American Rescue Plan Act of 2021 (P.L. 117-2): Public Health, Medical Supply Chain, Health Services, and Related Provisions

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SUMMARY

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Johnathan H. Duff, Coordinator
Analyst in Health Policy

Kavya Sekar, Coordinator
Analyst in Health Policy

American Rescue Plan Act of 2021 (P.L. 117-2): Public Health, Medical Supply Chain, Health Services, and Related Provisions

The American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) is the sixth major legislative package in a series to address domestic public health and health system challenges related to the Coronavirus Disease 2019 (COVID-19) pandemic—the most consequential and widespread domestic infectious disease emergency in over a century. This CRS report describes ARPA's public health, behavioral health, medical supply chain, and health-related workforce, services, and support provisions. These provisions provide mandatory appropriations to support related activities. Most of these public health-related provisions are found in Title II of the law. Many, but not all, of the provisions in this report are to be carried out by agencies and offices based in the Department of Health and Human Services (HHS), particularly those of the U.S. Public Health Service (PHS).

This report summarizes the following major ARPA provisions:

- **Public Health Infrastructure.** ARPA provides substantial funding for the continued public health response to the COVID-19 pandemic and more broadly for the nation's public health infrastructure and response capabilities. ARPA includes funding for the Centers for Disease Control and Prevention (CDC) for the nationwide vaccination program, vaccine confidence activities, data modernization, and assistance to state, local, territorial and tribal (SLTT) governments, among others. It also provides funding to HHS and CDC for testing, surveillance, and contact tracing, including tracking of variant viral strains.
- **Medical Countermeasures and Supply Chain.** ARPA builds on previous COVID-19 relief acts by providing funding to HHS for the research and development, manufacture, and purchase of medical countermeasures related to COVID-19 (or any disease with pandemic potential). It also provides funding for the Food and Drug Administration (FDA) to support medical countermeasures and other activities. ARPA additionally provides funding for activities under the Defense Production Act of 1950 related to the purchase, production, and distribution of medical supplies related to addressing the COVID-19 pandemic, as well as public health needs for infectious disease emergencies more broadly.
- **Health Workforce.** ARPA provides funding to augment the public health and health care workforce at the federal, state, and local levels. This funding includes financial support to recruit, train, and retain new health workers. In addition, the law creates new programs targeting health provider and public safety officer well-being and provides additional funding to further develop the behavioral health workforce generally. ARPA also provides additional funding to increase the number of providers who care for underserved and geographically isolated populations.
- **Health Care Infrastructure and Provider Support.** ARPA provides additional funding to certain types of health provider organizations, focusing on those that serve disadvantaged populations (e.g., community health centers and support for family planning programs). It includes provisions that specifically target rural health care providers and Certified Community Behavioral Health Clinics (CCBHCs).
- **Mental Health and Substance Use.** ARPA provides funding for Substance Abuse and Mental Health Services Administration (SAMHSA) programs for community behavioral health activities. Specifically, ARPA provides funding to SAMHSA's largest block grant programs and for school-based mental health, suicide prevention, childhood trauma, and pediatric mental health care access via telemedicine.
- **Aging and Disability Services.** ARPA provides funding for Administration for Community Living (ACL) aging and disability services programs. The law provides funding to Older Americans Act formula grant programs that provide nutrition and other supportive services with a focus on vaccine outreach and education. It also provides funding to address social isolation, funds the establishment of a National Technical Assistance Center on Grandfamilies and Kinship Families, and grants additional funding to prevent, detect, and treat elder abuse, in part through federal support to state Adult Protective Services (APS) programs.

Several of the programs funded by ARPA typically receive discretionary appropriations through the annual appropriations process. Many of these programs receive mandatory appropriations for the first time through ARPA. The funds for existing programs are generally provided "in addition to amounts otherwise available"—that is, to supplement prior regular and COVID-19-related supplemental appropriations. Some ARPA provisions either direct or allow for the funding of new activities; in these cases, the ARPA provision could generally serve as the authorization for such activities. All ARPA appropriations in this report are for FY2021, and those funds are available for multiple years or until expended.

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Introduction

The American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) is the sixth major legislative package in a series to address domestic public health and health system challenges related to the Coronavirus Disease 2019 (COVID-19) pandemic—the most consequential and widespread domestic infectious disease emergency in over a century. ARPA follows several earlier COVID-19 pandemic response measures enacted in 2020. ARPA includes provisions addressing a number of issues, such as tax credits, unemployment benefits, state fiscal relief, health, housing, education, and food assistance, among others.

This report describes ARPA's public health, behavioral health, medical supply chain, and health-related workforce, services, and support provisions. Most of these public health-related provisions are found in Title II of the law. Many, but not all, of the ARPA provisions in this report are carried out by agencies and offices in the Department of Health and Human Services (HHS), especially those of the U.S. Public Health Service (PHS).[1] This report does not address health care financing provisions of ARPA, which are addressed in CRS Report R46777, *American Rescue Plan Act of 2021 (P.L. 117-2): Private Health Insurance, Medicaid, CHIP, and Medicare Provisions*. This report also does not address certain provisions specific to federal health care systems outside of HHS; for example, provisions specific to the Veterans Health Administration.

ARPA follows five earlier major COVID-19-related relief laws that addressed public health and related issues:

- The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123), enacted on March 6, 2020.
- The Families First Coronavirus Response Act (FFCRA, P.L. 116-127), enacted on March 18, 2020.
- The Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136), enacted on March 27, 2020.
- The Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA, P.L. 116-139), enacted on April 24, 2020.
- The Consolidated Appropriations Act, 2021 (P.L. 116-260), enacted on December 27, 2020.[2]

Among other things, the prior COVID-19-related laws provided substantial funding, almost entirely in the form of supplemental discretionary appropriations, to the U.S. Public Health Service agencies and offices for COVID-19 pandemic response (as summarized in CRS Report

[1] The U.S. Public Health Service (PHS) comprises eight agencies and two offices within the Department of Health and Human Services (HHS). These include the Agency for Healthcare Research and Quality (AHRQ), the Agency for Toxic Substances and Disease Registry (ATSDR), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA). The two HHS offices that are a part of the Public Health Service (PHS) are the Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Office of Global Affairs (OGA). The Office of the Assistant Secretary for Health (OASH) is responsible for leadership and coordination of the Public Health Service. Other HHS operating divisions that are not a part of PHS include the Administration for Children and Families (ACF), the Administration for Community Living (ACL), and the Centers for Medicare & Medicaid Services (CMS). See HHS, "HHS Organizational Chart," https://www.hhs.gov/about/agencies/orgchart/index.html.

[2] Several divisions of P.L. 116-260, Consolidated Appropriations Act, 2021, included provisions that addressed public health issues (in addition to the regular appropriations in the law), including Divisions M, N, BB and CC.

R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*). Many of these agencies and offices receive additional funding through ARPA, as summarized in this report.

ARPA was considered by Congress through the budget reconciliation process.[3] (For a summary of the reconciliation process for ARPA, see "Budget Reconciliation Process" in CRS Report R46777, *American Rescue Plan Act of 2021 (P.L. 117-2): Private Health Insurance, Medicaid, CHIP, and Medicare Provisions*.) The funding in ARPA is distinct from the public health funding provided in the supplemental appropriations divisions[4] of earlier relief measures: per budget reconciliation requirements, it was provided in an authorizing rather than an appropriations measure.[5] Thus, the funding in ARPA is classified as mandatory rather than discretionary spending, because the funds are appropriated in an authorizing law.[6] The funding provided by ARPA is appropriated for FY2021 and each of the appropriations identified in this report is available for multiple years or until expended.

Many of the programs funded by ARPA are typically funded through the annual discretionary appropriations process. Some programs receive mandatory appropriations for the first time through ARPA. The ARPA funds for previously existing programs are generally provided "in addition to amounts otherwise available"—that is, to supplement funds made available through prior regular and supplemental appropriations laws.

In some instances, ARPA funding is for purposes specified in existing statutory authorizations, for example, funding for youth suicide prevention in Section 2710. In others, ARPA funding is for activities for which there is no preexisting dedicated program or program-specific statutory authorization. For example, funding for the public health workforce in Section 2501 of ARPA is not designated to an existing HHS statutory authority or program, but rather to the HHS Secretary to carry out specified activities. In these cases, the ARPA provision could generally serve as the authorization for such activities. In other instances, ARPA provides funding to be used broadly for certain activities, but the act does not identify specific amounts for existing statutory authorities, programs, or activities. For example, funding in Section 2402 is made available for genomic sequencing and surveillance activities at the Centers for Disease Control and Prevention (CDC). In these cases, executive branch officials and administering agencies would generally have discretion to allocate ARPA funding for existing programs or use it to fund new activities. Likewise, executive agencies would determine requirements for new activities funded through ARPA pursuant to the parameters specified in that law. Even when ARPA funding supports

[3] Consideration of ARPA began early in the 117th Congress. On February 8, 2021, House Ways and Means Committee Chairman Richard E. Neal released nine legislative proposals to be considered under the budget reconciliation instructions. On February 27, 2021, the House passed these proposals as part of the American Rescue Plan Act of 2021 (ARPA; H.R. 1319). On March 4, 2021, the Senate version of the American Rescue Plan Act of 2021, S.Amdt. 891 to H.R. 1319, was offered. On Saturday March 6, 2021, the Senate adopted S.Amdt. 891 and subsequently passed H.R. 1319, as amended. On March 10, 2021, the House agreed to the Senate-passed version of H.R. 1319 as amended by S.Amdt. 891. On March 11, 2021, the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) was signed into law. The versions of the bill passed on March 6 in the Senate and March 10 in the House are substantively identical to the law as enacted.

[4] Divisions of prior relief laws that included supplemental discretionary appropriations for public health purposes include Division A of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123); Division A of the Families First Coronavirus Response Act (FFCRA, P.L. 116-127); Division B of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136); Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA, P.L. 116-139); and Division M of Consolidated Appropriations Act, 2021 (P.L. 116-260).

[5] See CRS Report R44058, *The Budget Reconciliation Process: Stages of Consideration*.

[6] For a discussion of discretionary versus mandatory appropriations mechanisms, see CRS Report R44582, *Overview of Funding Mechanisms in the Federal Budget Process, and Selected Examples*.

activities similar to existing programs, new activities may be established through ARPA provisions. These new activities potentially may not be subject to the same requirements—such as reporting requirements—as existing activities authorized elsewhere in law. In some cases, ARPA provisions explicitly establish a new program, for example, the emergency pilot program for rural health care in Section 1002.

In addition, unlike prior pandemic-related relief laws, several ARPA public health provisions are not limited to pandemic-specific activities and may be used to address broader activities that have been highlighted by the pandemic. For example, several of the appropriations in the "Public Health Infrastructure" and "Medical Countermeasures and Supply Chain" sections allow funds to be used for activities related to other pathogens or diseases in addition to COVID-19. Many of the broader health-related infrastructure, workforce, and support program provisions in ARPA provide funding for related activities broadly (rather than specifically in response to the pandemic).

Report Overview

This report describes ARPA provisions related to public health, behavioral health, the medical supply chain, and health-related workforce, services, and support. The provision summaries are grouped under the following categorical report sections: (1) "Public Health Infrastructure," (2) "Medical Countermeasures and Supply Chain," (3) "Health Workforce," (4) "Health Care Infrastructure and Provider Support," (5) "Mental Health and Substance Use," and (6) "Aging and Disability Services." These provisions are found mostly in Title II of ARPA. (Exceptions include the medical supply enhancement provision in Title III, additional funding for aging and disability services in Title IX, and three health care infrastructure and provider support provisions in Titles I, IX, and XI, respectively.) Each report section includes a broad overview of the relevant context for each policy area and continues with a brief summary of related ARPA provisions, followed by the policy context (background) and a more detailed summary for each ARPA provision. This report describes the law as enacted on March 11, 2021, and will not be updated to track implementation or amendments to the law. Numbers that appear throughout this report may not necessarily add to totals due to rounding. A table with abbreviations used throughout the report is included in the **Appendix**.

The following is a snapshot of the ARPA provisions covered in this report:

Public Health Infrastructure. ARPA provides substantial funding for the continued public health response to the COVID-19 pandemic and more broadly for the nation's public health infrastructure and response capabilities. ARPA provides funding to the CDC for the nationwide vaccination program, vaccine confidence activities, data modernization, and assistance to state, local, territorial, and tribal (SLTT) governments, among others. It also provides funding to the HHS and CDC for testing, surveillance, and contact tracing, including tracking of variant viral strains.

Medical Countermeasures and Supply Chain. ARPA builds on previous COVID-19 supplemental measures by providing funding to HHS for the research and development, manufacture, and purchase of medical countermeasures related to COVID-19 or any disease with pandemic potential. It also provides funding for the Food and Drug Administration (FDA) to support medical countermeasures and other activities. ARPA provides funding for activities under the Defense Production Act of 1950 related to the purchase, production, and distribution of medical supplies related to combatting the COVID-19 pandemic, as well as public health needs for infectious disease emergencies more broadly.

Health Workforce: ARPA provides additional funding to augment the public health and health care workforce at the federal, state, and local levels. This financial support includes funding to recruit, train, and retain new health workers. In addition, the law creates new programs targeting health provider and public safety officer well-being and provides additional funding to further develop the behavioral health workforce generally. ARPA also provides additional funding to increase the number of providers who care for underserved and geographically isolated populations. This support includes funding for programs that train or that provide scholarships or loan repayments to health providers who care for underserved populations.

Health Care Infrastructure and Provider Support. ARPA provides additional funding to certain types of health provider organizations, focusing on those that serve disadvantaged populations (e.g., community health centers and support for family planning programs). It includes two provisions that specifically target rural health care providers. One of these provisions creates a fund similar to the existing Provider Relief Fund (PRF) but with a new funding stream available only to rural facilities. The other provision creates a new program within the U.S. Department of Agriculture (USDA) that makes grants to rural facilities for a number of purposes, including increased costs related to vaccine distribution.

Mental Health and Substance Use: ARPA provides funding for Substance Abuse and Mental Health Services Administration (SAMHSA) programs for community behavioral health activities. This funding includes support for SAMHSA's largest block grant programs, school-based mental health, suicide prevention, childhood trauma, and pediatric mental health care access via telemedicine.

Aging and Disability Services: ARPA provides funding to the Administration for Community Living (ACL) for aging and disability services programs. The law provides funding to Older Americans Act (OAA) formula grant programs that provide nutrition and other supportive services, with a focus on vaccine outreach and education and activities to address social isolation. The law also funds the establishment of a National Technical Assistance Center on Grandfamilies and Kinship Families, and provides additional funding to prevent, detect, and treat elder abuse, in part through federal support to state Adult Protective Services (APS) programs.

Table 1 lists the ARPA provisions included in this report, organized by the categories outlined above (the provisions are not organized sequentially). The table includes the section number, title, a brief description of the provision, the duration of funding availability, and the CRS points of contact for further questions from congressional staff. More information on each ARPA provision is found in the corresponding section later in the report.

