. 252). This is significant because the Sec. 256 sequestration rules apply only to a sequestration order issued under Sec. 254. Thus, OMB concluded that the Sec. 256 rules "do not apply to a Joint Committee sequestration, except to the extent those rules are otherwise made applicable by another provision of law." While Sec. 251A(8) of BBEDCA specifically applies the Sec. 256 rules to a Joint Committee sequestration of nonexempt *direct (i.e., mandatory)* spending, there is no such provision for *discretionary* spending in Sec. 251A(7).

[36] A small amount of the CHCF funding for health centers is provided to other types of facilities that are supported under the federal health center program, including those that serve the homeless and residents of public housing. This funding is fully sequestrable at the rate applicable to nonexempt mandatory programs.

[37] The revised discretionary spending limits for FY2014-FY2021 would be enforced through a separate sequestration process pursuant to BBEDCA Sec. 251 (see footnote 32).

[38] For more discussion and analysis of the impact of spending reductions triggered by the BCA, see CRS Report R42051, *Budget Control Act: Potential Impact of Sequestration on Health Reform Spending*, by C. Stephen Redhead.

Table 1. ACA Discretionary Spending: Health Centers and Clinics

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$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, and $8,333 million for FY2015; amounts in subsequent years based on previous year's funding, subject to adjustment. ***FY2011 funding = $2,581 million (incl. $1,000 million from the CHCF); FY2012 funding = $2,767 million (incl. $1,200 million from the CHCF); FY2013 funding = $2,944 million (incl. $1,465 million from the CHCF); FY2014 request = $3,767 million (incl. $2,200 million from the CHCF).***[a] [CFDA 93.224, 93.527] Note: ACA Sec. 10503(c) appropriated $1.5 billion for the period FY2011 through FY2015 for health center construction and renovation; see CRS Report R41301.
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 that 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.	SSAN for each of FY2010 through FY2014. Note: ACA Sec. 4101(a) appropriated a total of $200 million for SBHC construction and renovation; see CRS Report R41301.
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.	$50 million for FY2010, and SSAN for each of FY2011 through FY2014. Note: This new program received $15 million in FY2010 funds from the PPHF but has not received any funding since that time. [CFDA 93.515]

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
10504	New 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.	SSAN (no years specified).

Sources: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from HRSA's budget documents, including the FY2013 sequestration operating plan, 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 funding totals for health centers include the following amounts for the Federal Tort Claims Act (FTCA) program: FY2011 = $100 million; FY2012 = $95 million; FY2013 = $89 million; FY2014 request = $95 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 2. ACA Discretionary Spending: Health Care Workforce

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$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. ***FY2011 funding = $315 million (incl. $290 million from the CHCF); FY2012 funding = $295 million (all CHCF); FY2013 funding = $285 million (all CHCF); FY2014 request = $305 million (all CHCF).*** [CFDA 93.162, 93.288, 93.547]

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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. Funds are to be used to plan, develop and operate accredited training programs, including residency and internship programs, in family medicine, general internal medicine, and general pediatrics and to provide financial assistance (e.g., traineeships). (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 and with a record of training primary care providers, among other things.	For both grant programs, $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. A separate authorization of $750,000 for each of FY2010 through FY2014 is provided for capacity building grants to integrate academic units. ***FY2011 funding = $39 million; FY2012 funding = $39 million; FY2013 funding = $37 million; FY2014 request = $51 million.*** [CFDA 93.510, 93.514, 93.884] Note: For FY2010, this program received $198 million in PPHF funds in addition to its annual discretionary appropriation of $39 million.
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.	$30 million for each of FY2010 through FY2014 for loan repayments to pediatric specialists and surgeons; $20 million for each of FY2010 through FY2013 for loan repayments to mental health providers. ***FY2014 request = $5 million.***
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.	$25 million for FY2010, $50 million for each of FY2011 and FY2012, and SSAN for each fiscal year thereafter.
10501(l)	New PHSA Sec. 749B (HRSA)	**Rural physician training grants.** Requires the Secretary to (1) award grants 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).]	$4 million for each of FY2010 through FY2013.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$30 million for FY2010, and SSAN for each of FY2011 through FY2015; permits grantees to carry over funds for up to three fiscal years. ***FY2011 funding = $17 million; FY2012 funding = $20 million; FY2013 funding = $19 million (est.); FY2014 request = $21 million.*** [CFDA 93.059, 93.884] Note: HRSA also administers a state oral health workforce grant program (PHSA Sec. 340G): FY2011 funding = $16 million; FY2012 funding = $12 million; FY2013 funding = $11 million (est.); FY2014 request = $12 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.	SSAN (no years specified). Note: The Department of Defense and Full-Year Continuing Appropriations Act, 2011(P.L. 112-10) and the Consolidated Appropriations Act, 2012 (P.L. 112-74) prohibited HRSA funding for this demonstration program in FY2011 and FY2012, respectively. This prohibition was continued in FY2013 by the Full-Year Continuing Appropriations Act, 2013 (P.L. 113-6).

