



Selected Health Funding in the American Recovery and Reinvestment Act of 2009

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April 13, 2009

Congressional Research Service

7-5700

www.crs.gov

R40181

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Introduction

The American Recovery and Reinvestment Act (ARRA) of 2009, which the President signed into law on February 17, 2009 (P.L. 111-5), provided more than \$17 billion in supplemental FY2009 discretionary appropriations for biomedical research, public health, and other health-related programs within the Department of Health and Human Services (HHS). ARRA also included new authorizing language to promote health information technology (HIT) and establish a federal interagency advisory panel to coordinate comparative effectiveness research. ARRA funds were designated as emergency supplemental appropriations for FY2009. Regular FY2009 appropriations for HHS were included in the Omnibus Appropriations Act, 2009 (P.L. 111-8), enacted March 11, 2009.

This report discusses the health-related programs and activities funded by ARRA, including details of how the administering HHS agencies and offices plan to allocate, award, and spend the funds. It will be updated as new information becomes available. Unless otherwise noted, all the funds will remain available through the end of FY2010 (i.e., through September 30, 2010). **Table 1** summarizes ARRA's discretionary health funding, by HHS agency and office. **Table 2** provides more details on the funding, by type of activity funded, and includes a comparison of the amounts provided in ARRA, as enacted, with the funding recommendations in the earlier House and Senate versions of the legislation.

As part of its efforts to ensure transparency and accountability in the use of ARRA funds, the Office of Management and Budget (OMB) has issued detailed government-wide guidance for implementing ARRA and has established a website, "Recovery.gov," which allows the public to track ARRA spending.¹ The guidance requires each federal agency to establish a page on its existing website, linked to Recovery.gov, on which they must post all agency-specific information related to ARRA. HHS has created an ARRA website at <http://www.hhs.gov/recovery>.

ARRA also included discretionary funding for human services programs administered by HHS. It provided \$100 million to the Administration on Aging (AOA) for senior nutrition programs authorized under Title III of the Older Americans Act, and gave \$5.15 billion to the Administration for Children and Families (ACF) for the Child Care and Development Block Grant, the Community Services Block Grant, and Head Start. For more information on those funds, see CRS Report RL33880, *Older Americans Act (OAA) Funding*, and CRS Report R40211, *Human Services Provisions of the American Recovery and Reinvestment Act*.

Health Centers

ARRA provided \$2 billion to the Health Resources and Services Administration (HRSA) for grants to health centers authorized under Section 330 of the Public Health Service (PHS) Act. The Secretary is required to submit an operating plan to the Appropriations Committees with funding details and timelines before any funds are obligated. The plan is due within 90 days of enactment. The Secretary also must provide the committees with a report of actual expenditures not later than

¹ Executive Office of the President, Office of Management and Budget, *Initial Implementing Guidance for the American Recovery and Reinvestment Act of 2009*, Memorandum for the Heads of Departments and Agencies M-09-10, February 18, 2009, <http://www.recovery.gov/files/Initial%20Recovery%20Act%20Implementing%20Guidance.pdf>.

November 1, 2009, and every six months thereafter as long as ARRA funding for health centers remains available. HRSA has established a website for its ARRA health center funding at <http://bphc.hrsa.gov/recovery/default.htm>. For more information on health centers, see CRS Report RL32046, *Federal Health Centers Program*.

Infrastructure

Of the \$2 billion available, ARRA allocated \$1.5 billion for the construction and renovation of health centers and the acquisition of HIT systems. There is no regular appropriation of infrastructure funding for health centers. However, some health centers receive facilities and equipment funds in congressionally directed spending (earmarks).²

Patient Services

ARRA also provided \$500 million for grants to health centers to increase the number of underinsured and uninsured patients who receive health care, pharmacy, mental health, substance abuse and oral health services. Of that total, HRSA has allocated \$155 million for New Access Point grants, and \$340 million for Increased Demand for Services (IDS) grants. These funds supplement the FY2009 regular appropriation of \$2.2 billion for federal health centers.