Table 1. Brief Summaries of ARPA Public Health Provisions

Section Number	Section Title	Description of Section	Period of Availability[a]	CRS Points of Contact
		Public Health Infrastructure		
2301	Funding for COVID-19 vaccine activities at the Centers for Disease Control and Prevention	Section 2301 appropriates $7.5 billion to the CDC Director to plan, prepare for, promote, distribute, administer, monitor, and track COVID-19 vaccines. It also provides for additional SLTT vaccination program grants for certain eligible grantees.[b]	Until expended.	Sarah A. Lister Kavya Sekar
2302	Funding for vaccine confidence activities	Section 2302 appropriates $1 billion to the CDC Director to strengthen vaccine confidence, provide further information regarding vaccines, and to improve rates of vaccination throughout the United States.[b]	Until expended.	Sarah A. Lister Kavya Sekar

Section Number	Section Title	Description of Section	Period of Availability[a]	CRS Points of Contact
2401	Funding for COVID-19 testing, contact tracing, and mitigation activities	Section 2401 appropriates $47.8 billion to the HHS Secretary to carry out activities to detect, diagnose, trace, and monitor SARS-CoV-2 and COVID-19 infections and related strategies to mitigate the spread of COVID-19.	Until expended.	Kavya Sekar, Amanda K. Sarata, Sarah A. Lister
2402	Funding for SARS-CoV-2 genomic sequencing and surveillance	Section 2402 appropriates $1.75 billion to the CDC Director to expand and improve genomic sequencing and the surveillance of pathogens, including SARS-CoV-2.[b]	Until expended.	Kavya Sekar, Amanda K. Sarata, Sarah A. Lister
2404	Funding for data modernization and forecasting center	Section 2404 appropriates $500 million to the CDC Director to support public health data surveillance and infrastructure modernization initiatives, and to modernize the U.S. disease warning system to forecast and track hotspots for COVID-19 and other emerging biological threats.[b]	Until expended.	Kavya Sekar
		Medical Countermeasures and Supply Chain		
2303	Funding for supply chain for COVID-19 vaccines, therapeutics, and medical supplies	Section 2303 appropriates $6.05 billion to the HHS Secretary for medical countermeasure (MCM) research, development, manufacture, production, and purchase to prevent, prepare for, or respond to COVID-19 or "any disease with potential for creating a pandemic."	Until expended.	Kavya Sekar, Frank Gottron
2304	Funding for COVID-19 vaccine, therapeutic, and device activities at the Food and Drug Administration	Section 2304 appropriates $500 million to the HHS Secretary for various MCM activities at FDA.	Until expended.	Agata Bodie
3101	COVID-19 emergency medical supplies enhancement	Section 3101 appropriates $10 billion to support DPA actions related to the purchase, production, or distribution of medical supplies and equipment related to combatting COVID-19. After September 30, 2022, appropriations may be used for any activity "necessary to meet critical public health needs" related to any pathogen that has potential for creating a public health emergency as determined by the President.	Until September 30, 2025.	Michael H. Cecire, Heidi M. Peters
		Health Workforce		
2501	Funding for public health workforce	Section 2501 appropriates $7.66 billion to the HHS Secretary to establish, expand, and sustain the public health workforce, including the distribution of awards to state, local, and territorial public health departments.	Until expended.	Sarah A. Lister, Elayne J. Heisler
2502	Funding for Medical Reserve Corps	Section 2502 appropriates $100 million to the HHS Secretary to implement the MRC.	Until expended.	Sarah A. Lister
2602	Funding for National Health Service Corps	Section 2602 appropriates $800 million to the HHS Secretary to carry out the National Health Service Corps (NHSC) scholarship, loan repayment, and state loan repayment programs.	Until expended.	Elayne J. Heisler
2603	Funding for Nurse Corps	Section 2603 appropriates $200 million to the HHS Secretary to carry out the Nurse Corps program.	Until expended.	Elayne J. Heisler

Section Number	Section Title	Description of Section	Period of Availability[a]	CRS Points of Contact
2604	Funding for teaching health centers that operate graduate medical education	Section 2604 appropriates $330 million to the HHS Secretary to carry out the teaching health center program and award teaching health center development grants.	Until September 30, 2023.	Elayne J. Heisler
2703	Funding for mental health and substance use disorder training for health care professionals, paraprofessionals, and public safety officers	Section 2703 appropriates $80 million to the HRSA Administrator to award grants or contracts to specified entities to plan, develop, operate, or participate in evidence-informed strategies to reduce suicide, burnout, mental health conditions and substance use disorders among health care professionals and public safety officers.[b]	Until expended.	Elayne J. Heisler, Johnathan Duff
2704	Funding for education and awareness campaign encouraging healthy work conditions and use of mental health and substance use disorder services by health care professionals	Section 2704 appropriates $20 million to the CDC Director to carry out a national education and awareness campaign to encourage health care professionals, first responders, and their employers to (1) prevent mental health and substance use disorders and seek support and treatment, and (2) help identify risk factors in themselves and others and respond to such risks.[b]	Until expended.	Elayne J. Heisler, Johnathan H. Duff
2705	Funding for grants for health care providers to promote mental health among their health professional workforce	Section 2705 appropriates $40 million to the HRSA Administrator to award grants or contracts to health care entities to establish or expand evidence-informed protocols to promote mental health among their workforces.[b]	Until expended.	Elayne J. Heisler, Johnathan H. Duff
2711	Funding for behavioral health workforce education and training	Section 2711 appropriates $100 million to the HHS Secretary to carry out the behavioral health workforce education and training (BHWET) program.	Until expended.	Elayne J. Heisler
		Health Care Infrastructure and Provider Support		
2601	Funding for community health centers and community care	Section 2601 appropriates $7.6 billion to the HHS Secretary for grants or contracts for community health centers, or for grants specifically to FQHC-look-alikes, with not less than $20 million reserved for grants or contracts with Native Hawaiian Health Care System entities.	Until expended.	Elayne J. Heisler
2605	Funding for family planning	Section 2605 appropriates $50 million to the HHS Secretary to carry out the PHSA Title X program.	Until expended.	Angela Napili
2713	Funding for expansion grants for certified community behavioral health clinics	Section 2713 appropriates $420 million to the SAMHSA Assistant Secretary for Mental Health and Substance Use for grants to Certified Community Behavioral Health Clinics (CCBHCs).[b]	Until expended.	Johnathan H. Duff
1002	Emergency rural development grants for rural health care	Section 1002 appropriates $500 million to the USDA Secretary to establish an emergency pilot program to provide grants "to be awarded by the Secretary based on rural development needs related to the COVID-19 pandemic."	Until September 30, 2023.	Alyssa R. Casey
9911	Funding for providers relating to COVID-19	Section 9911 appropriates $8.5 billion to the HHS Secretary to make payments to eligible rural health care providers to account for lost revenue and increased health care-related expenses due to COVID-19.	Until expended.	Elayne J. Heisler
11001	Indian Health Service	Section 11001 appropriates $6.094 billion to the HHS Secretary for select IHS health services and public health activities, improvements to IHS facilities to respond to COVID-19, and for potable water delivery.	Until expended.	Elayne J. Heisler

Section Number	Section Title	Description of Section	Period of Availability[a]	CRS Points of Contact
		Mental Health and Substance Use		
2701	Funding for block grants for community mental health services	Section 2701 appropriates $1.5 billion to the HHS Secretary to carry out SAMHSA's MHBG program. Any amount awarded to a state from this amount must be expended by September 30, 2025.	Until expended.	Johnathan H. Duff
2702	Funding for block grants for prevention and treatment of substance abuse	Section 2702 appropriates $1.5 billion to the HHS Secretary to carry out SAMHSA's SABG program. Any amount awarded to a state from this amount must be expended by September 30, 2025.	Until expended.	Johnathan H. Duff
2706	Funding for community-based funding for local substance use disorder services	Section 2706 appropriates $30 million to the SAMHSA Assistant Secretary for Mental Health and Substance Use (in consultation with the CDC Director) to support "community-based overdose prevention programs, syringe services programs, and other harm reduction services."[b]	Until expended.	Johnathan H. Duff
2707	Funding for community-based funding for local behavioral health needs	Section 2707 appropriates $50 million to the SAMHSA Assistant Secretary for Mental Health and Substance Use for grants for specified activities to "address increased community behavioral health needs worsened by the COVID-19 public health emergency."[b]	Until expended.	Johnathan H. Duff
2708	Funding for the National Child Traumatic Stress Network	Section 2708 appropriates $10 million to the HHS Secretary to carry out the National Child Traumatic Stress Initiative "with respect to addressing the problem of high-risk or medically underserved persons who experience violence-related stress."	Until expended.	Johnathan H. Duff
2709	Funding for Project AWARE[c]	Section 2709 appropriates $30 million to the HHS Secretary to carry out activities "with respect to advancing wellness and resiliency in education."	Until expended.	Johnathan H. Duff
2710	Funding for youth suicide prevention	Section 2710 appropriates $20 million to the HHS Secretary for youth suicide prevention activities.	Until expended.	Johnathan H. Duff
2712	Funding for pediatric mental health care access	Section 2712 appropriates $80 million to the HHS Secretary for pediatric mental health care access.	Until expended.	Elayne J. Heisler
		Aging and Disability Services		
2921	Supporting Older Americans and their families	Section 2921 appropriates $1.434 billion to the HHS Secretary to carry out select OAA statutory formula grant programs.	Until expended.	Kirsten J. Colello
2922	National Technical Assistance Center on Grandfamilies and Kinship Families	Section 2922 appropriates $10 million to the ACL Administrator to establish a National Technical Center on Grandfamilies and Kinship Families to provide training, technical assistance, and resources for government programs, nonprofit and other community-based organizations, and Indian Tribes, tribal organizations, and urban Indian organizations.[b]	Until September 30, 2025.	Jared S. Sussman
9301	Additional funding for aging and disability services programs	Section 9301 appropriates $276 million to carry out EJA activities under SSA Title XX, Subtitle B. Of that total, not less than $100 million is reserved to enhance state APS programs for each fiscal year.	Until expended.	Kirsten J. Colello

Source: CRS analysis of the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2).

Notes: ACL = Administration for Community Living; APS = Adult Protective Services; BHWET = Behavioral Health Workforce Education and Training; CCBHC = Certified Community Behavioral Health Clinic; CDC = Centers for Disease Control and Prevention; COVID-19 = Coronavirus Disease 2019; DPA = Defense Production Act of 1950 (P.L. 81-774); EJA = Elder Justice Act; FDA = Food and Drug Administration; FQHC = Federally Qualified Health Center; FY = Fiscal Year; GME = Graduate Medical Education; HHS = Department of Health and Human Services; HRSA = Health Resources and Services Administration; IHS = Indian Health Service; MCM = Medical Countermeasures; MHBG = Community Mental Health Services Block Grant; MRC = Medical Reserve Corps; NHSC = National Health Service Corps; OAA = Older Americans Act (P.L. 89-73, as amended); (Project) AWARE = Advancing Wellness and Resilience in Education; PHSA = Public Health Service Act; SABG = Substance Abuse Prevention and Treatment Block Grant; SAMHSA = Substance Abuse and Mental Health Services Administration; SARS-CoV-2 = the name of the virus that causes COVID-19; SLTT = State, Local, Territorial, and Tribal; SSA = Social Security Act; USDA = U.S. Department of Agriculture.

a. "Period of availability" denotes the deadline for the federal government to obligate the funds.

b. Indicates ARPA provision where funding is appropriated to the HHS Secretary "acting through" the specified HHS agency head. Specified HHS agency leadership includes the ACL Administrator, CDC Director, HRSA Administrator, and SAMHSA Assistant Secretary for Mental Health and Substance Use.

c. Project AWARE stands for Advancing Wellness and Resiliency in Education.

Public Health Infrastructure

Background

The nation's public health system, at both the federal and the state, local, territorial, and tribal (SLTT) levels, is the foundation on which a successful outbreak or pandemic response rests. Significant federal investments in the system followed the anthrax attacks of 2001. After that, the threat of emerging infections continued, with an influenza pandemic in 2009, and U.S. domestic cases of Ebola and Zika virus infections during outbreaks in 2014 and 2016, respectively.[7]

Despite efforts to strengthen national public health capacity, according to some assessments, the system has continued to face challenges with shortfalls in funding, staffing, technological capability, and surge capacity. The National Academy of Medicine, in an April 2021 impact assessment, noted several challenges that have long affected the nation's public health system and have now affected its response to the COVID-19 pandemic. These challenges included institutional silos, inadequate and rigid funding streams, ambiguities over authority at different levels, and neglected infrastructure and workforce development.[8] The National Health Security Preparedness Index (NHSPI) is a public/private evaluation partnership that includes all 50 states and the District of Columbia. The NHSPI 2020 evaluation found that although state and national health security scores (called *Index Values*) continued to improve over prior years, the national scores remained below 6 (out of 10) for the domains of "Community Planning and Engagement" and "Healthcare Delivery."[9] Scores for "Countermeasure Management" were below 7 (out of 10).

[7] CRS memorandum for general distribution, *Historical Emergency Response Funding for Selected Infectious Disease Outbreaks*, May 21, 2020. Congressional clients may contact CRS to obtain a copy.

[8] Karen DeSalvo, Bob Hughes, Mary Bassett et al., *Public Health COVID-19 Impact Assessment: Lessons Learned and Compelling Needs*, National Academy of Medicine, April 7, 2021, https://nam.edu/public-health-covid-19-impact-assessment-lessons-learned-and-compelling-needs/.

[9] Robert Wood Johnson Foundation and partners, *National Health Security Preparedness Index, 2020 Release*, undated, figure 3, p. 5, https://nhspi.org/tools-resources/2020-key-findings/nhspi_2020_key_findings/. "Community Planning and Engagement" includes actions to develop and maintain supportive relationships among government agencies, community organizations, and individual households, and to develop shared plans for responding to disasters and emergencies. "Healthcare Delivery" includes actions to ensure access to high-quality medical services across the

The domestic response to the COVID-19 pandemic has strained the public health system with a challenging rollout of disease testing, prolonged shortages of other critical supplies, multiple disease surges that overwhelmed health care capacity in certain areas, and an unprecedented mass vaccination campaign.

Through emergency supplemental discretionary appropriations in five previous COVID-19 relief acts, Congress provided CDC with $15.3 billion. Much of this funding was provided for broad purposes, such as "to prevent, prepare for, and respond to coronavirus," while some of it was provided to focus on testing or vaccination activities, among others.[10] Almost half of the CDC funds were directed to extramural assistance (e.g., grants and cooperative agreements for SLTT and some for foreign assistance). Appropriations to the HHS Secretary in the Public Health and Social Services Emergency Fund (PHSSEF) provided additional funds for both broad and specific public health purposes, such as $47.4 billion for expansion of testing, surveillance, and contact tracing.

ARPA provides substantial funding for the continued public health response to the pandemic and to support the nation's public health infrastructure more broadly, including $10.75 billion to CDC for activities such as the nationwide vaccination program, vaccine confidence activities, data modernization, tracking of variant viral strains, and assistance to SLTT. ARPA provides almost $48 billion to the HHS Secretary for testing, contact tracing, and surveillance.

Public Health Infrastructure Provisions

Section 2301. Funding for COVID–19 Vaccine Activities at the Centers for Disease Control and Prevention

Background

COVID-19 vaccination is a means to reduce the spread of the disease and facilitate the resumption of pre-pandemic activities. In general, for COVID-19 vaccines to effectively reduce disease transmission, a large percentage of the population must be vaccinated.[11] Vaccination programs often aim to achieve *herd immunity* against an infectious disease. Extensive vaccination short of the herd immunity threshold would still aid in curbing disease spread and severe illness among the population.[12] Whether herd immunity for COVID-19 is achievable

continuum of care during and after disasters and emergencies.

[10] CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

[11] Centers for Disease Control and Prevention, "Benefits of Getting Vaccinated" April 2, 2021, at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/vaccine-benefits.html.

[12] A population is said to have reached herd immunity to a disease when a sufficient percentage of that population becomes immune to the disease, thus inhibiting ongoing transmission of the disease, which protects those who cannot be vaccinated (e.g., persons with compromised immune systems). U.S. Government Accountability Office, Science & Tech Spotlight: Herd Immunity for COVID-19, GAO-20-646SP, July 7, 2020, https://www.gao.gov/products/gao-20-646sp.

remains to be seen, with estimates ranging from 70%-90% of the population.[13] Given this benchmark, public health experts generally recommend vaccinating as many people as possible.[14]

COVID-19 mass vaccination planning for the United States has been underway since at least September 2020.[15] As initial supplies of vaccine were limited, the plan outlined that vaccines would be allocated to state health departments, which would then prioritize populations to receive vaccines (with guidance from CDC) and redistribute the vaccine to local public health departments and other partners for the purposes of mass administration.[16] Prior COVID-19 supplemental appropriations acts included funding for the vaccination campaign, particularly to support the operations of programs run by state and local health departments. In addition to broad funding for CDC public health activities, in the fifth COVID-19 pandemic supplemental measure (P.L. 116-260), a total of $8.75 billion was made available to the CDC for "activities to plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines to ensure broad-based distribution, access, and vaccine coverage."[17] Of that total, at least $4.5 billion was for SLTT grants or cooperative agreements.