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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 decision making. Eligible grantees include nursing schools, health care facilities (including NMHCs), or partnerships of the two.	SSAN for each of FY2010 through FY2014. See also ACA Sec. 5312 below, which reauthorized appropriations for several Title VIII nursing education programs including Sec. 831. ***FY2011 funding = $40 million; FY2012 funding = $40 million; FY2013 funding = $37 million; FY2014 request = $40 million.*** [CFDA 93.359, 93.503]
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.	SSAN for each of FY2010 through FY2014. ***FY2011 funding = $25 million; FY2012 funding = $25 million; FY2013 funding = $23 million; FY2014 request = $25 million.*** [CFDA 93.264]
5312	Amends PHSA Sec. 871; previously Sec. 841 (HRSA)	**Authorization of appropriations.** Reauthorizes funding for the following PHSA Title VIII nursing workforce programs: 1. Advanced nursing education (PHSA Sec. 811) – grants to accredited programs for advanced nurse education including combined registered nurse masters degree programs, authorized nurse practitioner programs, accredited nurse midwifery programs, and accredited nurse anesthesia programs. 2. Nursing workforce diversity (PHSA Sec. 821) – 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. 3. Nurse education, practice, quality, and retention (PHSA Sec. 831) – 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]	For PHSA Secs. 811, 821, 831, and new 831A (see ACA Sec. 5309(b) below), $338 million for FY2010, and SSAN for each of FY2011 through FY2016. ***Sec. 811: FY2011 funding = $64 million; FY2012 funding = $63 million; FY2013 funding = $60 million; FY2014 request = $83 million.*** [CFDA 93.124, 93.247, 93.358, 93.513] ***Sec. 821: FY2011 funding = $16 million; FY2012 funding = $16 million; FY2013 funding = $15 million; FY2014 request = $16 million.*** [CFDA 93.178] ***Sec. 831: see ACA Sec. 5309(a) above for funding amounts.***

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	SSAN for each of FY2010 through FY2012. See also ACA Sec. 5312 above.
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.	SSAN for each of FY2010 through FY2014.
5316	New 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.	SSAN for each of FY2011 through FY2014.
Geriatrics and Long-Term Care: Existing Program			
5305(c)	Amends and reauthorizes PHSA Sec. 865; previously Sec. 855 (HRSA)	**Geriatric nursing education and training.** 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.	SSAN for each of FY2010 through FY2014. ***FY2011 funding = $5 million; FY2012 funding = $4 million; FY2013 funding = $4 million; FY2014 request = $4 million.*** [CFDA 93.265]
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.	$10 million for the period FY2011 through FY2013.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
5305(a)	Amends PHSA Sec. 753 by adding new subsections (d)-(e) (HRSA)	**Geriatric workforce development; geriatric career incentive awards.** (1) 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. (2) 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.	(1) $10.8 million for the period FY2011 through FY2014. (2) $10 million for the period FY2011 through FY2013. Note: The three existing geriatric education and training programs authorized under PHSA Sec. 753(a)-(c), which support activities that are broadly comparable to those authorized in the new ACA programs, have received the following amounts: FY2011 funding = $34 million; FY2012 funding = $31 million, FY2013 funding = $29 million; FY2014 request = $31 million. [CFDA 93.156, 93.250, 93.969]
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. [See also **Table 14**.]	SSAN for each of FY2010 through FY2012, to remain available until expended.
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.	$43 million for FY2011, and SSAN for each of FY2012 through FY2015. ***FY2011 funding = $30 million (incl. $20 million from the PPHF); FY2012 funding = $33 million (incl. $25 million from the PPHF); FY2013 funding = $8 million; FY2014 request = $8 million (incl. $5 million from the PPHF).*** [CFDA 93.117, 93.249, 93.516, 93.964]