On March 2, 2009, HHS announced the release of \$155 million in New Access Point competitive grants to establish 126 new health centers located in 39 states, Puerto Rico, and American Samoa. The award amounts range from \$478,000 to \$1,300,000.³

On March 27, 2009, HHS announced the release of \$338 million in IDS grants to 1,128 federally qualified health centers in all 50 states, the District of Columbia, Puerto Rico, and the other U.S. territories.⁴ The awards are based on a formula.⁵ The project period for all IDS grantees is limited to two years, from March 27, 2009, through March 26, 2011. Health centers will use the funds over the next two years to create or retain approximately 6,400 jobs and provide care to an estimated additional 2.1 million patients, including 1 million uninsured people.⁶

Health Workforce Programs

ARRA provided \$500 million to HRSA for PHS Act workforce programs. Of this total, \$300 million is for the National Health Service Corps (NHSC), \$75 million of which is to remain available through September 30, 2011, and \$200 million is for the health professions programs authorized in PHS Act Title VII and Title VIII. Funds may also be used to develop interstate licensing agreements to promote telemedicine. The requirements for reporting to the

² The FY2009 omnibus appropriations act included \$310 million in congressionally directed spending for health facilities, including funding for numerous specified health centers.

³ More information on health centers is at <http://www.hhs.gov/recovery/hrsa/healthcentergrants.html>. For a list of the New Access Point grantees, go to <http://www.hhs.gov/recovery/hrsa/applicant.html>.

⁴ For a list of the IDS grants by state, go to <http://www.hhs.gov/recovery/programs/hrsa/idsgawards.html>.

⁵ Under the formula, each health center receives \$100,000 (base allocation) + \$6.00 per insured patient + \$19.00 per uninsured patient. Patient information is based on the CY2008 Uniform Data System (UDS) data.

⁶ Information on the IDS grants is at http://bphc.hrsa.gov/recovery/ids_faq.htm.

Appropriations Committees that apply to the use of the ARRA health center funds (described above) also apply to the workforce funding. HRSA has yet to announce details of how the workforce funds will be expended. The FY2009 omnibus appropriations act included \$135 million for NHSC and \$393 million for health professions programs.

Biomedical and Behavioral Research

ARRA provided \$10.0 billion directly to the National Institutes of Health (NIH) for biomedical research and extramural research facilities, plus \$400 million more through a transfer from AHRQ for comparative effectiveness research (discussed below). Of the \$10.0 billion, the law provided \$8.2 billion to the Office of the Director for support of NIH extramural and intramural research. Most of that funding, \$7.4 billion, is for transfer to the NIH institutes and centers and the Common Fund in proportion to their regular appropriations. The remaining \$800 million is available for use at the Director's discretion, with an emphasis on short-term (two-year) projects, including \$400 million that may be used under the Director's flexible research authority. Also included in the \$10.0 billion total was \$1 billion to the National Centers for Research Resources (NCRR) for grants to construct and renovate university research facilities, as well as \$300 million to NCRR for grants for shared instrumentation and other capital research equipment at extramural research facilities. Finally, the Buildings and Facilities account received \$500 million for construction, repair, and improvement of NIH intramural facilities.

NIH received a total of \$30.3 billion at the program level in regular FY2009 appropriations, so the additional funds from ARRA have boosted NIH's resources by nearly one-third. NIH says it expects to spend as much of the ARRA funding as possible in FY2009, although the funds are available for two years. The \$8.2 billion in ARRA research funding will be used by the institutes and centers and the Director for a wide variety of competitive grant programs and intramural research, as is the case with the regular appropriations. NIH does intend, however, to "follow the spirit of the ARRA by funding projects that will stimulate the economy, create or retain jobs, and have the potential for making scientific progress in 2 years." The \$1 billion for NCRR construction and renovation grants for extramural research facilities will be spent under a program that has received no funding since FY2005, while the \$300 million for shared instrumentation grants is several times larger than the usual funding for that program.