Provision

Section 2301 appropriates $7.5 billion, to remain available until expended, to the CDC Director for activities to plan, prepare for, promote, distribute, administer, monitor, and track COVID-19 vaccines.[18] The provision directs the CDC Director to (1) conduct activities to enhance, expand, and improve nationwide COVID-19 vaccine distribution and administration (including activities related to the distribution of ancillary vaccine supplies), and (2) provide technical assistance, guidance, and support, and to award grants or cooperative agreements to SLTT public health departments to improve COVID-19 vaccine distribution and administration. CDC and awardees may use funds for facility enhancements, transportation for vaccinees, mobile vaccination units, and other specified activities.

This provision also provides for additional SLTT vaccination program grants for certain eligible grantees according to an allotment formula proportional to the CDC Public Health Emergency Preparedness cooperative agreement allotments for FY2020 (as specified).[19] The provision requires the HHS Secretary to determine which grantees received allocations of CDC grant funds

[13] Christie Aschwanden, "Five Reasons why COVID Herd Immunity is Probably Impossible," *Nature*, March 18, 2021; Jon Cohen, "How Soon Will COVID-19 Vaccines Return Life to Normal?" *Science*, February 16, 2021; and Mayo Clinic, "Herd Immunity and COVID-19 (Coronavirus): What You Need to Know," March 3, 2021, https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/herd-immunity-and-coronavirus/art-20486808.

[14] Gypsyamber D'Souza and David Dowdy, *What is Herd Immunity and How Can We Achieve it with COVID-19?*, Johns Hopkins Bloomberg School of Public Health, April 6, 2021, https://www.jhsph.edu/covid-19/articles/achieving-herd-immunity-with-covid19.html.

[15] U.S. Department of Health and Human Services, "Trump Administration Releases COVID-19 Vaccine Distribution Strategy," press release, September 16, 2020.

[16] U.S. Department of Health and Human Services, "COVID-19 Vaccine Distribution: The Process," March 17, 2021, at https://www.hhs.gov/coronavirus/covid-19-vaccines/distribution/index.html; and Centers for Disease Control and Prevention, "COVID-19 Pandemic Vaccination Planning: Update for State and Local Public Health Programs," press release, August 4, 2020.

[17] CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

[18] Section 2301 appropriates funding to the HHS Secretary "acting through" the CDC Director.

[19] The Public Health Emergency Preparedness (PHEP) cooperative agreement is a grant program that provides annual funding to 62 state, territorial, and local grantees. It is authorized by Public Health Service Act, §319C-1 [42 U.S.C. §247d–3a]. See CDC, "Public Health Emergency Preparedness (PHEP) Cooperative Agreement," https://www.cdc.gov/cpr/readiness/phep.html.

for their vaccination programs under Title III of Division M of Consolidated Appropriations Act, 2021 (P.L. 116-260), *that were less* than they would have received by following the alternative proportional allocation directed in this section, and to award the difference to such grantees within 21 days of enactment.

This provision does not specify how much of the total appropriation is to be awarded as SLTT grants or cooperative agreements, and generally gives discretion to CDC to determine SLTT award amounts (aside from the required supplemental awards).

Section 2302. Funding for Vaccine Confidence Activities

Background

Vaccine confidence refers to the trust that the general public has in the safety and efficacy of vaccines as life-saving measures, as well as the policies and processes underpinning vaccine development and safety assurance.[20] Lapses in vaccine confidence may contribute to *vaccine hesitancy*, which refers to members of the public delaying or refusing vaccination, despite availability.[21] Vaccine hesitancy is often multifactorial, driven by confidence, access, awareness, among other factors. A rise in vaccine hesitancy may contribute to a rise in vaccine-preventable disease, as fewer people opt to receive the vaccine.[22] Although national vaccination coverage rates for most recommended childhood vaccines meet target levels, these rates obscure underlying trends in recent years where a third of young children have delayed or missed at least one recommended vaccine.[23] CDC has found that the measles outbreaks in 2018 and 2019—the highest levels of U.S. measles cases since the early 1990s—were driven, in part, by widespread misinformation about vaccines in certain communities.[24]

Although surveys show fewer Americans declining to be vaccinated for COVID-19 over time,[25] CDC has stated that an increase in vaccine confidence may increase vaccine uptake and in turn lessen the severity of the COVID-19 pandemic.[26] Some studies have found associations between exposure to COVID-19 vaccine misinformation and declines in vaccination intent.[27]

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[20] U.S. Department of Health and Human Services, "Featured Priority: Vaccine Confidence," August 6, 2019, at https://www.hhs.gov/vaccines/featured-priorities/vaccine-confidence/index.html.

[21] For a practical example on how vaccine confidence can influence the resurgence of communicable disease, see National Vaccine Advisory Committee, *Assessing the State of Vaccine Confidence in the United States; Recommendations from the National Vaccine Advisory Committee*, November, 2015, pp. 573-595, https://www.hhs.gov/sites/default/files/nvpo/about/vaccines/nvac-vaccine-confidence-public-health-report-2015.pdf.

[22] Eve Dube, Caroline Laberge, Maryse Guay et al., "Vaccine Hesitancy: An Overview," *Human Vaccines and Immunotherapeutics*, vol. 9, no. 8 (August 1, 2013), pp. 1763-1773.

[23] National Academy of Medicine, *Vaccine Access and Hesitancy Part One of a Workshop Series Proceedings of a Workshop- in Brief*, August 2020, p. 3.

[24] Ibid., and CDC, "Measles Cases and Outbreaks," last updated March 9, 2021, https://www.cdc.gov/measles/cases-outbreaks.html.

[25] See for example Emmarie Huetteman, "Covid Vaccine Hesitancy Drops Among All Americans, New Survey Shows," *Kaiser Health News*, March 30, 2021, https://khn.org/news/article/covid-vaccine-hesitancy-drops-among-americans-new-kff-survey-shows/.https://khn.org/news/article/covid-vaccine-hesitancy-drops-among-americans-new-kff-survey-shows.

[26] Centers for Disease Control and Prevention, "Vaccinate with Confidence," April 5, 2021, at https://www.cdc.gov/vaccines/covid-19/vaccinate-with-confidence.html.

[27] See, for example, Sahil Loomba, Alexandre de Figueiredo, Simon J. Piatek et al., "Measuring the Impact of COVID-19 Vaccine Misinformation on Vaccination Intent in the UK and USA," *Nature Human Behavior*, vol. 5 (2021),

Provision

Section 2302 appropriates $1 billion to the CDC Director,[28] to remain available until expended, to (1) strengthen vaccine confidence in the United States (and its territories and possessions); (2) provide further information and education with respect to vaccines authorized for emergency use or licensed by the FDA;[29] and (3) to improve rates of vaccination throughout the United States and its territories and possessions. The provision refers to the Public Health Service Act (PHSA) Section 313 authority for a public awareness campaign on the importance of vaccinations, established in Section 311 of Division BB of Consolidated Appropriations Act, 2021 (P.L. 116-260). Section 2302 does not address COVID-19 vaccines specifically, and thus may be used to fund efforts to boost confidence for vaccines other than those for COVID-19.

Section 2401. Funding for COVID-19 Testing, Contact Tracing, and Mitigation Activities

Background

COVID-19 testing and contact tracing efforts continue to be critical in the effort to reduce community transmission of COVID-19 infection. Throughout the pandemic, efforts to boost testing, contact tracing, and associated activities have faced numerous challenges, including lack of coordination and disjointed efforts among states; supply chain issues; ongoing stress on the nation's public health and laboratory infrastructure; and difficulties scaling up contact tracing programs and obtaining information on contacts from exposed individuals.[30] A prior relief law, PPPHCEA (P.L. 116-139), required HHS to submit testing strategy reports to Congress every 90 days until funds under the act are expended; these reports had been submitted to Congress three times in 2020.[31] The Government Accountability Office (GAO) has noted that these strategies did not meet best practices for national strategy formulation and, in particular, did not provide clear and explicit goals, activities, and performance measures.[32] Upon assuming office, President Biden established a COVID-19 Pandemic Testing Board to coordinate testing efforts nationally through an executive order[33] issued on January 21, 2021, a component of his national strategy for pandemic response.[34] The Biden Administration has not yet published a comprehensive national testing strategy.

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pp. 337-48.

[28] Section 2302 appropriates funding to the HHS Secretary "acting through" the CDC Director.

[29] CRS Report R46427, *Development and Regulation of Medical Countermeasures for COVID-19 (Vaccines, Diagnostics, and Treatments): Frequently Asked Questions*.

[30] Karen DeSalvo, Bob Hughes, Mary Bassett et al., *Public Health COVID-19 Impact Assessment: Lessons Learned and Compelling Needs*, National Academy of Medicine, April 7, 2021, https://nam.edu/public-health-covid-19-impact-assessment-lessons-learned-and-compelling-needs/; John Schneider, Willie Love, Laura Rusie et al., "COVID-19 Contact Tracing Conundrums: Insights From the Front Lines," *American Journal of Public Health*, April 7, 2021; and CRS In Focus IF11774, *COVID-19 Testing Supply Chain*.

[31] U.S. Government Accountability Office, *COVID-19: Sustained Federal Action Is Crucial as Pandemic Enters Its Second Year*, GAO-21-387, March 31, 2021, pp. 90-91, https://www.gao.gov/assets/gao-21-387.pdf.

[32] U.S. Government Accountability Office, *COVID-19 Critical Vaccine Distribution, Supply Chain, Program Integrity, and Other Challenges Require Focused Federal Attention*, January 2021, pp. 79-90, https://www.gao.gov/assets/gao-21-265.pdf.

[33] Executive Order 13996, 86 *Federal Register* 7197, January 21, 2021.

[34] White House, *National Strategy for the COVID-19 Response and Pandemic Preparedness*, January 2021, p. 12, https://www.whitehouse.gov/wp-content/uploads/2021/01/National-Strategy-for-the-COVID-19-Response-and-

Previous COVID-19 pandemic relief acts included funds to support public health efforts to increase testing capacity, expand and train contact tracing and case investigation staff, and improve internal and public data sharing.[35] In particular, PPPHCEA (P.L. 116-139) and Consolidated Appropriations Act, 2021 (P.L. 116-260), supplemental appropriations provided a total of $47.4 billion specifically for the expansion of testing, contact tracing and related activities. These funds were in addition to several other broad accounts and funding that could be used for testing-related purposes.[36] As reported by GAO in March 2021, HHS reported total obligations of $42.9 billion for testing-related activities as of February 28, 2021.[37]

Provision

Section 2401 appropriates $47.8 billion to the HHS Secretary, to remain available until expended, to carry out activities to detect, diagnose, trace, and monitor SARS–CoV–2 (the virus that causes COVID-19) and COVID-19 infections, and related strategies to mitigate the spread of COVID-19. Funds are to be used to carry out the following pandemic response activities: (1) implement a national testing, contact tracing, surveillance, and mitigation strategy; (2) provide grant or cooperative agreement funding and technical guidance to SLTT public health departments for this effort; (3) support the development, manufacture, procurement, and distribution of supplies necessary for administering tests (e.g., personal protective equipment), and the acquisition, construction, renovation, or alteration of nonfederal sites used for the production of COVID-19 tests and related supplies; (4) invest in improving laboratory and contact tracing capacity, including through academic and research labs, community testing sites and organizations, and mobile testing services, as well as investments with respect to quarantine and isolation of contacts; (5) support public health data sharing through information technology, data modernization, and reporting; (6) provide grants to SLTT to improve the public health workforce; and (7) cover administrative and program support costs.

This provision does not specify how much of the total appropriation is to be awarded as SLTT grants or cooperative agreements, and generally gives discretion to the HHS Secretary to determine SLTT award amounts.

Section 2402. Funding for SARS–CoV–2 Genomic Sequencing and Surveillance

Background

Coronaviruses constantly change and mutate. The emergence of new variants may lead to increased transmissibility, different symptoms and severity of disease, different groups at risk of the virus and disease, and/or decreased effectiveness of medical countermeasures (e.g., vaccines, treatments). Identifying and tracking virus variants primarily relies on *genomic surveillance*—ongoing and systematic genomic sequencing of virus samples collected from patients to classify sequences and identify epidemiological characteristics associated with certain sequences.[38]

Pandemic-Preparedness.pdf.

[35] CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

[36] Ibid.

[37] U.S. Government Accountability Office, *COVID-19: Sustained Federal Action Is Crucial as Pandemic Enters Its Second Year*, GAO-21-387, March 31, 2021, p. 92, https://www.gao.gov/assets/gao-21-387.pdf.

[38] CDC, "SARS-CoV-2 Variant Classifications and Definitions," https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/variant-surveillance/variant-info.html.

Genomic surveillance is complex, involving not only sequencing viral genomes, but also developing capabilities to process and analyze large volumes of data. Such efforts involve specialized equipment, software, personnel, and bioinformatics expertise, as well as coordinated strategies to identify and prioritize patient samples for sequencing and to determine subsequent public health and health care responses.[39]

CDC has expanded genomic surveillance efforts nationally in late 2020 and early 2021 through several efforts, including by collecting patient samples from states and other jurisdictions for sequencing, by partnering with commercial and other laboratories, and by facilitating genomic surveillance capacity within jurisdictions through grant funding. CDC has used appropriations available in several prior supplemental appropriations acts to fund these efforts.[40]

Provision

Section 2402 appropriates $1.75 billion to the CDC Director, to remain available until expended, to (1) conduct, expand, and improve activities to sequence genomes, identify mutations, and survey the circulation of pathogens, including SARS-CoV-2; (2) award grants and cooperative agreements to SLTT public health departments and laboratories to increase genomic surveillance capacity, including by using genome sequencing to identify outbreaks and clusters of diseases or infections such as COVID-19, and developing response strategies based on such data; (3) enhance and expand informatics capabilities of the public health workforce; and (4) award grants to construct, alter, or renovate facilities to improve genomic sequencing and surveillance capacity. While the provision header refers to "SARS-CoV-2," the provision language refers to genomic surveillance and sequencing of pathogens broadly; therefore, the funding may have implications for genomic surveillance for other pathogens and diseases.

Section 2404. Funding for Data Modernization and Forecasting Center

Background

The public health response to an infectious disease emergency involves many types of data—in the context of the COVID-19 pandemic, this has included data on testing, cases, hospitalizations, and deaths, among others. While the public health sector collects and analyzes such data to inform its response efforts, much of the data rely on records and reporting from mostly private health care entities, such as laboratories and hospitals. Data reporting requirements and systems are often governed by law and policy at the state and subfederal levels. Prior to the pandemic, public health data sharing often relied on outdated means of exchange, such as by paper or fax-based methods as well as manual data input processes.

In 2014, following broad implementation of interoperable electronic health records in the health care system, CDC initiated a surveillance strategy to modernize the means of data exchange

[39] James S. Koopman and Betsy Foxman, "Chapter 26: Using Genetic Sequence Data for Public Health Surveillance," in *Transforming Public Health Surveillance: Proactive Measures for Prevention, Detection and Response* (Elsevier: 2016), ed. Scott JN McNabb, J Mark Conde, Lisa Ferland et al., pp. 362-363; and Kelsey Lane Warmbrod, Rachel West, Matthew Frieman et al., *Staying Ahead of the Variants: Policy Recommendation to Identify and Manage Current and Future Variants of Concerns*, Johns Hopkins Bloomberg School of Public Health: Center for Health Security, Feburary 2021, https://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2021/20210216-covid19-variants.pdf; and CRS In Focus IF11789, *COVID-19 Variants: Vaccines, Diagnostics, and Therapeutics*.