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$195 million for FY2010, and SSAN for each of FY2011 through FY2015.
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.	$60 million for FY2010, and SSAN for each of FY2011 through FY2015.
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.	SSAN for each of FY2010 through FY2014.
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. [CFDA 93.065]	$39.5 million for each of FY2010 through FY2013 ($24.5 million for EIS, and $5 million each for epidemiology, laboratory science, and informatics).
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 and 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]

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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 (including for training) by the Surgeon General, in order to bolster the available workforce for both routine and emergency public health missions.	$17.5 million for each of FY2010 through FY2014 ($5 million for recruitment and training, $12.5 million for the Ready Reserve Corps).
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 under PHSA Title VII (Health Professions Education) 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. 807.	SSAN for each of FY2010 through FY2015.
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 under PHSA Title VIII (Nursing Workforce Development) 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.	SSAN for each of FY2010 through FY2015.
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.	$50 million for each of FY2010 through FY2015, and SSAN for each subsequent fiscal year. ***FY2011 funding = $24 million; FY2012 funding = $23 million; FY2013 funding = $21 million; FY2014 request = $23 million.*** [CFDA 93.157]

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
5402	Amends PHSA Sec. 740 (HRSA)	**Authorization of appropriations.** Reauthorizes funding for the following PHSA Title VII workforce diversity programs: 1. Scholarships for disadvantaged students (PHSA Sec. 737) – grants to health professions schools for awarding scholarships to students from disadvantaged backgrounds with financial need. 2. Faculty loan repayment program (PHSA Sec. 738) – loan repayment program for health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college for at least two years. 3. Health careers opportunity program (PHSA Sec. 739) – grants to health professions schools and other educational institutions to improve recruitment and academic preparation of students from disadvantaged backgrounds.	For Sec. 737, $51 million for FY2010, and SSAN for each of FY2011 through FY2014. For Sec. 738, $5 million for each of FY2010 through FY2014. For Sec. 739, $60 million for FY2010, and SSAN for each of FY2011 through FY2014. ***Sec. 737: FY2011 funding = $49 million; FY2012 funding = $47 million; FY2013 funding = $44; FY2014 request = $47 million.*** [CFDA 93.925] ***Sec. 738: FY2011 funding = $1 million; FY2012 funding = $1 million; FY2013 funding = $1 million; FY2014 request = $1 million.*** [CFDA 93.923] ***Sec. 739: FY2011 funding = $22 million; FY2012 funding = $15 million; FY2013 funding = $14 million; FY2014 request = $0.*** [CFDA 93.822]
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.	$125 million for each of FY2010 through FY2014; funds may be carried over for up to three fiscal years. ***FY2011 funding = $33 million; FY2012 funding = $27 million; FY2013 funding = $28 million; FY2014 request = $0.*** [CFDA 93.107, 93.824]
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. [CFDA 93.189]	$5 million for each of FY2010 through FY2014, and SSAN for each subsequent fiscal year.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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 and high-demand population. Priority for psychology grants given to institutions that focus on the needs of specified vulnerable groups. Priority for grants to train professional and paraprofessional child and adolescent mental health workers given to applicants that can, among other things, assess workforce needs and that have programs designed to increase the number of child and adolescent mental health workers serving high-priority populations.	$35 million for the period of FY2010 through FY2013 ($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). ***HRSA: FY2012 funding = $10 million (all PPHF); FY2013 funding = $0; FY2014 request = $0. Note: SAMHSA's FY2014 budget requests $35 million to expand the mental and behavioral health workforce, through a partnership with HRSA.*** [CFDA 93.732] Note: HRSA's graduate psychology education program, which predates ACA, received $3 million in each of FY2011, FY2012, and FY2013. The FY2014 request is for the same amount.
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.	For the National Center, $7.5 million for each of FY2010 through FY2014; for state and regional centers, $4.5 million for each of FY2010 through FY2014; and for longitudinal evaluations, SSAN for FY2010 through FY2014. ***FY2011 funding = $3 million; FY2012 funding = $3 million; FY2013 funding = $3 million; FY2014 request = $5 million.*** Note: These amounts also include funding for Sec. 792 (health professions data) and Sec. 806 (nursing grant program data). [CFDA 93.300]
Policy and Planning: New Programs			
5101	New 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.	SSAN (no years specified).