Plans for the ARRA funding are being tracked on the NIH Recovery website (<http://www.nih.gov/recovery>), which includes a site listing current grant funding opportunities (<http://grants.nih.gov/recovery>). NIH is focusing activities on (1) funding new and recently peer reviewed, highly meritorious research grant applications that can be accomplished in two years or less; (2) giving targeted supplemental awards to current grants to push research forward; and (3) supporting a new initiative called the NIH Challenge Grants in Health and Science Research (at least \$200 million to fund 200 or more grants) for research on specific topics that would benefit from significant two-year jumpstart funds. Announcements soliciting applications for the NCRR construction/renovation grants and the instrumentation grants have also been posted. Some recent announcements include plans to support about \$60 million in grants for research to address the heterogeneity in autism spectrum disorders, and availability of \$21 million over two years for educational opportunities in NIH-funded laboratories for students and science educators.

Comparative Effectiveness Research

ARRA provided \$1.1 billion to the Agency for Healthcare Research and Quality (AHRQ) for comparative effectiveness research. The funds are to be used to support research that (1) compares the clinical outcomes, effectiveness, and appropriateness of preventive, diagnostic, and therapeutic items, services, and procedures, and (2) encourages the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data. Of the total, \$400 million is to be transferred to NIH and \$400 million is to be allocated at the discretion of the Secretary. The Secretary is required to use up to \$1.5 million for an Institute of Medicine (IOM) study on national priorities for comparative effectiveness research, to be submitted to Congress no later than June 30, 2009. AHRQ may not use more than 1% of the \$300 million that remain under its own discretion for additional FTEs. According to the agency, that amount (i.e., \$3 million) translates into approximately 15 FTEs (two-year appointments).

In addition to appropriating funds for comparative effectiveness research, ARRA established an interagency advisory panel to help coordinate and support the research. The Federal Coordinating Council for Comparative Effectiveness Research, composed of up to 15 senior officials (including physicians and others with clinical expertise) from federal agencies with health-related programs, is required to report to the President and Congress annually. Importantly, ARRA included language stating that (1) the Council may not mandate coverage, reimbursement, or other policies for public and private payers of health care, and (2) Council reports and recommendations may not be construed as mandates or clinical guidelines for payment, coverage, or treatment. On March 19, 2009, HHS announced the members of the Council.⁷

AHRQ's existing research on comparative effectiveness, pursuant to Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), is part of the agency's "Effective Health Care Program." ARRA's comparative effectiveness funding will dramatically increase the amount of federally funded research in this area. The FY2009 omnibus appropriations act provided AHRQ with \$50 million for comparative effectiveness research (an increase of \$20 million from FY2008). AHRQ has yet to announce how the ARRA comparative effectiveness funds will be allocated and expended.⁸

Health Information Technology

ARRA provided \$2 billion to the HHS Office of the National Coordinator for Health Information Technology (ONCHIT) to fund activities and grant programs authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was incorporated in ARRA. Of that amount, \$300 million is to support regional health information exchange networks. In addition, the Secretary is instructed to transfer \$20 million to the National Institute of Standards and Technology (NIST) for HIT standards analysis and testing. The HIT funding will become available for obligation once the Secretary submits an annual operating plan to the Appropriations Committees with details of funding allocations and how they align with the objectives of the federal HIT strategic plan. The FY2009 plan is due within 90 days of enactment.

⁷ A list of the names of the 15 Council members is at <http://www.hhs.gov/recovery/programs/os/cerbios.html>.

⁸ http://effectivehealthcare.ahrq.gov/documents/2009_0306AHRQCompEffectivenessFunding.html

Subsequent annual plans are due by November 1 of each year. The Secretary also must provide the committees with a report of actual HIT expenditures not later than November 1, 2009, and every six months thereafter as long as ARRA funding for HIT remains available. The FY2009 omnibus appropriations act provided \$61 million for ONCHIT.