[40] CRS In Focus IF11789, *COVID-19 Variants: Vaccines, Diagnostics, and Therapeutics*; and CDC, "Genomic Surveillance for SARS-CoV-2 Variants," https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/variant-surveillance.html.

between the public health and health care sectors, including by facilitating electronic reporting of death records, disease cases, and laboratory results. CDC received specific funding of $50 million to support these efforts starting in FY2020 appropriations (P.L. 116-94), following a white paper by the Council of State and Territorial Epidemiologists (CSTE) calling for the creation of a "public health data superhighway" to facilitate automatic, interoperable public health data exchange.[41] Still, by the time of the pandemic, reliance on nonelectronic or inefficient reporting methods remained pervasive in the public health system, affecting the timeliness, completeness, and accuracy of data for response.[42]

In addition, public health responses to infectious disease threats often rely on forecasting, or estimates of the future spread of infectious diseases and projected impacts of various public health interventions on disease spread (e.g., stay-at-home orders, mask mandates). During the COVID-19 pandemic, disease forecasting efforts were affected by several challenges: inherent scientific uncertainties; availability and quality of the underlying data; differing methodologies and purposes for models; and disagreements or misunderstandings about how to interpret and use model outputs for decisionmaking.[43] Dozens of different models and forecasts of varying quality were created by research institutions around the country, adding to the confusion and uncertainty.[44] Some observers have advocated for creating a national disease forecasting center, similar to the National Weather Service, to coordinate and lead such efforts and serve as an "early warning system" for infectious disease threats.[45]

Prior COVID-19 relief measures provided CDC with broad funding to support public health surveillance, data modernization, and disease forecasting. In particular, CDC received not less than $500 million in the CARES Act (P.L. 116-136) specifically for "public health data surveillance and analytics infrastructure modernization." With these new funds, CDC has expanded electronic reporting of test results, cases, and deaths. It has also begun to make investments to more broadly modernize public health data systems and sharing across jurisdictions, systems, and sectors.[46] Through an executive order issued on January 26, 2021, the Biden Administration established a coordinated interagency structure to improve and modernize public health data for pandemic response and other public health threats.[47]

[41] The white paper is available from Council of State and Territorial Epidemiologists, "CSTE Releases White Paper—Driving Public Health in the Fast Lane," press release, October 1, 2019, https://www.cste.org/news/474011/CSTE-Releases-White-Paper—Driving-Public-Health-in-the-Fast-Lane.htm.

[42] CRS Report R46588, *Tracking COVID-19: U.S. Public Health Surveillance and Data*.

[43] U.S. Government Accountability Office, *Science and Tech Spotlight: COVID-19 Modeling*, GAO-20-582SP, June 2020, https://www.gao.gov/assets/gao-20-582sp.pdf.

[44] Jin Jin, Neha Agarwala, Prosenjit Kundu et al., "Transparency, Reproducibility, and Validation of COVID-19 Projection Models," *Johns Hopkins Bloomberg School of Public Health: COVID-19 School of Public Health Insights*, June 22, 2020, https://www.jhsph.edu/covid-19/articles/transparency-reproducibility-and-validation-of-covid-19-projection-models.html.

[45] See, for example, Sara Del Valle, "We Need to Forecast Epidemics like we Forecast the Weather," *STAT News*, July 27, 2020.

[46] CDC, "CDC Data Modernization Initiative - Notable Milestones: 2019-2021," https://www.cdc.gov/surveillance/surveillance-data-strategies/milestones_2019-2020.html.

[47] Executive Order 13994, "Ensuring a Data-Driven Response to COVID–19 and Future High-Consequence Public Health Threats," 86 *Federal Register* 15, January 26, 2021.

Provision

Section 2404 appropriates $500 million to the CDC Director,[48] to remain available until expended, to support public health data surveillance and infrastructure modernization initiatives and to establish, expand, and maintain efforts to modernize the United States disease warning system to forecast and track hotspots for COVID-19, virus variants, and other emerging biological threats. These efforts include academic and workforce support for analytics and informatics infrastructure and data collection systems. Though the provision header refers to a "center," the provision language does not explicitly direct funds to be used to establish a center. In addition, the provision language refers to "other emerging biological threats"; therefore, the funds may have implications for public health data and forecasting efforts broader than those specifically in response to the COVID-19 pandemic.

Medical Countermeasures and Supply Chain

Background

At the onset of the pandemic, there were few treatment options for COVID-19 and no vaccines available to prevent the disease. Increased demand for personal protective equipment (PPE) and other medical supplies disrupted medical product supply chains, resulting in shortages. This situation highlighted larger issues about U.S. reliance on foreign sources of medical products and the federal government's ability to oversee the supply chain and mitigate future disruptions.[49]

A critical part of the COVID-19 public health response has been the development and manufacture of medical countermeasures (MCMs), that is, medical products that may be used to treat, prevent, or diagnose conditions associated with emerging infectious diseases or chemical, biological, radiological, or nuclear agents. MCMs include biologics (e.g., vaccines, monoclonal antibodies), drugs (e.g., antimicrobials, antivirals), and medical devices (e.g., diagnostic tests, PPE).[50] The federal government—primarily through the National Institutes of Health (NIH), the Biomedical Advanced Research and Development Authority (BARDA), the FDA, and the Department of Defense (DOD)—has supported the research and development (R&D), regulation, manufacture, and purchase of MCMs for COVID-19.[51] In addition, the Trump and Biden Administrations have taken actions related to the Defense Production Act (DPA) to support the domestic manufacture of MCMs for COVID-19, including vaccines, PPE, diagnostics, and related supplies.[52] The DPA confers presidential authorities to mobilize domestic industry to expand production and allocation of goods, materials, and services. As a result of these efforts, a number of treatments and vaccines for COVID-19 are now available, and millions of Americans

[48] Section 2404 appropriates funding to the HHS Secretary "acting through" the CDC Director.

[49] For additional information, see CRS Report R46628, *COVID-19 and Domestic PPE Production and Distribution: Issues and Policy Options*; CRS Report R46507, *FDA's Role in the Medical Product Supply Chain and Considerations During COVID-19*; and CRS In Focus IF11488, *Personal Protective Equipment (PPE) and COVID-19: FDA Regulation and Related Activities*.

[50] For additional information, see CRS Report R46427, *Development and Regulation of Medical Countermeasures for COVID-19 (Vaccines, Diagnostics, and Treatments): Frequently Asked Questions*.

[51] Under the Trump Administration, these efforts, particularly those related to vaccines, were conducted primarily under Operation Warp Speed (OWS), an interagency partnership between HHS and DOD. The Biden Administration had indicated that OWS would be restructured and renamed.

[52] CRS Insight IN11470, *Defense Production Act (DPA): Recent Developments in Response to COVID-19*, and CRS Insight IN11593, *New Presidential Directives on the Defense Production Act (DPA) and the COVID-19 Pandemic*.

have been vaccinated. However, medical product shortages and supply chain vulnerability concerns have continued throughout the pandemic.[53]

Previous COVID-19 supplemental measures provided funding for the R&D, regulation, manufacture, and purchase of COVID-19 MCMs. This funding was provided to accounts within NIH, FDA, and DOD, as well as to the Public Health and Social Services Emergency Fund (PHSSEF) under the HHS Office of the Secretary. The PHSSEF receives annual appropriations for the routine operations of several HHS offices, including the Office of the HHS Assistant Secretary for Preparedness and Response (ASPR), where BARDA resides. This account is also used for one-time or short-term funding, such as emergency supplemental appropriations.[54]

ARPA continues the efforts of previous COVID-19 supplemental measures by providing $6.05 billion in funding to HHS for the R&D, manufacture, and purchase of MCMs related to COVID-19 or any disease with pandemic potential, as well as $500 million for FDA activities to support MCM regulatory and other activities. ARPA also provides $10 billion for activities under the DPA related to the purchase, production, and distribution of medical supplies related to combatting the COVID-19 pandemic, as well as public health needs more broadly.

Medical Countermeasures and Supply Chain Provisions

Section 2303. Funding for Supply Chain for COVID-19 Vaccines, Therapeutics, and Medical Supplies

Background

Many operating divisions within HHS support research and development related to infectious diseases, as well as the development, manufacture and—for emergency circumstances in particular—procurement of medical products such as vaccines, therapeutics, and medical supplies.[55] These include, but are not limited to, ASPR, BARDA, FDA, CDC, and NIH, each of which has played a major role in the federal response to develop, manufacture, and make available medical products for COVID-19. In particular, NIH and BARDA have supported medical product research and development, and BARDA has awarded contracts and other agreements to private companies for the development, manufacture, and purchase of MCMs such as vaccines, therapeutics, and ancillary medical supplies (e.g., needles, syringes, vials). For these response efforts, HHS has partnered with additional agencies and departments, such as DOD.[56] From the five COVID-19 supplemental appropriations measures enacted in 2020, a total of not less than $4.8 billion (accounting for transfers) was made available to NIH, and a total of not less than $24.2 billion was specifically designated for BARDA (through set-asides in the PHSSEF account), with additional funds that could be allocated to the agency from broad appropriations in

[53] FDA, "Medical Device Shortages During the COVID-19 Public Health Emergency," accessed March 31, 2021, https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/medical-device-shortages-during-covid-19-public-health-emergency. See also CRS Insight IN11544, *Supply Chain Considerations for COVID-19 Vaccine Manufacturing*, and CRS Insight IN11560, *Operation Warp Speed Contracts for COVID-19 Vaccines and Ancillary Vaccination Materials*.

[54] CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

[55] HHS, "About HHS," 2021, https://www.hhs.gov/about/index.html.

[56] CRS Report R46427, *Development and Regulation of Medical Countermeasures for COVID-19 (Vaccines, Diagnostics, and Treatments): Frequently Asked Questions*.

the PHSSEF account. In addition, funds for CDC and FDA have been made available, in part, to support those agencies' research and manufacturing efforts.[57]

Provision

Section 2303 appropriates $6.05 billion to the HHS Secretary, to remain available until expended, for various MCM activities to prevent, prepare for, or respond to COVID-19, the SARS-CoV-2 virus and related variants, or "any disease with potential for creating a pandemic." These activities include research, development, manufacturing, production, and purchase of vaccines, therapeutics, and ancillary medical supplies.

This provision is notable in two ways. First, this provision gives the HHS Secretary discretion to allocate funds among the various HHS operating divisions, without specifying which operating divisions are to receive funds or how much each are to receive. In typical discretionary appropriations acts, funds for MCM-related purposes are appropriated to HHS accounts that fund specific agencies or offices within HHS; for example, appropriations are made to NIH Institute and Center (IC) accounts or to the PHSSEF account that funds BARDA. Second, this provision provides these funds to prevent, prepare for, or respond to any disease with potential for creating a pandemic—not COVID-19 alone. Therefore, an undefined amount of funds may be used for and/or remain available to support MCM activities for other infectious disease threats.

Section 2304. Funding for COVID-19 Vaccine, Therapeutic, and Device Activities at the Food and Drug Administration

Background

FDA regulates the safety, effectiveness, and quality of MCMs through premarket and postmarket activities. With respect to its premarket work, FDA has granted marketing approval, clearance, and emergency use authorization (EUA) to COVID-19 therapeutics, vaccines, diagnostics, and other medical devices (e.g., respirators and ventilators).[58] In addition, FDA has issued guidance to facilitate COVID-19 MCM development and marketing authorization. As part of its postmarket work, FDA has monitored medical product shortages[59] and worked with the pharmaceutical industry and federal partners to accelerate the adoption of advanced manufacturing technologies (i.e., technologies that may improve product quality, reduce shortages, and speed time to market).[60]

[57] CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

[58] FDA, Emergency Use Authorization, "Coronavirus Disease 2019 (COVID-19) EUA Information," https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#covid19euas.

[59] See for example, FDA, "Medical Device Shortages During the COVID-19 Public Health Emergency," accessed March 31, 2021, https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/medical-device-shortages-during-covid-19-public-health-emergency; and "Drug Shortages," accessed March 31, 2021, https://www.fda.gov/drugs/drug-safety-and-availability/drug-shortages.

[60] FDA, "Accelerating the Adoption of Advanced Manufacturing Technologies to Strengthen Our Public Health Infrastructure," January 15, 2021, https://www.fda.gov/news-events/fda-voices/accelerating-adoption-advanced-manufacturing-technologies-strengthen-our-public-health. See also, FDA, "Advanced Manufacturing," updated January 16, 2021, https://www.fda.gov/emergency-preparedness-and-response/mcm-issues/advanced-manufacturing.

Previous COVID-19 supplemental measures provided funding to FDA for various regulatory activities. Across four of the five supplemental laws, FDA received a total of $218 million.[61] This included $196 million to the agency's salaries and expenses account to "prevent, prepare for, and respond to coronavirus domestically and internationally."[62] These funds were to be used for activities such as pre- and postmarket work on MCMs, EUAs, monitoring of medical product supply chains, advanced manufacturing, and related administrative activities. In addition, PPPHCEA (P.L. 116-139) directed a transfer of $22 million from the PHSSEF to FDA to support activities associated with "diagnostic, serological, antigen, and other tests, and related administrative activities."[63]

Provision

Section 2304 provides $500 million to the HHS Secretary, to remain available until expended, for various MCM activities at FDA. Such activities include FDA's evaluation of continued performance, safety, and effectiveness of COVID-19 vaccines, therapeutics, and diagnostics, including with respect to emerging SARS-CoV-2 variants; facilitation of advanced continuous manufacturing activities related to the manufacture of vaccines and related materials; inspections related to manufacturing of vaccines, therapeutics, and devices that were delayed or canceled because of COVID-19; review of devices authorized for use for the treatment, prevention, or diagnosis of COVID-19; and oversight of the supply chain and mitigation of COVID-19 MCM shortages.

Section 3101. COVID-19 Emergency Medical Supplies Enhancement

Background

The Defense Production Act of 1950 (DPA) confers broad presidential authorities to mobilize domestic industry in service of the *national defense*, defined in statute as various military activities and "homeland security, stockpiling, space, and any directly related activity" (50 U.S.C. §4552), including emergency preparedness activities under the Stafford Act, which has been used for public health emergencies. DPA authorities include (1) provisions under Title I to prioritize contracts and allocate scarce goods, materials, and services; (2) financial incentives under Title III to expand productive capacity for critical materials and goods; and (3) coordination, information gathering, and other supporting provisions under Title VII.[64]

Actions under DPA authorities are generally funded through typical or supplemental agency appropriations, with the exception of Title III projects, which receive direct appropriations through the DPA Fund. The DPA Fund is a statutory, "no year" DPA account managed by DOD but statutorily available for Title III actions across the federal government. Although DPA Fund monies may carry over, the statute places an annual cap of $750 million, beyond which funds may be forfeited. However, the CARES Act temporarily lifted this cap for two years from enactment, or through late March 2022.

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[61] CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

[62] P.L. 116-123, Division A; P.L. 116-136, Division A; and P.L. 116-260, Division M.

[63] P.L. 116-139, Division B.

[64] CRS Insight IN11619, *New COVID-19 Defense Production Act (DPA) Actions: Implementation Considerations*; CRS Insight IN11229, *Stafford Act Assistance for Public Health Incidents*; and CRS Report R43767, *The Defense Production Act of 1950: History, Authorities, and Considerations for Congress*.

Prior to the enactment of ARPA, the use of DPA Fund monies, particularly $1 billion appropriated under the CARES Act, was a source of dispute between congressional and DOD leadership.[65] The dispute centered on DOD's use of DPA Fund monies, which included investments in the nonmedical defense industrial base.[66] In all, approximately two-thirds of CARES Act DPA Fund appropriations were obligated for defense industrial base investments, rather than for domestic health-related investments. In January 2021, the Biden Administration issued several executive orders invoking the DPA to augment pharmaceutical supply chains to address the COVID-19 pandemic, particularly for vaccines. In a February 2021 briefing, White House COVID-19 Supply Chain Coordinator Timothy W. Manning noted that the Biden Administration's DPA efforts required congressional appropriations to achieve their intended effects.[67]

Provision

Section 3101 provides $10 billion to support DPA actions under Titles I, III, and VII (i.e., all active DPA titles) with respect to the "purchase, production (including the construction, repair, and retrofitting of government-owned or private facilities as necessary), or distribution of medical supplies and equipment (including durable medical equipment) related to combatting the COVID-19 pandemic." The legislation specifies various relevant articles, including in vitro diagnostic products and their chemical or material components; personal protective equipment (PPE), such as face masks, nitrile gloves, and N95 respirators; as well as "drugs, devices, and biological products" authorized for treating or preventing COVID-19, such as vaccines. Funds are available until September 30, 2025. However, after September 30, 2022, appropriations may be used for any activity "necessary to meet critical public health needs," with respect to any pathogen that has potential for creating a public health emergency, as determined by the President.