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
5102	New 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.	For planning grants, $8 million for FY2010, and SSAN for each subsequent fiscal year. For implementation grants, $150 million for FY2010, and SSAN for each subsequent fiscal year. Note: This program received $6 million in FY2010 funds from the PPHF. [CFDA 93.509]

Sources: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from HRSA's budget documents, including the FY2013 sequestration operating plan, 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 offer 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, and $78 million in FY2013. The FY2014 request is for $83 million. The authorization of appropriations for Sec. 846 expired at the end of FY2007 and was not reauthorized by ACA.

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 3. ACA Discretionary Spending: Prevention and Wellness

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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 offices of women's health in OS, CDC, AHRQ, HRSA, and FDA. Grants, agreements, or contracts may be awarded for activities of the OS office to establish an information center and coordinating committee. Activities at the other offices include making recommendations regarding grant-making through other agency accounts, not direct grant-making. 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.	For the new offices, SSAN for each of FY2010 through FY2014. For NIH and SAMHSA offices, SSAN (no years specified). ***OS Office on Women's Health: FY2011 funding = $34 million; FY2012 funding = $34 million; FY2013 funding = $33 million; FY2014 request = $27 million.*** ***NIH Office of Research on Women's Health: FY2011 funding = $42 million; FY2012 funding = $42 million; FY2013 funding = $40 million (est.); FY2014 request = $43 million.***
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.	SSAN for each fiscal year to carry out the activities of the USPSTF and the TFCPS. ***AHRQ funding for USPSTF: FY2011 funding = $11 million (incl. $7 million from the PPHF); FY2012 funding = $11 million (incl. $7 million from the PPHF); FY2013 funding = $10 million (incl. $6 million from the PPHF) (est.); FY2014 request = $11 million.***
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.	Authority expired at end of FY2005; ACA does not authorize new funding. ***Funding for all CDC's existing oral health programs under Sec. 317M: FY2011 = $15 million; FY2012 = $15 million, FY2013 funding = $14 million; FY2014 request = $16 million.***
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. Permanently reauthorizes state immunization grants. Requires new immunization demonstration grants.	SSAN for each of FY2010 through FY2014 for demonstration grants; SSAN (no years specified) for other authorities. ***Funding for the Sec. 317 vaccination program: FY2011 = $589 million (incl. $100 million from the PPHF); FY2012 = $620 million (incl. $190 million from the PPHF); FY2013 = $528 million (incl. $119 million from the PPHF and transfers); FY2014 request = $581 million (incl. $72 million from the PPHF).*** [CFDA 93.185, 93.268, 93.533, 93.539] Note: The amounts above include funding for program implementation and accountability.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
10334	Amends PHSA Sec. 1707 (OS) and PHSA Title IV (NIH)	**Offices of Minority Health.** Elevates the existing OS Office of Minority Health and NIH National Center on Minority Health and Health Disparities (NCMHD); instructs the OS office to award grants and undertake other activities to improve minority health status; and gives the new NIH National Institute on Minority Health and Health Disparities (NIMHD) responsibility for minority health disparities research and other health disparities research at NIH.	SSAN for each of FY2011 through FY2016 for OS office. ***NIMHD: FY2011 funding = $276 million; FY2012 funding = $276 million; FY2013 funding = $260 million; FY2014 request = $283 million.*** ***OS Office of Minority Health: FY2011 funding = $56 million; FY2012 funding = $56 million; FY2013 funding = $40 million; FY2014 request = $41 million.***