The HITECH Act is intended to promote the widespread adoption of HIT for the electronic sharing of clinical data among hospitals, physicians, and other health care providers.⁹ To that end, the HITECH Act includes three sets of provisions. First, it codifies ONCHIT within the Office of the HHS Secretary. Created by a presidential executive order in 2004, ONCHIT has played an important role directing HIT activities both inside and outside the federal government. It has focused on developing technical standards necessary to achieve interoperability among varying electronic health record (EHR) applications; establishing criteria for certifying that HIT products meet those standards; ensuring the privacy and security of electronic health information; and helping facilitate the creation of prototype health information networks. The goal is to develop a national capability to exchange standards-based health care data in a secure computer environment. The HITECH Act requires the HHS Secretary, by December 31, 2009, to issue a comprehensive set of initial HIT standards.

Second, the HITECH Act through a number of mechanisms provides financial incentives for HIT use among health care providers. It establishes several grant programs to provide funding for investing in HIT infrastructure, purchasing certified EHRs, training, and the dissemination of best practices. It also authorizes grants to states for low-interest loans to help providers finance HIT. In addition to the grant programs, the HITECH Act authorizes HIT incentive payments under the Medicare and Medicaid programs.

Finally, the HITECH Act includes a series of privacy and security provisions that amend and expand the current federal standards under the Health Insurance Portability and Accountability Act (HIPAA). Among other things, it establishes a breach notification requirement for health information that is not encrypted, strengthens enforcement of the HIPAA standards, places new restrictions on marketing activities by health plans and providers, and creates transparency by allowing patients to request an audit trail showing all disclosures of their electronic health information. For more information, see CRS Report R40161, *The Health Information Technology for Economic and Clinical Health (HITECH) Act*.

Disease Prevention

ARRA provided \$1 billion to the HHS Secretary for a Prevention and Wellness Fund, for three specified activities: (1) \$300 million to the Centers for Disease Control and Prevention (CDC) for the PHS Act “Section 317” immunization program; (2) \$650 million for evidence-based clinical and community-level prevention and wellness programs, authorized by the PHS Act, that address chronic diseases; and (3) \$50 million for state activities to reduce healthcare-associated infections (HAIs). The immunization program received \$496 million in regular FY2009 appropriations.

⁹ The HITECH Act appears in two ARRA titles. Division A, Title XIII includes the provisions dealing with (1) ONCHIT, standards and certification; (2) grant, loan, and demonstration programs; and (3) privacy and security. Division B, Title IV includes the Medicare and Medicaid HIT incentives.

On April 9, 2009, HHS announced the allocation of Section 317 immunization funds to the existing 64 state, territorial, and municipal public health department grantees.¹⁰ The funds are to be distributed as follows: \$200 million in specified amounts to each grantee; \$50 million in amounts not yet specified for program operation grants, for grantees to deliver vaccines and strengthen their immunization programs; and \$18 million for innovation grants to increase vaccination rates and improve reimbursement practices.¹¹ The remaining \$32 million is to be used for immunization information, communication, education, and evidence development activities.

The fate of the additional disease prevention funds has not yet been announced. With respect to the \$650 million for evidence-based prevention and wellness programs, earlier versions of the ARRA legislation and accompanying reports mentioned certain specific programs (at CDC and other HHS agencies) that would meet this objective, but the conference report and the enacted law do not so specify. With respect to the \$50 million for state activities to reduce healthcare-associated infections (HAIs), the law and conference report do not elaborate further. In January 2009, HHS published a national strategy and action plan to reduce HAIs.¹² Also, in FY2009 omnibus appropriations, Congress provided a \$22 million increase in HHS-wide funding for HAI reduction activities, and made the final allotment of FY2009 prevention block grant¹³ funding to states contingent upon their certification that they will submit an HAI reduction plan to the Secretary by January 1, 2010.

Indian Health Care

ARRA provided \$500 million for the Indian Health Service (IHS), with \$415 million going to the IHS health facilities account and \$85 million going to HIT activities. Within the health facilities account, \$227 million was for health care facilities construction (to complete up to two facilities on IHS's current priority list for which work has already been initiated), \$100 million was for facilities maintenance and improvement, \$68 million was for sanitation facilities construction, and \$20 million was for equipment (including HIT). The \$85 million for HIT activities, to include telehealth services, fell under the Indian health services account but could include HIT-related infrastructure activities, and was to be allocated at the discretion of the IHS director.