Compared with typical and previous DPA-related appropriations made to the DPA Fund, Section 3101 more directly appropriates funding for health and medical countermeasures for infectious diseases. According to the accompanying explanatory statement on the bill, the House Financial Services Committee—the DPA's statutory committee of jurisdiction in the House of Representatives—specifies an expectation that the funds be used exclusively for health and medical resources, primarily employed by HHS, and appropriated in a new HHS account other than the DPA Fund.[68] The House report language also describes a clear intent to appropriate those funds to HHS, which is consistent with the original House Financial Services Committee bill text, which also cited HHS directly.[69] Section 3101 contains other novelties with regard to DPA-related

[65] For more information, see CRS Report R46628, *COVID-19 and Domestic PPE Production and Distribution: Issues and Policy Options*.

[66] For a selection of congressional inquiries related to the DPA fund, see U.S. Congress, House Financial Services, Letter to DOD and HHS, July 14, 2020, at https://financialservices.house.gov/uploadedfiles/ltr_to_hhs_and_fema_7142020.pdf; and Letter from Hon. James E. Clyburn, Chairman, House Select Subcommittee on the Coronavirus Crisis; Hon. Maxine Waters, Chairwoman, House Committee on Financial Services; Hon. Carolyn B. Maloney, Chairwoman, House Committee on Oversight and Reform; and Hon. Stephen F. Lynch, Chairman, House Subcommittee on National Security, to Hon. Mark T. Esper, Secretary of Defense, October 2, 2020, at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2020-10-02.Clyburn%20Waters%20CBM%20SFL%20%20to%20Esper-%20DOD%20re%20CARES%20Act.pdf.

[67] CRS Insight IN11619, *New COVID-19 Defense Production Act (DPA) Actions: Implementation Considerations*, and CRS Insight IN11593, *New Presidential Directives on the Defense Production Act (DPA) and the COVID-19 Pandemic*.

[68] Chairwoman Maxine Waters, "American Rescue Plan Act of 2021," Explanatory Statement on H.R. 1319, *Congressional Record*, daily edition, vol. 167, part 45 (March 10, 2021), p. H1281, https://www.congress.gov/117/crec/2021/03/10/CREC-2021-03-10-pt1-PgH1196.pdf.

[69] U.S. Congress, House Committee on the Budget, *American Rescue Plan Act of 2021: Report of the Committee on the*

appropriations. As it does not make use of the DPA Fund, Section 3101 does not amend or modify the DPA Fund's annual cap. Instead, funds are available for use until September 30, 2025. In addition, because Section 3101 makes funding available for all actions under the DPA, the $10 billion may set a new precedent, given that past DPA-related appropriations were made only to the Title III account (the DPA Fund), and other actions were funded from non-DPA appropriations.[70]

Health Workforce

Background

COVID-19 pandemic preparedness and response has required mobilization of the public health workforce and the patient care workforce to test, treat, and vaccinate patients. For both workforces, the pandemic revealed underlying challenges related to workforce shortages overall, in certain disciplines, and in specific geographic locations. In addition, the pandemic may have exacerbated issues related to clinician burnout. One survey found that 52% of providers reported experiencing burnout and 62% reported that worry or stress during the pandemic has adversely affected their mental health.[71]

Though concerns about the patient care workforce have persisted throughout the pandemic, prior pandemic response measures did not include additional funding for federal workforce programs,[72] such as those administered by the Health Resources and Services Administration (HRSA) to support training for the primary care, public health, and behavioral health workforces. These laws did, however, provide substantial funding to support public health workforce support, as discussed below. Historically, the federal government has supported some programs to train the clinical and public health workforces.

ARPA provides additional funding for new and existing federal programs to augment the public health and health care workforce at the federal, state, and local levels, including $7.66 billion to recruit, train, and retain new public health workers. The law also creates new programs to target health provider and public safety officer well-being and provides additional funding to programs that support developing the behavioral health workforce generally. ARPA also provides additional funding for existing programs that seek to increase the number of providers who care for underserved and geographically isolated populations. This financial support includes additional

Budget, report to accompany H.R. 1319 together with minority views, 117th Cong., 1st sess., February 21, 2021, H.Rept. 117-7 (Washington: GPO, 2021), https://www.congress.gov/117/crpt/hrpt7/CRPT-117hrpt7.pdf.

[70] For more discussion of the potential impact of this issue, see CRS Insight IN11619, *New COVID-19 Defense Production Act (DPA) Actions: Implementation Considerations*, by Michael H. Cecire, Nina M. Hart, and Heidi M. Peters.

[71] Scott Clement, Cece Pascual, and Monica Ulamanu, "Stress on the Front Lines of Covid-19: Health Care Workers Share the Hardest Part of Working During the Pandemic," *Washington Post*, April 6, 2021, https://www.washingtonpost.com/health/2021/04/06/stress-front-lines-health-care-workers-share-hardest-parts-working-during-pandemic/. Other studies have shown increased anxiety, depression, sleep problems, and distress among health care workers during the COVID-19 pandemic. See, for example, Ashley E. Muller, Elisabet V. Hafstad, Jan P. W. Himmels et al., "The Mental Health Impact of the COVID-19 Pandemic on Healthcare Workers, and Interventions to Help Them: A Rapid Systematic Review," *Psychiatry Research*, vol. 293 (November 2020).

[72] States license health care providers and determine their scope of practice. To increase the workforce available to provide clinical care, states have waived a number of licensure requirements. See, for example, Federation of State Medical Boards, *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*, March 31, 2021, https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf.

funding for existing programs that train health providers in outpatient settings who provide care to underserved populations, as well as for programs that provide scholarship and loan repayments to health providers in exchange for providing care to underserved populations. The additional funding does not require that the new providers work in COVID-19-related health care. The funding represents an increase to existing programs that in some cases substantially exceeds recent annual program funding levels.

Health Workforce Provisions

Section 2501. Funding for Public Health Workforce

Background

The nation's public health workforce is expected to prepare for and respond to public health emergencies, such as the opioid epidemic and COVID-19 pandemic, as well as to routine community health burdens, such as diabetes and sexually transmitted infections. This workforce has decreased since 2010, based in part on state budget constraints, uncertain funding sources, and other factors. According to a 2019 survey of state health departments by the Association of State and Territorial Health Officials (ASTHO),[73]

> the [State Health Agency] SHA workforce comprises a diverse group of people who work in fields ranging from administrative work and financial operations to healthcare and environmental health. Between 2010 and 2019, the overall SHA workforce decreased by 15.3% from 108,059 to 91,540 full-time equivalents (FTEs). On average, the workforce has decreased by over 5,500 FTEs every three years since 2010.
>
> In 2019, only 9.9% of the workforce represented staff who focus on preparedness efforts.[74]

The National Association of County & City Health Officials (NACCHO)[75] reported a similar trend among the workforce in local health departments (LHDs), saying,

> Since 2008, the estimated number of LHD full-time equivalents (FTEs) decreased from 162,000 to 136,000 in 2019—a decrease of approximately 16%.... During roughly that same time period, the overall population increased by about 8%. Despite a slight increase in the number of both FTEs and all employees from 2016 to 2019 … the workforce has not fully recovered from the cuts suffered during and after the Great Recession.[76]

According to ASTHO, from 2015 through 2018, HHS funding (excluding Medicare and Medicaid) provided about 22% of SHA revenues overall through various awards to support public health activities, including hiring, training, and retention of staff to carry out these activities.[77]

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[73] ASTHO is a national nonprofit organization representing U.S. state and territorial public health officials and staff. See Association of State and Territorial Health Officials, "About Us," https://www.astho.org/About/.

[74] Association of State and Territorial Health Officials (ASTHO), "Data Brief: State Public Health Resources and Capacity," March 23, 2020, https://www.astho.org/Research/Data-and-Analysis/Data-Brief-on-State-Public-Health-Resources-and-Capacity/.

[75] NAACHO is a national nonprofit organization representing U.S. local public health department officials and staff. See National Association of County & City Health Officials, "About Us," https://www.naccho.org/about.

[76] NACCHO, "NACCHO's 2019 Profile Study: Changes in Local Health Department Workforce and Finance Capacity Since 2008; Research Brief," May, 2020, https://www.naccho.org/uploads/downloadable-resources/2019-Profile-Workforce-and-Finance-Capacity.pdf. The brief refers to the Great Recession of 2007-2009.

[77] Calculated by CRS from ASTHO, "ASTHO Profile of State Public Health," vol. 4, Funding; Modal 4: Expenditures, All States, undated, https://www.astho.org/profile/#openModal4.

This federal funding level was sustained during the survey period, whereas revenues from state sources declined.[78]

The five COVID-19 pandemic supplemental appropriations measures enacted in 2020 provided substantial additional financial assistance that nonfederal public health agencies have used or can use to hire, train, and retain staff for the pandemic response, among other expenditures. This assistance included not less than $2.45 billion to CDC for grants to SLTT health organizations, among other funding.[79]

Provision

Section 2501 appropriates $7.66 billion to the HHS Secretary, to remain available until expended, to carry out activities to establish, expand, and sustain the public health workforce. These funds are to be used in part to make awards to state, local, and territorial public health departments[80] to carry out the following activities in particular:

- Recruit, hire, and train public health workers to serve in specified roles, including community health work, case investigation and contact tracing, epidemiology and laboratory analysis, information management, communications, and any other positions as may be required to prevent, prepare for, and respond to the COVID-19 pandemic. These workers may be employed by the jurisdictional health department or by nonprofit private or public organizations that have expertise in implementing public health programs and established relationships with the jurisdiction, particularly in medically underserved areas.
- Acquire personal protective equipment, data management and other technology, and other necessary supplies.
- Pay administrative costs and activities necessary for awardees to implement activities funded under this section.
- Make subawards to local health departments for these activities.

Funding provided by this section is not designated to an existing HHS agency, program, project, or activity. Its implementation is presumably left to the HHS Secretary's discretion. Of note, other sections in ARPA (e.g., Sections 2401, 2402) also provide funding in part to support the public health workforce.[81]

Section 2502. Funding for Medical Reserve Corps

Background

The Medical Reserve Corps (MRC), authorized under PHSA Section 2813, is a nationwide cadre of volunteers who are recruited, rostered, and trained by local entities to assist with the response to public health emergencies.[82] According to HHS, the MRC "comprises approximately … 185,000 volunteers in roughly 800 community-based units located throughout the United States

[78] Ibid.

[79] CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

[80] Tribal public health departments are not explicitly mentioned in Section 2501. However, tribal entities may receive funds through states or local public health departments.

[81] See the "Public Health Infrastructure Provisions" section of this report.

[82] The MRC is authorized in PHSA §2813; 42 U.S.C. 300hh–15.

and its territories."[83] MRC units may serve as local response assets and may, under state authority, be deployed within a state or be offered to another state as a form of mutual aid.[84]

MRC units typically do not receive federal funding to recruit, train, or deploy. Rather, HHS provides technical assistance, and it has received an annual appropriation of approximately $6 million per year in recent years to do so.[85]

Provision

Section 2502 appropriates $100 million to the HHS Secretary, to remain available until expended, to implement the MRC by reference to its authority in PHSA Section 2813.[86]

Section 2602. Funding for National Health Service Corps

Background

The National Health Service Corps (NHSC) provides scholarships and loan repayments to certain health professionals in exchange for providing care in a health professional shortage area (HPSA). Health professionals receiving these benefits commit to working for a period of time that varies based on the length of the scholarship or the number of years of loan repayment received.[87] The NHSC consists of three programs: (1) a federal scholarships program authorized in PHSA Section 338A, (2) a federal loan repayment program authorized in PHSA Section 338B, and (3) a state-operated loan repayment program authorized in PHSA Section 338I. The State Loan Repayment program authorized in PHSA Section 338I provides one-to-one matching grants for states to operate loan repayment programs that are similar to the federally run programs but that give states flexibility to expand the types of providers eligible, the amounts available for loan repayment, and the length of the service commitment.

The NHSC receives mandatory funding from the Community Health Center Fund (CHCF), which provided $310 million for the program in FY2021. For FY2021, the NHSC also received $120 million in discretionary appropriations for loan repayment for substance use treatment providers, with $15 million of that amount reserved to place providers at Indian Health Service (IHS) facilities.[88]

Provision

Section 2602 appropriates $800 million to the HHS Secretary, available until expended, to carry out the NHSC scholarship, loan repayment, and state loan repayment programs, by referencing authorities under PHSA Sections 338A, 338B, and 338I. The provision reserves $100 million for

[83] HHS, Office of the Assistant Secretary for Preparedness and Response (ASPR), "Medical Reserve Corps," https://www.phe.gov/about/oem/prep/Pages/mrc.aspx.

[84] For an overview of state-to-state mutual aid for emergency response, see Federal Emergency Management Agency (FEMA), "Emergency Management Assistance Compact (EMAC): Overview for National Response Framework," undated, https://www.fema.gov/pdf/emergency/nrf/EMACoverviewForNRF.pdf.

[85] HHS, "Civilian Volunteer Medical Reserve Corps," *Public Health and Social Services Emergency Fund: Justification of Estimates for Appropriations Committee, FY2021*, undated, pp. 54-58, https://www.hhs.gov/sites/default/files/fy-2021-phssef-cj.pdf.

[86] 42 U.S.C. §300hh–15(a), Volunteer Medical Reserve Corps.

[87] CRS Report R44970, *The National Health Service Corps*.

[88] The National Health Service Corps has received a total of $430 million in combined mandatory and discretionary appropriations since FY2019.

the state loan repayment program. It waives the program's matching requirement and specifies that a state may use no more than 10% of its award for administering the state loan repayment program.

Section 2603. Funding for Nurse Corps

Background

The Nurse Corps program, authorized under PHSA Section 846, provides scholarships and loan repayments to certain health professionals in exchange for providing care in a health professional shortage area for a period of time (the required service time varies, based on the length of the scholarship or the number of years of loan repayment received). Though the program is similar to the NHSC, it includes a broader range of nurses than are eligible for the NHSC (e.g., registered nurses are eligible) and permits individuals to fulfill their service commitment at hospitals, while the NHSC permits service commitments only at critical access hospitals and Indian Health Service hospitals.[89] For FY2021, the Nurse Corps program received $88.6 million in discretionary appropriations.

Provision

Section 2603 appropriates $200 million to the HHS Secretary for the Nurse Corps program, by reference to its authority in PHSA Section 846, which is available until expended.

Section 2604. Funding for Teaching Health Centers that Operate Graduate Medical Education

Background

The Teaching Health Center Graduate Medical Education (THCGME) program, authorized under PHSA Section 340H, provides direct and indirect graduate medical education (GME) payments to support medical and dental residents training at qualified teaching health centers (i.e., outpatient health care facilities that provide care to underserved patients).[90] Direct GME payments support resident and preceptor salaries, while indirect payments are intended to provide for the indirect costs associated with training residents (e.g., higher patient costs due to additional tests that residents order as part of their training).[91] The program supports the costs of residents in training, but it has not provided funds to develop new programs or to offset the costs of becoming eligible (i.e., the accreditation process).

PHSA Section 749A authorizes grants to develop new teaching health centers (THCs), which were first authorized in 2010 but have never been funded. THCGME, which provides payments for the residents in training, has received direct appropriations since it began in 2011. Most recently, the THCGME program received $126.5 million for each of FY2021 through FY2023 in Section 301 of Division BB of the Consolidated Appropriations Act, 2021 (P.L. 116-260). Prior to this extension, the program had received a number of shorter-term extensions. The lack of stable funding may make it challenging for THCs to expand the number of residents in training or for

[89] CRS Report R44970, *The National Health Service Corps*; and HRSA, "Apply to the Nurse Corps Loan Repayment Program," https://bhw.hrsa.gov/funding/apply-loan-repayment/nurse-corps.