10412	Reauthorizes PHSA Sec. 312 (HRSA)	**Rural access to emergency devices.** Reauthorizes a program of grants to community partnerships for the purchase and distribution of automatic external defibrillators (AEDs) in rural communities, and to support AED training for first responders.	$25 million for each of FY2003 through FY2014. ***FY2011 funding = $0.2 million; FY2012 funding = $1 million; FY2013 funding = $2 million; FY2014 request = $0.*** [CFDA 93.259]
Community-Based Prevention: New Programs			
4004	New 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.	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. However, HHS reported using $30 million in FY2012 PPHF funds for tobacco prevention media activities and prevention education and outreach. HHS did not allocate PPHF funds for comparable activities in FY2013, or request such funds for FY2014. CRS did not find comparable information for FY2011.
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.	SSAN (no years specified).
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.	SSAN for FY2010 through FY2014.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
4102(d)	New 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).	SSAN (no years specified) for PRAMS; SSAN for each of FY2010 through FY2014 for NOHSS; no explicit authorization of appropriations for NHANES/MEPS expansion.
4201	New authority (CDC)	**Community transformation grants.** Requires CDC to fund competitive grants for the implementation, evaluation, and dissemination of evidence-based community preventive health activities.	SSAN for each of FY2010 through FY2014. ***FY2011 funding = $145 million (all PPHF); FY2012 funding = $226 million (all PPHF); FY2013 funding = $146 million (all PPHF); FY2014 request = $146 million (incl. $136 from the PPHF).*** [CFDA 93.531]
4202(a)	New authority (CDC)	**Community wellness pilot program.** Requires CDC to award grants 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.	SSAN for each of FY2010 through FY2014.
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.	SSAN (no years specified).
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.	$190 million for each of FY2010 through FY2013 (at least $95 million for epidemiology, $60 million for information management, and $32 million for laboratories). ***Funding for Epidemiology and Laboratory Capacity (ELC): FY2011 = $40 million (all PPHF); FY2012 = $40 million (all PPHF); FY2013 funding = $40 million (PPHF and transfers); FY2014 request = $40 million (all PPHF).***
10407	New authority (CDC)	**Diabetes activities.** Requires CDC to conduct several diabetes prevention activities including state assessments, vital statistics, physician education, and funding of an Institute of Medicine (IOM) report.	SSAN (no years specified).
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.	SSAN for each of FY2011 through FY2015 for both the surveillance system and the expanded research program. ***CDC: FY2012 funding = $2 million; FY2013 funding = $2 million; FY2014 request = $2 million (all PPHF).***

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$9 million for each of FY2010 through FY2014. ***FY2011 funding = $5 million; FY2012 funding = $5 million; FY2013 funding = $5 million; FY2014 request amount not specified.***
10501(g)	New PHSA Sec. 399V-3 (CDC)	**National diabetes prevention program.** Among other things, requires the Secretary to award grants for community-based diabetes prevention program model sites.	SSAN for each of FY2010 through FY2014. ***FY2011 funding = $0 million; FY2012 funding = $10 million (all PPHF); FY2013 funding = $0; FY2014 request = $0.***
Workplace Wellness: New Program			
10408	New 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.	$200 million for the period of FY2011 through FY2015, to remain available until expended. ***FY2011 funding = $10 million (all PPHF); FY2012 funding = $10 million (all PPHF); FY2013 funding = $0; FY2014 request = $0.***

Sources: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from agency budget documents, including the FY2013 sequestration operating plans, available at http://www.hhs.gov/budget/, and communications with the CDC Washington Office.