IHS constructs and maintains hospitals, clinics, and health centers throughout Indian Country, and also funds construction of Indian sanitation facilities. The \$415 million provided by ARRA for IHS facilities was more than the \$390.2 million provided by the FY2009 omnibus appropriations act. ARRA funds added \$227 million to the FY2009 omnibus's \$40 million for health care facilities construction; added \$100 million to the FY2009 omnibus's \$53.9 million for facilities maintenance and improvement; added \$68 million to the FY2009 omnibus's \$95.9 million for sanitation facilities construction; and added \$20 million to the FY2009 omnibus's \$22.1 million

¹⁰ Grantees are all 50 states (including the District of Columbia), all territories, and the cities of New York, Chicago, Philadelphia, Houston, and San Antonio. For a state by state list of Section 317 awards, go to <http://transparency.cit.nih.gov/RecoveryGrants/grant.cfm?grant=vaccines>.

¹¹ Grantees may apply for innovation grants after they are announced at <http://www.grants.gov/>.

¹² HHS, *HHS Action Plan to Prevent Healthcare-Associated Infections*, January 2009, <http://www.hhs.gov/ophs/initiatives/hai/>.

¹³ The Preventive Health and Health Services block grant is a program of grants to states, authorized in Part A of Title XIX of the PHS Act and administered by CDC, which provides flexible funding to address state-identified public health priorities.

for equipment. ARRA required that the \$227 million for health care facilities construction be used to complete up to two facilities from the current priority list. IHS announced that one of the facilities will be a hospital in Nome, Alaska.¹⁴

IHS has existing HIT operations for both personal health services and public health activities, funded chiefly through the hospital and health clinics budget in IHS's health services account. The FY2009 omnibus appropriations act added \$2.5 million to existing funding in this budget item for HIT activities. The additional \$85 million for HIT in ARRA is to be allocated by the IHS director, with expenditures to be on further development of existing management and EHR software and on telehealth infrastructure and development, with 20% going to hardware.

IHS received its appropriations under ARRA's Title VII, which required that funds for facilities and infrastructure were to be expended with preference for projects that could be started and completed expeditiously, with the goal of spending at least 50% of the funds for activities that could be started within 120 days of ARRA enactment. The same title required reports to the Appropriations Committees of general expenditure plans within 30 days and detailed expenditure plans within 90 days. IHS facilities and equipment funds are allocated on the basis of priority formulas. ARRA excluded IHS health facilities funds from the usual annual spending caps for medical equipment, and also excluded them from ARRA's general provision requiring payment of prevailing wage rates under the Davis-Bacon Act for construction and repair projects. (Separate prevailing wage rate requirements apply to IHS construction activities.) IHS had no special website for expenditure of ARRA funds, as of March 20, 2009.

For more information, see CRS Report RL33022, *Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues*.

Table I. ARRA Discretionary Health Funding, by Agency/Office
(\$ millions)

Agency/Office	Funding	Explanation
Health Resources and Services Administration (HRSA)	2,500	ARRA's funding for HRSA includes \$1.5 billion for health center renovation and repair, \$500 million for health center grants and HIT acquisition, and \$500 million for the National Health Service Corps and other health workforce programs.
National Institutes of Health (NIH)	10,000	ARRA's funding for NIH includes \$1.3 billion for non-federal research facility construction, renovation, and equipment; \$8.2 billion for intramural and extramural research; and \$500 million for NIH buildings and facilities.
Agency for Healthcare Research and Quality (AHRQ)	1,100	This funding is for comparative effectiveness research. Of the total, \$300 million is for AHRQ, \$400 million is to be transferred to NIH, and \$400 million is to be allocated at the Secretary's discretion.
Indian Health Service (IHS)	500	ARRA's funding for IHS includes \$415 million for Indian health facility construction, maintenance, and equipment (including HIT), and \$85 million for HIT, including telehealth.