[90] CRS Report R44376, *Federal Support for Graduate Medical Education: An Overview*.

[91] Ibid.

new programs to develop. THCGME payments support residents currently in training; however, programs need to become accredited and recruit faculty and potential residents before residents begin their training. In addition, residency training at a THC is generally three years, which is a longer interval than several of the funding extensions for the program. The lack of stable funding may impede the development of new programs and deter potential residents from considering these programs.[92]

Provision

Section 2604 appropriates $330 million to the HHS Secretary for the teaching health center program to remain available until September 30, 2023. These amounts may be used for GME payments for teaching health centers authorized under PHSA Section 340H and for grants for teaching health center development authorized under PHSA Section 749A. The section permits funds to be used to make GME payments that would exceed the amount appropriated for the program in a given fiscal year and the capped amount used to determine the program's direct and indirect graduate medical education payment amounts.

The provision specifies that ARPA funds may be used to

- make payments to establish newly approved THCGME programs;
- increase the per-resident amount that THCGME programs receive by $10,0000 per resident trained;
- make payments to existing programs to maintain residency positions;
- make GME payments to existing programs to add new residents;
- award teaching health center development grants; and
- provide for the administrative and other costs related to THCGME programs.

Sections 2703-2705. Funding for Behavioral Health for Health Service Professionals

Background

Concerns about the mental health and well-being of the health professional and first responder workforce preceded the COVID-19 pandemic, but the pandemic exacerbated these concerns.[93] Health care professionals may experience significant stress, burnout, and/or be exposed to traumatic events in doing their jobs. Compounded over time, exposure to traumatic events or stressful job demands may contribute to diminished mental health and wellness. Prior to the pandemic, the National Academy of Medicine (NAM) had undertaken the Clinician Wellbeing and Resilience project[94] at the request of a number of provider organizations that recognized

[92] For program funding information through 2020, see CRS Report R46331, *Health Care-Related Expiring Provisions of the 116th Congress, Second Session*.

[93] Thomas Bodenheimer and Christine Sinsky, "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider," *Annuals of Family Medicine*, vol. 12, no. 6 (November 2014), pp. 573-576, for historical information; and Victor J. Dzau, Darrell Kirch, and Thomas Nasca, "Preventing a Parallel Pandemic—A National Strategy to Protect Clinicians' Well-Being," *New England Journal of Medicine*, vol. 383 (August 6, 2020), pp. 513-515.

[94] National Academy of Medicine, "Action Collaborative on Clinician Well-Being and Resilience," https://nam.edu/initiatives/clinician-resilience-and-well-being/.

mental health and burnout issues within their workforce.[95] After March 2020, NAM's work expanded to address issues that arose during the pandemic and to share strategies to mitigate burnout. This work focused on strategies that could be undertaken for all types of health professionals at all levels, from students to licensed professionals. It also focused on individual-, workplace-, and system-level interventions that could be undertaken to reduce burnout and increase provider well-being.

Although HHS supports the provision of mental health prevention and treatment services generally, few federal programs focus explicitly on improving the mental well-being of the health workforce. Rather, existing federal programs target mental health more broadly or provide support during emergency situations.[96] For example, SAMHSA supports education and training, prevention programs, early intervention activities, treatment services, and technical assistance—including sometimes for specific populations (such as health care personnel). Through an interagency agreement with the Federal Emergency Management Agency (FEMA), SAMHSA operates the Crisis Counseling Assistance and Training Program (CCP), which provides behavioral health outreach and psycho-educational services to individuals in areas affected by disasters. CCP is not specifically designed for health workers, but the program can serve them as response personnel.[97]

Provisions

Section 2703 appropriates $80 million to the HRSA Administrator,[98] to remain available until expended, to award grants or contracts to specified entities to plan, develop, operate, or participate in evidence-informed strategies to reduce suicide, burnout, and mental health conditions and substance use disorders among health care professionals and public safety officers. Grantees are required to develop training targeted to health professions (including students, trainees, paraprofessionals and their employers) and public safety officers and their employers. Grants must be awarded in a manner that considers the needs of rural and medically underserved communities and must be awarded to health professional schools, academic health centers, state and local government, Indian Tribes (ITs) or Tribal Organizations (TOs), employers of health care professionals and public safety officers, or other appropriate public or private nonprofit entities or consortia of such entities.

Section 2704 appropriates $20 million to the CDC director,[99] to remain available until expended, in consultation with the medical professional community, to carry out a national evidence-based education and awareness campaign directed at health care professionals, first responders, and the employers of such professionals. The campaign is required to encourage this workforce to (1) prevent mental health and substance use disorders and seek support and treatment, and (2) help identify risk factors in themselves and others and respond to such risks.

Section 2705 appropriates $40 million, to remain available until expended, for HRSA to award grants or contracts to health care entities, as specified, to establish or expand evidence-informed

[95] National Academy of Medicine, "Action Collaborative on Clinician Well-Being and Resilience: Sponsors," https://nam.edu/initiatives/clinician-resilience-and-well-being/sponsors/.

[96] For more information, see CRS Report R46555, *Federal Efforts to Address the Mental Health of First Responders: Resources and Issues for Congress*.

[97] SAMHSA, *Practitioner Training; Disaster Technical Assistance Center (DTAC); Crisis Counseling Assistance Program (CCP)*, https://www.samhsa.gov/dtac/ccp.

[98] Section 2703 appropriates funding to the HHS Secretary "acting through" the HRSA Administrator.

[99] Section 2704 appropriates funding to the HHS Secretary "acting through" the CDC Director.

protocols to promote mental health among their workforce.[100] Grants must be awarded in a manner that considers the needs of rural and medically underserved communities.

Section 2711. Funding for Behavioral Health Workforce Education and Training

Background

PHSA Section 756 authorizes the Behavioral Health Workforce Education and Training (BHWET) Program, which was codified in the Helping Families in Mental Health Crisis Reform Act of 2016 (Division B of the 21st Century Cures Act, P.L. 114-255).[101] The program provides grants to support the training of the behavioral health workforce, including paraprofessionals. The program was amended in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271), which added language specifying that providers trained in trauma-informed care are eligible to participate. The SUPPORT Act extended the program's authorization of appropriations of $50 million for each fiscal year through FY2023.[102] For FY2021, the program received an appropriation of $112 million in the Consolidated Appropriations Act, 2021.

Provision

Section 2711 appropriates $100 million to the HHS Secretary, available until expended, for the BHWET program by reference to its authority in PHSA Section 756.

Health Care Infrastructure and Provider Support

Background

In response to the COVID-19 pandemic, some health care providers limited in-person visits and cancelled elective procedures to reduce the spread of COVID-19, prepare for COVID-19 patients, and conserve medical supplies such as PPE. As a consequence, some providers reported forgone revenue and/or significant financial challenges, making it difficult to sustain services.[103] To address these concerns, the Provider Relief Fund (PRF) was established in the CARES Act. In total, the Provider Relief Fund has received $178 billion for grants to be awarded to health care providers for lost revenue and increased expenses due to the pandemic.[104] Separate from PRF, prior COVID-19 pandemic response laws also included funding for specific types of providers, including health centers that receive grants to provide care to underserved populations regardless of their ability to pay, and facilities that receive funding from the Indian Health Service (IHS).

Further, ARPA provides additional funding to certain types of health providers—generally those that target disadvantaged populations (e.g., community health centers and support for family

[100] Section 2301 appropriates funding to the HHS Secretary "acting through" the HRSA Administrator.

[101] CRS Report R44718, *The Helping Families in Mental Health Crisis Reform Act of 2016 (Division B of P.L. 114-255)*.

[102] CRS Report R45423, *Public Health and Other Related Provisions in P.L 115-271, the SUPPORT for Patients and Communities Act*.

[103] For more information on the PRF, see CRS Insight IN11438, *The COVID-19 Health Care Provider Relief Fund*.

[104] CRS Insight IN11438, *The COVID-19 Health Care Provider Relief Fund*.

planning programs). Some of these funding programs are tailored to specific purposes related to the COVID-19 pandemic, while others are available for health care infrastructure and provider support more broadly.

Rural facilities faced financial challenges prior to the pandemic that may have been exacerbated by it.[105] Though rural facilities received support from the PRF, data suggest that rural providers have not received a proportionate share from the fund.[106] Research examining the effects of the pandemic on hospitals also found that rural hospitals fared worse than other hospitals because they were financially challenged prior to the pandemic—the pandemic further exacerbated such challenges.[107] ARPA includes two provisions that specifically target rural health care providers. One creates a fund that is similar to the PRF, but with a new funding stream available only to rural facilities. The other creates a new program within the USDA to make grants to rural facilities for a number of purposes, including increased costs related to vaccine distribution.

Unlike other sections of this report, several of the below provisions are not in Title II of ARPA (three of six provisions are in Titles I, IX, and XI, respectively).

Health Care Infrastructure and Provider Support Provisions

Section 2601. Funding for Community Health Centers and Community Care

Background

The federal health center program, authorized by PHSA Section 330 and administered by HRSA, provides grants to not-for-profit organizations and state and local government entities to operate outpatient health centers. Participation in the program requires grantees to provide care regardless of a patient's ability to pay, and grant funding is provided to support this care. These centers are also required to be located in medically underserved areas (MUAs) or to provide care to a population that is designated as underserved.[108] Health centers are part of the health care safety net, and they have received a total of $2 billion in funding under three of the five COVID-19 supplemental appropriations measures.[109] In general, funds have been used to supplement existing health centers. Funds made available under PPPHCEA for testing were also used for grants to Federally Qualified Health Center (FQHC) look-alikes, which are facilities similar to health centers in terms of location, services provided, and population served, but that do not receive PHSA Section 330 grants.[110]

[105] Karyn Schwartz and Tricia Neuman, *Funding for Health Care Providers During the Pandemic: An Update*, Kaiser Family Foundation, Policy Watch, Washington, DC, March 24, 2021, https://www.kff.org/policy-watch/funding-for-health-care-providers-during-the-pandemic-an-update/.

[106] Amy Lotven, "Senate Approves Amendment Boosting Provider Relief Fund," *Inside Health Policy*, February 5, 2021, https://insidehealthpolicy.com/daily-news/senate-approves-amendment-boosting-provider-relief-fund.

[107] Christi A. Grimm, Principle Deputy Inspector General, *Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery*, HHS Office of the Inspector General, OEI-09-21-00140, Washington, DC, March 2021, https://oig.hhs.gov/oei/reports/OEI-09-21-00140.pdf.

[108] CRS Report R43937, *Federal Health Centers: An Overview*.

[109] See discussion in the "Health Resources and Services Administration" section in CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

[110] See Appendix B of CRS Report R43937, *Federal Health Centers: An Overview*. These are defined in statute at Section 1861(aa)(4)(B) of the Social Security Act.

Provision

Section 2601 appropriates $7.6 billion to the HHS Secretary, to remain available until expended, for PHSA Section 330 grants or contracts to federal health centers or for grants specifically to FQHC look-alikes. Section 2601 also reserves $20 million of the amount appropriated for grants or contracts with Native Hawaiian Health Care System entities as specified. The provision specifies uses of these funds for COVID-19-related activities, including those related to vaccines, testing, treatment, and the acquisition of mobile equipment or the making of infrastructure modifications for these purposes. Funds may also be used to hire personnel to assist with these activities. Entities receiving funds under this section may use the amounts received for pandemic-related expenses that were incurred since the declaration of Public Health Emergency by the HHS Secretary, effective January 27, 2020.

Section 2605. Funding for Family Planning

Background

The PHSA Title X Family Planning Program provides grants to public and nonprofit agencies for family planning services, research, and training.[111] It is the only domestic federal program dedicated solely to family planning and related preventive health services.[112] In 2019, PHSA Title X served 3.1 million clients; 87% were female, 64% had incomes at or below the federal poverty guidelines, and 84% had incomes at or below 200% of the federal poverty guidelines.[113]

During the COVID-19 pandemic, PHSA Title X clinics have continued to provide services.[114] CDC released guidance on "ensuring access to family planning services during COVID-19," for example through telehealth, curbside pickup, providing a one-year supply of oral contraceptives, and providing an advance supply of emergency contraception.[115] According to John Snow, Inc., a survey conducted in May 2020 found that 87% of PHSA Title X providers reported that they were providing telehealth services, compared with 11% about a year earlier.[116]

[111]CRS In Focus IF10051, *Title X Family Planning Program*.

[112] Office of Population Affairs, Office of the Secretary, Department of Health and Human Services, "Compliance With Title X Requirements by Project Recipients in Selecting Subrecipients," 81 *Federal Register* 61640, September 7, 2016, https://www.federalregister.gov/d/2016-21359/p-10.

[113] Christina Fowler, Julia Gable, Beth Lasater et al., *Family Planning Annual Report: 2019 National Summary*, Office of Population Affairs, Office of the Assistant Secretary for Health, Department of Health and Human Services, Washington, DC, September 2020, pp. ES-2, 25, https://opa.hhs.gov/sites/default/files/2020-09/title-x-fpar-2019-national-summary.pdf.

[114] Title X Grantee Profiles have examples of grantees' COVID-19 responses. HHS, Office of Population Affairs, *Learn More About Our Grantees*, https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-turns-50#learn.

[115] Centers for Disease Control and Prevention, *Ensuring Access to Family Planning Services During COVID-19*, https://www.cdc.gov/reproductivehealth/contraception/covid-19-family-planning-services.html. The Title X-funded Reproductive Health National Training Center also released COVID-19 resources for Title X providers, https://rhntc.org/search?keys=covid.

[116] John Snow, Inc. (JSI), *Telemedicine: The Future of Family Planning Care*, July 7, 2020, https://www.jsi.com/telemedicine-the-future-of-family-planning-care/. JSI is a public health management consulting and research organization that manages the Title X-funded Reproductive Health National Training Center.

The Consolidated Appropriations Act, 2021, appropriated $286.5 million in annual discretionary funding for PHSA Title X in FY2021, the same as the FY2020 funding level.[117] Prior to ARPA, the program had received the same annual appropriations level since FY2014.[118]

Provision

Section 2605 appropriates $50 million to the HHS Secretary, to remain available until expended, for the Title X program.[119]

Section 2713. Funding for Expansion Grants for Certified Community Behavioral Health Clinics

Background

Section 223(a) of the Protecting Access to Medicare Act of 2014 (P.L. 113-93) authorized funding to improve community-based behavioral health services through a demonstration program to establish certified community behavioral health clinics (CCBHCs). CCBHCs are facilities operated by nonprofit organizations or governmental or tribal entities that offer a comprehensive range of services, including risk assessment, outpatient mental health and substance use treatment, case management, psychiatric rehabilitation services, peer and family supports, 24-hour crisis management, and primary care medical services, among others. To be certified, CCBHCs are required to maintain partnerships with other health and social service providers.

In 2015, 24 states received planning grants. In 2016, eight states were selected to participate in the initial demonstration program. These states received an enhanced Medicaid federal medical assistance percentage (FMAP, i.e., federal matching) rate for CCBHC services, and the CCBHCs in these states received an enhanced payment rate through a prospective payment system methodology. Two additional states were added to the demonstration program in 2020.

FY2020 appropriations (P.L. 116-94) authorized a CCBHC Expansion grant program and provided $200 million to fund this part of the program. Grants awarded under the expansion grant program provided up to $2 million to facilities that met the certification criteria to increase access and improve the quality of their behavioral health services. (Only CCBHCs in the demonstration program receive the enhanced Medicaid FMAP rate.) In 2020, 33 states participated in the CCBHC Demonstration and Expansion Grant programs.

In the previous COVID-19 supplemental measures, a total of not less than $850 million was made available for the CCBHC Expansion grant program.[120] For FY2021, the CCBHC program

[117] P.L. 116-260, Consolidated Appropriations Act, 2021, Division H, Title II; P.L. 116-94, Further Consolidated Appropriations Act, 2020, Division A, Title II, 133 Stat. 2558.