Table 4. ACA Discretionary Spending: Maternal and Child Health

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$3 million for FY2010, and SSAN for each of FY2011 and FY2012.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 5. ACA Discretionary Spending: Health Care Quality

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$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.
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.	See ACA Sec. 3013(a)&(c) above.
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.	SSAN for each of FY2010 through FY2014.
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 is available and, where appropriate, be provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions.	SSAN for each of FY2010 through FY2014.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$20 million for FY2010 through FY2014.
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.	SSAN (no years specified).
3508/3511	New 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.	SSAN (no years specified).
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.	$3.5 million for FY2010, and SSAN for each of FY2011 through FY2015. ***FY2011 funding = $5 million.*** [CFDA 93.191]

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
Health Care Coordination: New Programs			
3502/3511	New 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.	SSAN (no years specified).
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.	SSAN (no years specified).
3506	New PHSA Sec. 936 (AHRQ)	**Program to facilitate shared decision making.** 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 decision making. Also requires the Secretary to award grants to providers for the development and implementation of shared decision-making techniques.	SSAN for FY2010 and each subsequent fiscal year.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$120 million for each of FY2011 and FY2012, and SSAN for each of FY2013 and FY2014.
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.	$50 million for FY2010, and SSAN for each of FY2011 through FY2014. Note: SAMHSA's Primary & Behavioral Health Care Integration (PBHCI) program, authorized under PHSA Sec. 520A, predates ACA and has received the following amounts: FY2011 funding = $63 million (incl. $35 million from the PPHF); FY2012 = $66 (incl. $35 million from the PPHF); FY2013 funding = $29; FY2014 request = $28 million (all PPHF).
10333	New PHSA Sec. 340H	**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.	SSAN for each of FY2011 through FY2015.
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.	$100 million for each of FY2011 through FY2015, and $150 million for each of FY2016 through FY2020.

Sources: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from agency budget documents, including the FY2013 sequestration operating plans, available at http://www.hhs.gov/budget/.

Table 6. ACA Discretionary Spending: Nursing Homes

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
6112	New 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).	SSAN (no years specified); a monitored chain must contribute a portion of costs of the demonstration, as determined by the Secretary.
6114	New 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 two 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.	SSAN (no years specified).

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 7. ACA Discretionary Spending: Health Disparities Data Collection

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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. [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.]	SSAN for each of FY2010 through FY2014; however, data may not be collected unless funds are directly appropriated for such purpose.
5605	New 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. [Note: GAO released its study in March 2011. See http://www.gao.gov/new.items/d11396.pdf.]	$10 million for FY2010, and $7.5 million for each of FY2011 through FY2018, with amounts appropriated to remain available until expended.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 8. ACA Discretionary Spending: Emergency Care and Trauma Services

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$100 million for FY2009, and SSAN for each of FY2010 through FY2015.
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).	$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. ***FY2011 funding = $21 million; FY2012 funding = $21 million; FY2013 funding = $20 million; FY2014 request = $21 million.*** [CFDA 93.127]
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 that serve a medically underserved population.	$24 million for each of FY2010 through FY2014. Note: This provision reauthorized funding for several existing trauma care grant programs in PHSA Title XII Parts A and B (i.e., Secs. 1202, 1203, and 1211-1222), as well as for the new program (i.e., Sec. 1204).
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 medical care systems and emergency medicine, including pediatric emergency medical care. Also requires the Secretary to support research on the economic impact of coordinated emergency care systems.	SSAN for each of FY2010 through FY2014.
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.	$100 million for each of FY2010 through FY2015.

Sources: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from HRSA's budget documents, including the FY2013 sequestration operating plan, available at http://www.hrsa.gov/about/budget/index.html.