¹⁴ HHS, "Indian Health Service 30-Day Report to Congress, General Plan for Expenditure of Recovery Act Funds," <http://www.hhs.gov/recovery/reports/ihreport.html>.

Agency/Office	Funding	Explanation
Office of the HHS Secretary		
Office of the National Coordinator for Health Information Technology	2,000	This funding is for grants and other activities under the Health Information Technology for Economic and Clinical Health (HITECH) Act.
Public Health and Social Services Emergency Fund (PHSSEF)	50	This funding is for HHS cybersecurity.
Prevention and Wellness Fund	1,000	Of the total, \$300 million is for CDC's immunization program, \$650 million is for prevention and wellness programs, and \$50 million is for state programs to reduce healthcare-associated infections.

Source: Table prepared by the Congressional Research Service, based on the ARRA conference report (H.Rept. 111-16).

Table 2. ARRA Discretionary Health Funding, by Activity
(\$ millions)

Activity (Agency/Office)	House passed	Senate passed	Enacted	Explanation
Health Centers				
HRSA	1,500	1,870	2,000	ARRA provides \$1.5 billion for the renovation and repair of health centers and the acquisition of HIT systems; the remaining \$500 million is for center grants. The House recommended \$1 billion for center renovation and HIT acquisition, and \$500 million for center grants. The Senate recommended \$1.87 billion for construction, renovation and equipment for health centers.
Health Workforce				
HRSA	600	0	500	ARRA provides \$500 million for PHS Act health workforce programs. Of this total, \$300 million is for the National Health Service Corps (\$75 million of which is to remain available through September 30, 2011), and \$200 million is for education and training programs authorized in Title VII (Health Professions) and Title VIII (Nursing Training) of the PHS Act. Funds may also be used to develop interstate licensing agreements to promote telemedicine. The House recommended \$600 million for health workforce programs; the Senate recommended no such funding.
HHS Buildings and Facilities				
CDC	462	412	0	The House and Senate both recommended funding for CDC for the acquisition of real property, equipment, construction, and renovation of facilities, including necessary repairs and improvements to leased laboratories. The House also included a requirement to relocate and consolidate property and facilities of the National Institute for Occupational Safety and Health (NIOSH). ARRA provides no funding for CDC buildings and facilities.
NIH	500	500	500	ARRA provides \$500 million for high-priority repair, construction, and improvement projects for NIH facilities on the Bethesda, MD campus and other agency locations, as recommended by the Senate. The House and Senate both recommended the same amount, but the House would have allowed funding only for repair and improvement projects.
IHS	550	410	415	ARRA provides \$415 million for Indian health facilities. Within this amount, \$227 million is for health care facilities construction, \$100 million is for facilities maintenance and improvement, \$68 million is for sanitation facilities construction, and \$20 million is for equipment (including HIT). The funds are not subject to the annual spending caps for medical equipment. The House recommended \$550 million for Indian health facilities construction projects, deferred maintenance, and the purchase of equipment and related services (including HIT), all to be allocated at the discretion of the IHS Director. The Senate recommended \$410 million for the Indian Health Facilities account.
HRSA	88	88	0	The House and Senate both recommended funding to cover the costs of temporary relocation of staff during renovation or replacement of the headquarters building for the Public Health Service. ARRA includes no such funding.