[118] P.L. 115-245, Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019, and Continuing Appropriations Act, 2019, Division B, Title II, 132 Stat. 3070; P.L. 115-141, Consolidated Appropriations Act, 2018, Division H, Title II, 132 Stat. 716; P.L. 115-31, Consolidated Appropriations Act, 2017, Division H, Title II, 131 Stat. 521; P.L. 114-113, Consolidated Appropriations Act, 2016, Division H, Title II, 129 Stat. 2602; P.L. 113-235, Consolidated and Further Continuing Appropriations Act, 2015, Division G, Title II, 128 Stat. 2468; P.L. 113-76, Consolidated Appropriations Act, 2014, Division H, Title II, 128 Stat. 365.

[119] This provision increases the funds available for this program in FY2021 by 17%, the first increased funding level for the program since FY2014.

[120] The CARES Act included not less than $250 million of the total appropriation for SAMHSA, and Division M of the Consolidated Appropriations Act, 2021, included not less than $600 million.

received $250 million in discretionary appropriations in the Consolidated Appropriations Act, 2021.

Provision

Section 2713 appropriates $420 million to the SAMHSA Assistant Secretary for Mental Health and Substance Use,[121] to remain available until expended, for grants for Certified Community Behavioral Health Clinics pursuant to Section 223(a) of the Protecting Access to Medicare Act of 2014.[122]

Section 1002. Emergency Rural Development Grants for Rural Health Care, and Section 9911. Funding for Providers Related to COVID-19

Background

As noted above, in response to the COVID-19 pandemic, some health care providers limited in-person visits and cancelled elective procedures to reduce the spread of COVID-19, to prepare for an influx of COVID-19 patients, and to conserve PPE. As a consequence, some providers reported forgone revenue and significant financial challenges, making it difficult to sustain services.[123] This situation was particularly challenging for providers that had struggled financially prior to the pandemic, as was the case for a number of rural hospitals.[124]

To address some of the providers' financial concerns, the PRF was established in the CARES Act. The fund provided grants to health care providers for lost revenue and increased expenses due to the COVID-19 pandemic. The PRF was written with broad language, giving the Administration discretion both in how funds could be allocated and in the potential application and documentation requirements. The most recent amendment to the fund authority created some statutory requirements for the fund and its future uses. Specifically, the Consolidated Appropriations Act, 2021, defined uses of the fund, defined lost revenue to reflect the definition in the HHS Frequently Asked Questions released in June 2020, and specified application processes, among other things.[125]

HHS has allocated the PRF using general and targeted distributions. Among the targeted distributions was an allocation of $11.3 billion for rural facilities (rural providers and suppliers were also eligible for general distributions). This targeted distribution provided funds to rural hospitals (including critical access hospitals), rural health clinics, and rural community health centers.[126] Notably, rural clinician practices or suppliers did not receive funds as part of this allocation.

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[121] Section 2713 appropriates funding to the HHS Secretary "acting through" the SAMHSA Assistant Secretary for Mental Health and Substance Use.

[122] 42 U.S.C. §1396a note.

[123] For more information on the PRF, see CRS Insight IN11438, *The COVID-19 Health Care Provider Relief Fund*.

[124] Christi A. Grimm, Principle Deputy Inspector General, *Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery*, HHS Office of the Inspector General, OEI-09-21-00140, Washington, DC, March 2021, https://oig.hhs.gov/oei/reports/OEI-09-21-00140.pdf.

[125] The current reporting requirements that use the June 2020 definition of lost revenue can be found at HHS, "General and Targeted Distributions Post-Payment Notice of Reporting Requirements," January 15, 2021, https://www.hhs.gov/sites/default/files/provider-post-payment-notice-of-reporting-requirements-january-2021.pdf.

[126] CRS Insight IN11438, *The COVID-19 Health Care Provider Relief Fund*; and HHS, Provider Relief Fund: CARES Act Provider Relief Fund: General Information: Targeted Distributions," https://www.hhs.gov/coronavirus/cares-act-

The various COVID-19 pandemic response measures have also included funds that target rural health providers and that include funds targeted to rural communities as part of a broader focus on underserved populations. Specifically, the fourth COVID-19 relief measure, PPPHCEA, included $225 million for grants to rural health clinics (RHCs)—small outpatient clinics located in rural areas—for COVID-19 testing. These funds could be used "for building or construction of temporary structures, leasing of properties, and retrofitting facilities as necessary to support COVID–19 testing."[127] Division M of Consolidated Appropriations Act, 2021 also included $300 million for the CDC to target "high-risk and underserved populations, including racial and ethnic minority populations and rural communities." Similarly, that measure also included not less than $2.5 billion to the PHSSEF account for "strategies for improving testing capabilities and other purposes ... in high-risk and underserved populations, including racial and ethnic minority populations and rural communities as well as identifying best practices for states and public health officials to use for contact tracing in high-risk and underserved populations, including racial and ethnic minority populations and rural communities."[128]

In addition to HHS support for rural providers both during and prior to the pandemic, the USDA Rural Development agency administers some programs that support rural health care facilities and telemedicine.[129] For example, the Community Facilities programs finance the construction, improvement, or purchase of equipment for essential community facilities in rural areas, including health care facilities. The Distance Learning and Telemedicine Program provides grants to eligible entities in rural areas to fund the acquisition of distance learning and telemedicine equipment and software.

In recent years, Congress has increasingly directed USDA to address rural health care access, particularly through assistance to rural hospitals. For example, the Agriculture Improvement Act of 2018 (2018 farm bill; P.L. 115-334) authorized USDA to use loans or loan guarantees under certain rural business or infrastructure programs to refinance rural hospital debt if such refinancing would preserve access to a health service in a rural community or meaningfully improve the financial position of the hospital.[130] In the FY2020 and FY2021 Agriculture Appropriations Acts, Congress provided a total of $3 million to USDA to provide technical assistance to improve the long-term operations and financial health of rural hospitals.[131]

Provisions

Section 1002 appropriates $500 million to the USDA Secretary to establish an emergency pilot program to provide grants "to be awarded by the Secretary based on rural development needs related to the COVID-19 pandemic." The provision authorizes grant funds to be used to

- increase capacity for vaccine distribution;

provider-relief-fund/general-information/index.html#phase15.

[127] See PHSSEF account in Title I, Division B of P.L. 116-139. See also HHS, HRSA, "HHS Provides $225 Million for COVID-19 Testing in Rural Communities," press release, May 20, 2020, https://public3.pagefreezer.com/content/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2020/05/20/hhs-provides-225-million-for-covid19-testing-in-rural-communities.html.

[128] See CDC and PHSSEF appropriations in Division M of P.L. 116-260.

[129] USDA Rural Development is the mission area within USDA responsible for rural infrastructure and economic development assistance. For more information, see CRS Report RL31837, *An Overview of USDA Rural Development Programs*.

[130] P.L. 115-334, §6103.

[131] P.L. 116-94, Division B, Title VII, §753, provided $1 million, and P.L. 116-260, Division A, Title VII, §770 provided $2 million.

- provide medical supplies to increase medical surge capacity;
- reimburse for revenue lost during the COVID-19 pandemic, including revenue lost prior to the awarding of the grant;
- increase telehealth capabilities;
- construct temporary or permanent structures to provide health care services, including vaccine administration and testing;
- support staffing needs for vaccine distribution and testing; and
- engage in any other efforts to support rural development determined to be critical to address the COVID-19 pandemic, including nutritional assistance to vulnerable individuals, as determined by the USDA Secretary.

Eligible applicants include public bodies, nonprofit corporations or associations, and federally recognized Indian tribes. Grants must support facilities that are located in, and primarily serve, low-income, rural areas. Appropriated funds are to remain available through FY2023. The provision authorizes USDA to use up to 3% of funds for administrative purposes and up to 2% of funds to provide technical assistance to eligible applicants, including assistance in identifying and planning for facility needs, applying for financing, and improving the management of the facility.

Section 9911 creates a new Section 1150C of the Social Security Act (SSA), "Funding for Providers Relating to COVID-19." The provision appropriates $8.5 billion to make payments to rural health care providers to account for lost revenue and increased health care-related expenses due to COVID-19. These funds are available until expended. The provision also specifies application requirements for providers to receive funds and use of funds, and defines key terms in ways that are substantively similar to those specified in Division M of the Consolidated Appropriations Act, 2021, for the PRF. The provision defines an eligible health care provider differently than in Division M of Consolidated Appropriations Act, 2021, and in prior laws appropriating funds to the PRF, which did not specify that providers needed to be in specific geographic locations or be enrolled in specific public programs to participate. ARPA defines an eligible health care provider for these payments as a Medicare, Medicaid, or CHIP provider or supplier that provides COVID-19 diagnoses, testing, or care and is a rural provider or supplier.

The provision further defines rural providers and suppliers as

- a provider or supplier that is a rural provider or is treated as a rural provider under the Medicare statute (as defined);[132]
- a provider or supplier that is not located in a rural area, but is determined by the HHS Secretary to serve rural patients;
- a rural health clinic (as defined);[133]
- a home health, hospice, or long-term services and supports provider or supplier that provides supplies or services in an individual's home that is located in a rural area (as defined);[134] or
- any other rural provider or supplier as defined by the HHS Secretary.

[132] SSA §§1886(d)(2)(D) and 1886(d)(8)(E), respectively.

[133] SSA §1861(aa)(2).

[134] SSA §1886(d)(2)(D).

Section 11001. Indian Health Service

Background

The Indian Health Service (IHS) provides health care to American Indian and Alaska Native populations. Such health care is provided either directly—by providing funds for Indian Tribes (ITs) or Tribal Organizations (TOs) to operate health care facilities—or through grants to Urban Indian Health Organizations (UIOs) to provide care to American Indians and Alaska Natives in urban areas.[135] More than two-thirds of IHS facilities are operated by ITs/TOs through contracts or compacts authorized under the Indian Self-Determination and Education Assistance Act (ISDEAA, P.L. 93-638). ITs/TOs generally contract or compact for services that IHS would have otherwise provided by entering into a funding agreement that delineates the services funded under the agreement.

IHS generally provides services free of charge to approximately 2.6 million eligible American Indians and Alaska Natives in 37 states.[136] Available services vary by facility, and when services are not available, IHS may refer patients to outside providers through its purchased/referred care (PRC) program. Though IHS facilities do not charge directly for services, they may bill for services provided to IHS beneficiaries who have coverage through public programs (e.g., Medicaid) or private insurance. The amount received from third-party reimbursements varies by facility, but some tribal facilities report that more than half of their budgets comes from third-party revenue.[137]

Funding has been provided to IHS for COVID-19 pandemic response, in part, because of the agency's role as a direct health care provider. In that role, the agency supports testing, treatment, and vaccination services for its service population, which has been disproportionally affected by the pandemic. A number of IHS areas, including the Navajo area, experienced early and sustained outbreaks of COVID-19 infections. Data show high COVID-19 mortality rates among American Indians and Alaska Natives compared with other racial and ethnic groups.[138] IHS, like other health systems, experienced increased demand for intensive COVID-related services, while seeing declining revenue because of cancelled or delayed routine and elective care.[139] In addition to providing health services related to COVID-19, IHS supports certain public health and health education activities (similar to those of CDC). IHS also has several public health workforce programs, including public health nursing programs and the community health representative

[135] The Indian Health Service (IHS) also provides grants to Urban Indian Organizations (UIOs) that operate smaller health facilities in urban areas. These facilities vary in terms of the services available, with some providing comprehensive services, whereas others provide information and referral services. Outside of the grants they receive, UIOs are generally not eligible for funds from the overall IHS budget, with some exceptions. See CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

[136] HHS, IHS, *Fiscal Year 2021 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf. Facilities operated by IHS are prohibited to charge for services; facilities operated by Indian Tribes, Tribal Organizations, or UIOs may charge for services.

[137] Christopher D. Chavis, *Indian Health 101: Fulfilling a Promise*, National Indian Health Board, Washington, DC, November 17, 2020, p. slide 19, https://www.nihb.org/aian-heritage-month/wp-content/uploads/2020/11/Indian-Health-101.pdf.

[138] Jessica Arrazola et al., *COVID-19 Mortality Among American Indian and Alaska Native Persons—14 States, January–June 2020*, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly (69)(49), Atlanta, GA, December 11, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a3.htm?s_cid=mm6949a3_w.

[139] See CRS Insight IN11333, *COVID-19 and the Indian Health Service*.

program, which trains American Indians and Alaska Natives to provide health-promotion and disease-prevention activities.[140]

In prior COVID-19 supplemental appropriations measures, IHS received supplemental discretionary funding totaling $1.1 billion provided to agency accounts and a total of not less than $1.8 billion in directed transfers and set-asides, either (1) to agency accounts or (2) to be allocated at the discretion of the IHS Director in other accounts. In total, accounting for transfers and set-asides, budgetary resources of at least $2.8 billion were made available either to IHS accounts or at the direction of the IHS Director. In addition, a total of not less than $320 million was reserved for tribal entities (i.e., ITs/TO/UIOs) from funds that were appropriated to other HHS accounts, but not specifically directed to IHS in prior COVID-19 supplemental appropriations measures.

Provision

Section 11001 appropriates a total of $6.094 billion to IHS to remain available until expended. It specifies the following uses of these funds:

- $5.48 billion for health services and public health activities, which includes
  - $2 billion for lost reimbursements;
  - $500 million for PRC;
  - $140 million for information technology, telehealth infrastructure, and IHS's electronic health record system;[141]
  - $84 million for UIOs;
  - $600 million for vaccine-related activities, including activities that may relate to detecting, diagnosing, monitoring, and tracing COVID-19 and expanding the public health workforce;
  - $1.5 billion to detect, diagnose, and monitor COVID-19, including vaccine-related activities and activities related to expanding the public health workforce;
  - $240 million to establish, expand, and sustain a public health workforce, including for vaccine, testing, or disease mitigation purposes; and
  - $420 million for mental health and substance abuse prevention and treatment services, where funds may be for infrastructure, telehealth, or facilities for mental health and substance abuse prevention and treatment services;
- $600 million to lease, purchase, construct, alter, renovate, or equip health facilities to respond to the COVID-19 virus; and
- $10 million for potable water delivery.

The section specifies that funds appropriated in this provision are to be used to restore amounts incurred to prevent, prepare, or respond to the pandemic that were incurred from January 30,

[140] For information on IHS's public health workforce programs, see HHS, IHS, *Fiscal Year 2021 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf, pp. 135-155.

[141] Upgrading IHS's health information technology infrastructure and its electronic health record has been a long-term agency priority not specific to COVID-19. IHS, like other health system has increased its use of telehealth during COVID-19. For information about IHS information technology modernization efforts, see U.S. Department of Health and Human Services, Indian Health Service, FY2021, "Justification of Estimates for Appropriations Committees," https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf, pp. 94-103.

2020, through the date of enactment (March 11, 2021). The section also specifies that any funds made available to IT/TOs under ISDEAA contracts or compacts are made on a one-time basis and may be used only for the purposes specified in this section.

Mental Health and Substance Use

Background

Circumstances surrounding the pandemic—including lifestyle changes instituted to prevent the spread of the virus—appear to have negatively affected the mental health of many Americans.[142] Studies show elevated levels of emotional distress, anxiety, depression, substance use, and drug-related overdoses in 2020 and early 2021 compared with the same time period in previous years.[143] On account of these increases, CDC reported that "support systems to mitigate mental health consequences as the pandemic evolves will continue to be urgently needed."[144] In addition, physical distancing measures and temporary stay-at-home orders associated with the pandemic have altered the service delivery for mental health and substance use treatment. Many behavioral health service providers have increased their use of telehealth modalities to deliver treatment.[145] Still, limits on face-to-face service provision and other economic consequences of the pandemic have led to clinic closures and other reductions to treatment service capacity.[146]

Emergency financial support for behavioral health activities provided in the previous supplemental COVID-19 funding measures sought to address the high demand for mental health and substance use disorder treatment services and decreased capacity in the system. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency primarily responsible for supporting community-based mental health and substance abuse treatment and prevention services. SAMHSA received a total of $4.7 billion in supplemental appropriations in the CARES Act ($425 million) and Consolidated Appropriations Act, 2021

[142] See, for example, Colin Planalp, Giovann Alarcon, and Lynn Blewett, *90 Percent of U.S. Adults Report Increased Stress due to Pandemic*, State Health Access Data Assistance Center (SHADAC), Minneapolis, MN, May 26, 2020, https://www.shadac.org/SHADAC_COVID19_Stress_AmeriSpeak-Survey. For more information, see CRS Report R46831, *Behavioral Health During the COVID-19 Pandemic: Overview and Issues for Congress*.