Table 9. ACA Discretionary Spending: Elder Justice

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	SSAN (no years specified). See also new SSA Sec. 2024 below.
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.	SSAN (no years specified). See also new SSA Sec. 2024 below.
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).	$6.5 million for FY2011, and $7.0 million for each of FY2012 through FY2014.
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.	$4 million for FY2011, $6 million for FY2012, and $8 million for each of FY2013 and FY2014.
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.	For new SSA Sec. 2041: $20 million for FY2011, $17.5 million for FY2012, and $15 million for each of FY2013 and FY2014.
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 SSA Sec. 2041.
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 SSA Sec. 2041.
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.	$3 million for FY2011, and $4 million for each of FY2012 through FY2014.

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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 provided by states and local governments.	$100 million for each of FY2011 through FY2014.
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.	$25 million for each of FY2011 through FY2014.
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.	$5 million for FY2011, $7.5 million for FY2012, and $10 million for each of FY2013 and FY2014.
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.	$10 million for each of FY2011 through FY2014.
6703(b)	New 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 provide and improve training of surveyors investigating allegations of abuse in programs and LTC facilities that receive payments under Medicare or Medicaid.	$12 million for the period of FY2011 through FY2014.
6703(b)	New 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.	$5 million for each of FY2011 through FY2014.
6703(c)	New 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.	SSAN (no years specified) to carry out these activities, with funding not to exceed $500,000.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 10. ACA Discretionary Spending: Biomedical Research

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$500 million for FY2010, and SSAN for subsequent fiscal years. Other funds appropriated under the PHSA may not be allocated to CAN. ***FY2012 funding = $10 million; FY2013 funding = $9 million; FY2014 request = $50 million.***

Sources: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from NIH's budget documents, including the FY2013 sequestration operating plan, 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 the new Center. It also redesignated PHSA Sec. 402C as Sec. 480.

Table 11. ACA Discretionary Spending: Biologics

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
7002	Amends PHSA Sec. 351 (FDA)	**FDA approval of follow-on 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. [Note: On February 9, 2012, FDA released three guidance documents to assist industry in developing biosimilar products and submitting them to the agency for approval. See http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/default.htm.]	SSAN for each of FY2010 through FY2012.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 12. ACA Discretionary Spending: 340B Drug Pricing

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	SSAN for FY2010 and each succeeding fiscal year. ***FY2011 funding = $4 million; FY2012 funding = $4 million; FY2013 funding = $4 million; FY2014 request = $6 million (proposed new user fee program).***

Sources: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from HRSA's budget documents, including the FY2013 sequestration operating plan, available at http://www.hrsa.gov/about/budget/index.html.

Table 13. ACA Discretionary Spending: Medical Malpractice

ACA Section	Statutory Authority (Agent)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	$50 million for the period FY2011 through FY2015.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 14. ACA Discretionary Spending: Pain Care Management

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
4305(a)	New 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. [Note: IOM released its report on June 29, 2011. See http://painconsortium.nih.gov/.]	SSAN for each of FY2010 and FY2011.

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 15. ACA Discretionary Spending: Medicaid

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
2705	New 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.	SSAN (no years specified).
2706	New 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.	SSAN (no years specified).

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).

Table 16. ACA Discretionary Spending: Medicare

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
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.	SSAN for each of FY2011 and FY2012, to remain available until expended. ***FY2011 funding = $41 million; FY2012 funding = $41 million; FY2013 funding = $38 million; FY2014 request = $26 million.*** [CFDA 93.241]

Sources: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Funding amounts are taken from HRSA's budget documents, including the FY2013 sequestration operating plan, available at http://www.hrsa.gov/about/budget/index.html.

Table 17. ACA Discretionary Spending: Private Health Insurance

ACA Section	Statutory Authority (Agency)	Summary of Provision	Authorization of Appropriations *Funding (FY2011-FY2014)*
1334	New 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. Note: On March 11, 2013, OPM published a final rule to implement the multi-state plan program (78 *Federal Register* 15560).	SSAN (no years specified).

Source: Table prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).

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