Activity (Agency/Office)	House passed	Senate passed	Enacted	Explanation
Biomedical/Behavioral Research Facilities (Extramural)				
NIH, NCRR	1,500	300	1,300	ARRA provides \$1.3 billion to NCRR, of which \$1 billion is for competitive grants and contracts under PHS Act Sec. 481A to construct, renovate, or repair existing non-federal research facilities. It waives various requirements for matching funds and support of regional centers for primate research, and shortens the time (from 20 years to 10 years) for required future use of the research facility. It also permits use of \$300 million for shared instrumentation and other capital research equipment. The House recommended \$1.5 billion for awards to renovate or repair existing facilities, and permitted use of funds for shared instrumentation and other capital research equipment. The Senate recommended funds only for shared instrumentation and other capital research equipment.
Biomedical Research				
NIH	1,500	9,200	8,200	ARRA provides \$8.2 billion to the Office of the Director for support of additional scientific research (extramural and intramural). The funds are not subject to small business set-aside requirements. Of the total, \$7.4 billion is to be transferred to the Institutes and Centers of NIH and to the Common Fund in proportion to regular appropriations (certain accounts are not eligible for these funds). The remaining \$800 million is available at the Director's discretion, with an emphasis on short-term (2-year) projects, including \$400 million that may be used under the Director's flexible research authority. The House recommended \$1.5 billion, all for transfer proportionally to the Institutes, Centers, and Common Fund, with half for FY2009 and half for FY2010. The Senate recommended \$9.2 billion, with \$7.85 billion for proportional transfer and \$1.35 billion for the Director's discretionary use.
Comparative Effectiveness				
AHRQ	1,100	1,100	1,100	ARRA provides \$1,100 million to AHRQ for comparative effectiveness research. Of the total: \$300 is for AHRQ; \$400 million is to be transferred to NIH and may be allocated to the Institutes, Centers, and Common Fund; and \$400 million is to be allocated at the Secretary's discretion to (1) conduct, support, or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of preventive, diagnostic, and therapeutic items, services, and procedures, and (2) encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data. The Secretary is to fund an Institute of Medicine study, to be submitted to Congress no later than June 30, 2009. The study must include recommendations on the national priorities for comparative effectiveness research. The Secretary is also instructed to consider any recommendations submitted by the Federal Coordinating Council for Comparative Effectiveness Research. The House and Senate both recommended the same amount of funding.

Activity (Agency/Office)	House passed	Senate passed	Enacted	Explanation
Health Information Technology				
Office of the Secretary, ONCHIT	2,000	3,000	2,000	ARRA provides \$2 billion, to remain available until expended, to implement the HITECH Act and promote the widespread adoption of electronic health records, of which \$300 million is to support regional health information exchange networks. It transfers \$20 million to NIST for HIT standards analysis and testing. The House and Senate both recommended HIT funding.
IHS	0	85	85	ARRA provides \$85 million for HIT, including telehealth, to be allocated at the discretion of the IHS Director. The Senate recommended the same amount for HIT (and, separately, added \$50 million for contract health care services). The House did not recommend a specific amount for HIT; however, funding for Indian health facilities (described earlier in the table) may be used for the purchase of equipment, including HIT.
Public Health Preparedness				
Office of the Secretary, PHSSEF	430	0	0	The House recommended funding for advanced research and development of countermeasures through the Biomedical Advanced Research and Development Authority (BARDA; PHS Act Sec. 319L). ARRA includes no such funding.
	420	0	0	The House recommended funding for preparedness for an influenza pandemic, including procurement of countermeasures and equipment. Funds could be used for construction or renovation of privately owned facilities for the production of vaccine and other biologics. ARRA includes no such funding.
	50	0	50	ARRA provides funds to improve information technology security (i.e., cybersecurity) at HHS. The House recommended the same amount of funding.
Disease Prevention				
	3,000	0	1,000	ARRA provides \$1 billion for a Prevention and Wellness Fund to be administered by the Secretary. Of the total, \$300 million is to be transferred to CDC for the immunization program, \$650 million is for evidence-based clinical and community-level prevention and wellness programs that address chronic disease, and the remaining \$50 million is for state activities to reduce healthcare-associated infections. The House recommended \$3 billion for a Prevention and Wellness Fund.

Source: Table prepared by the Congressional Research Service using (i) the text of H.R. 1, as passed by the House on January 28, 2009, (ii) the text of Senate Amendment 570 to H.R. 1, as passed by the Senate on February 10, 2009, and (iii) the text of the ARRA conference report (H.Rept. 111-16).

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