[143] See, for example, Anjel Vahratian, Stephen J. Blumberg, Emily P. Terlizzi et al., Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic - United States, August 2020-February 2021, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)* vol. 70, March 26, 2021, https://www.cdc.gov/mmwr/volumes/70/wr/mm7013e2.htm; and Liz Hamel, Audrey Kearney, Ashley Kirzinger et al., *Coronavirus: Reopening, Schools, and the Government Response*, Kaiser Family Foundation, KFF Health Tracking Tracking Poll - July 2020, July 27, 2020, https://www.kff.org/coronavirus-covid-19/report/kff-health-tracking-poll-july-2020/.

[144] Mark E. Czeisler, Rashon I. Lane, Emiko Petrosky et al., *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic - United States, June 24-30, 2020*, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)*, vol. 69, no. 32, Atlanta, GA, August 14, 2020, p. 1055.

[145] Ateev Mehrotra, Michael Chernew, and David Linesky, *The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients*, The Commonwealth Fund, New York, NY, October 15, 2020, https://www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels.

[146] The National Council for Behavioral Health, *Demand for Mental Health and Addiction Services Increasing as COVID-19 Pandemic Continues to Threaten Availability of Treatment Options*, National Council for Behavioral Health Member Survey Polling Presentation, Washington, DC, September 2020, https://www.thenationalcouncil.org/press-releases/demand-for-mental-health-and-addiction-services-increasing-as-covid-19-pandemic-continues-to-threaten-availability-of-treatment-options/.

($4.25 billion). These measures provided funding for emergency substance use and mental health needs, children's mental health, suicide prevention, and SAMHSA's state block grant programs.

ARPA continues the efforts of the previous COVID-19 supplemental measures by providing funding to SAMHSA for community behavioral health activities. The measure provides funding for SAMHSA's largest block grant programs, school-based mental health, suicide prevention, childhood trauma, and pediatric mental health care access via telemedicine.

Mental Health and Substance Use Provisions

Sections 2701-2702. Funding for Block Grants for Community Mental Health Services and Prevention and Treatment of Substance Abuse

Background

SAMHSA provides most of its financial support for community-based behavioral health activities through two block grants authorized in Title XIX of the PHSA: the Community Mental Health Services Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG).[147] Both block grant programs distribute funds to states (including the District of Columbia and territories) according to a statutory formula.[148] The states, in turn, distribute funds to local government entities and nonprofit organizations for behavioral health-related treatment and prevention activities in accordance with a required state plan. Of the total $4.25 billion made available to SAMHSA in Division M of the Consolidated Appropriations Act, 2021, $1.65 billion was designated for each of the MHBG and SABG. For FY2021, the MHBG and SABG received $737 million and $1.8 billion in annual appropriations, respectively.[149]

Provisions

Section 2701 appropriates $1.5 billion to the HHS Secretary for SAMHSA's Community Mental Health Services Block Grant (MHBG) to remain available until expended. Any amount awarded to a state shall be expended by the state by September 30, 2025.

Section 2702 appropriates $1.5 billion to the HHS Secretary for SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SABG) to remain available until expended. Any amount awarded to a state shall be expended by the state by September 30, 2025.

[147] For more information, see CRS Report R46426, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs*.

[148] See PHSA Title XIX. For more information, see CRS Report R46426, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs*.

[149] Provided in Division H of Consolidated Appropriations Act, 2021 (P.L. 116-260).

Sections 2706-2707. Funding for Community-Based Funding for Local Substance Use Disorder Services and Local Behavioral Health Needs

Background

In the previous COVID-19 supplemental measures, a total of not less than $340 million was made available for emergency substance abuse or mental health needs.[150] These funds provide crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for children and adults affected by the COVID-19 pandemic.[151] SAMHSA gave states significant flexibility in how they use these funds to support behavioral health-related activities.

Of note, since FY1990, annual appropriations for HHS agencies have generally included a provision prohibiting any funds from being used for syringe service programs (i.e., programs in which sterile needles or syringes are made available to injection drug users in exchange for used needles or syringes to mitigate the spread of related infections, such as hepatitis C and HIV/AIDS).[152] Starting in FY2016, the provision was modified to allow funds provided in the annual appropriations acts to be used for syringe service programs under the following conditions: (1) federal funds may not be used to purchase the needles, but may be used for other aspects of such programs; (2) the state or local jurisdiction must demonstrate, in consultation with CDC, that it is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use; and (3) the program must be operating in accordance with state and local law.

Provisions

Section 2706 appropriates $30 million to the SAMHSA Assistant Secretary for Mental Health and Substance Use (in consultation with CDC) for overdose prevention programs and related activities.[153] Specifically, it requires SAMHSA to award grants to certain entities for specified activities to support "community-based overdose prevention programs, syringe services programs, and other harm reduction services." Grants shall be used for preventing and controlling the spread of infectious diseases, distributing opioid overdose reversal medications, connecting individuals with education and services, and encouraging individuals with SUDs to reduce the negative health impacts of substance use.

Section 2707 appropriates $50 million to the SAMHSA Assistant Secretary for Mental Health and Substance Use to address community behavioral health needs.[154] Specifically, it requires

[150] Not less than $100 million in the third measure and not less than $240 million in the fifth measure.

[151] Eligibility included territories and tribes/tribal organizations. See Substance Abuse and Mental Health Services Administration, *Emergency Grants to Address Mental Health and Substance Use Disorders during COVID-19*, Funding Opportunity Announcement FG-20-006, April 1, 2020, https://www.samhsa.gov/grants/grant-announcements/fg-20-006.

[152] The one exception is the FY1992 Labor-HHS Appropriations Act (P.L. 102-170), which appears to have included no such provision. Since the provision's inception in FY1990, there has been variation in its scope and application during certain fiscal years. For example, the Labor-HHS Appropriations Act for FY1998 (P.L. 105-78) made the ban subject to action by the HHS Secretary. The Labor-HHS Appropriations Acts for FY2010 (P.L. 111-117, Division D) and FY2011 (P.L. 112-10, Division B) applied the ban only in locations that local authorities determined to be inappropriate.

[153] Section 2707 appropriates funding to the HHS Secretary "acting through" the SAMHSA Assistant Secretary for Mental Health and Substance Use.

[154] Section 2922 appropriates funding to the HHS Secretary "acting through" the SAMHSA Assistant Secretary for

SAMHSA to award grants to certain entities to "address increased community behavioral health needs worsened by the COVID-19 public health emergency." Grants shall be used for promoting care coordination, training the behavioral health workforce, expanding evidence-based integrated models of care, providing behavioral health services through telehealth, and expanding preventive care and crisis intervention services.

Section 2708. Funding for the National Child Traumatic Stress Network

Background

The National Child Traumatic Stress Network was established under PHSA Section 538 as part of the National Child Traumatic Stress Initiative to improve behavioral health services for children exposed to traumatic events.[155] Grant funding supports the development and promotion of effective community practices, mostly through information and trainings by a network of centers. The National Child Traumatic Stress Network program is administered by SAMHSA. Of the total amount in Division M of the Consolidated Appropriations Act, 2021, made available to SAMHSA, $10 million was designated for the National Child Traumatic Stress Network. For FY2021, the National Child Traumatic Stress Initiative received $72 million in annual discretionary appropriations in Division H of Consolidated Appropriations Act, 2021.

Provision

Section 2708 appropriates $10 million to the HHS Secretary, available until expended, for PHSA Section 538 and activities related to the National Child Traumatic Stress Initiative "with respect to addressing the problem of high-risk or medically underserved persons who experience violence-related stress."

Section 2709. Funding for Project AWARE

Background

Administered by SAMHSA, Project AWARE (Advancing Wellness and Resilience in Education) provides competitive grants designed to identify children and youth in need of mental health services, increase access to mental health treatment, and promote mental health literacy among teachers and school personnel.[156] The grants are available to states and other eligible entities. Project AWARE consists of three components: (1) Project AWARE State Educational Agency (SEA) grants (known as Project AWARE *State* or *SEA* grants), (2) Mental Health Awareness Training (MHAT) grants, and (3) Resiliency in Communities After Stress and Trauma (ReCAST) grants.

The purpose of the AWARE State grants is to build or expand the capacity of State Educational Agencies, in partnership with State Mental Health Agencies, to (1) increase awareness of mental health issues among school-aged youth, (2) provide training for school personnel and other adults to detect mental health issues, and (3) connect school-aged youth with behavioral health issues

Mental Health and Substance Use.

[155] For more information, see https://www.samhsa.gov/child-trauma.

[156] U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), *Justification of Estimates for Appropriations Committees for FY2020*, http://www.hhs.gov/budget.

and their families to needed services.[157] Project AWARE State grantees use funds to train teachers and other school personnel on mental health awareness and how to connect school-aged youth to needed services. Other activities may include school-based mental health and wellness programs, increased mental health services for school-aged youth, and implementation of evidence-based mental health interventions, among others.

Project AWARE does not have an explicit authorization in statute. Project AWARE operates through SAMHSA's general Priority Mental Health Needs of Regional and National Significance (Mental Health PRNS) authorities under PHSA Section 520A.

Of the total amount in Division M of the Consolidated Appropriations Act, 2021, made available to SAMHSA, $50 million was appropriated to SAMHSA's Project AWARE program. For FY2021, Project AWARE received $107 million in annual discretionary appropriations in Division H of Consolidated Appropriations Act, 2021.

Provision

Section 2709 appropriates $30 million to the HHS Secretary, to remain available until expended, to carry out PHSA Section 520A "with respect to advancing wellness and resiliency in education."

Section 2710. Funding for Youth Suicide Prevention

Background

SAMHSA supports several suicide prevention initiatives, including the National Strategy for Suicide Prevention, which focuses on adult suicide prevention, and the Garrett Lee Smith (GLS) State and Campus suicide grant programs, which address youth and young adult suicide. In 2004, the Garrett Lee Smith Memorial Act (P.L. 108-355) explicitly authorized three suicide prevention programs at SAMHSA under PHSA Sections 520E and 520E-2—two grant programs and a resource center. Specifically, the law authorized SAMHSA to support the planning, implementation, and evaluation of statewide youth suicide early intervention and prevention strategies; to provide grants to institutions of higher education to reduce student mental health problems; and to fund a national technical assistance center for suicide prevention. In FY2021, SAMHSA received $90 million to carry out suicide prevention activities, with roughly half designated for youth suicide prevention.

The prior COVID-19 supplemental measures provided a total of not less than $100 million for suicide prevention generally, including not less than $50 million in the CARES Act and not less than $50 million in Division M of the Consolidated Appropriations Act, 2021.

Provision

Section 2710 appropriates $20 million to the HHS Secretary to remain available until expended for carrying out PHSA Sections 520E and 520E–2 with respect to youth suicide prevention activities.

[157] SAMHSA, *Project AWARE (Advancing Wellness and Resiliency in Education) State Education Agency Grants*, Funding Opportunity Announcement, October 24, 2018, https://www.samhsa.gov/grants/grant-announcements/sm-19-003.

Section 2712. Funding for Pediatric Mental Health Care Access

Background

In 2016, the 21st Century Cures Act added a new PHSA Section 330M, which created the Pediatric Mental Health Care Access program within the HRSA Maternal and Child Health Bureau. The program provides grants or cooperative agreements to states to promote behavioral health integration into pediatric primary care using telehealth.[158] The program funds 21 statewide or regional programs that provide teleconsultation, training, and technical assistance to pediatric primary care providers to diagnose, treat, and refer children with behavioral health conditions.[159] The program authorization of appropriations was $9 million for the period FY2018-FY2020 to carry out the grant program. The program received an appropriation of $10 million for each of FY2018 through FY2021.

Provision

Section 2712 appropriates $80 million to the HHS Secretary, to remain available until expended, to carry out PHSA Section 330M for pediatric mental health care access.

Aging and Disability Services

Background

Many older adults and individuals with disabilities rely on federally funded programs that provide nutrition and other supportive services in order to live independently in their communities.[160] Amidst the ongoing COVID-19 pandemic, older adults and those with certain chronic conditions are at higher risk for severe illness if infected with the virus. Physical distancing measures and stay-at-home orders associated with the pandemic have affected nutrition programs that many older adults rely on for their daily nutrition intake. For example, nutrition services at group meal sites are no longer available or accessible. Alternatively, other nutrition services, such as home-delivered meals (e.g., "meals on wheels"), have been in greater demand as older adults adhere to recommendations to avoid gathering with individuals outside their household. In addition, caregiving to individuals of all ages has faced increased challenges during the pandemic, with the disruption of in-person child care, distance education for school-age children, and maintaining home and community-based long-term services and supports for older adults and individuals with disabilities. In particular, grandfamilies and kinship families may be vulnerable to economic hardship due to challenges associated with increased food and housing insecurity during the

[158] HHS, HRSA, "Pediatric Mental Health Care Access Program," https://mchb.hrsa.gov/training/projects.asp?program=34.

[159] HHS, HRSA, *Justification of Estimates for Appropriations Committees for FY2021*, https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2021.pdf, pp. 215-218.

[160] About 10.9 million older persons were served by Older Americans Act (OAA) state formula grant programs under Title III of the act, including the provision of 149.8 million home-delivered meals; 73.2 million congregate meals; 20.4 million rides to medical appointments, grocery stores, and other activities; 49.3 million hours of personal care, homemaker, and chore services; and 12.1 million hours of adult day care/adult day health services in 2019. U.S. Department of Health and Human Services, Administration for Community Living, *AGing Integrated Database (AGID), State Program Reports, Data at a Glance*, https://agid.acl.gov/DataGlance/SPR/.

pandemic.[161] In addition, evidence suggests an increase in the prevalence of elder abuse during the pandemic.[162]

Additional funding for aging and disability services programs and activities provided in the previous COVID-19 relief measures sought to address increased demand for nutrition and other supportive services to older adults, people with disabilities, and their family caregivers. It also provided additional funding for the prevention, detection, and treatment of abuse among seniors and people with disabilities, as well as addressing quality of care in long-term care settings. The Administration for Community Living (ACL), within HHS, is responsible for supporting older adults and people with disabilities to live independently in the community. ACL received a total of $1.295 billion in additional appropriations through prior COVID-19 relief measures, including in FFRCA ($250.0 million), the CARES Act ($870.0 million), and Division N of Consolidated Appropriations Act, 2021 ($175.0 million). These measures provided funding for senior nutrition services; supportive services, including transportation and homemaker or chore services, as well as respite and other services to support family caregivers; and abuse prevention, among other activities.

ARPA continues the efforts of the previous COVID-19 relief measures by providing funding to ACL for aging and disability services programs. The law provides funding to OAA formula grant programs that provide nutrition and other supportive services with a focus on vaccine outreach and education and activities to address social isolation. The law also funds the establishment of a National Technical Assistance Center on Grandfamilies and Kinship Families, and provides additional funding to prevent, detect, and treat elder abuse, in part through federal support to state Adult Protective Services (APS) programs.

Aging and Disability Services Provisions

Section 2921. Supporting Older Americans and Their Families

Background

The Older Americans Act (OAA; P.L. 89-73, as amended) is the primary federal vehicle for the delivery of social and nutrition services for older persons.[163] These include supportive services, congregate nutrition services (meals served at group sites such as senior centers, schools, churches, and senior housing complexes), home-delivered nutrition services, family caregiver support, community service employment, the long-term care ombudsman program, and services to prevent the abuse, neglect, and exploitation of older persons. The OAA also supports grants to older Native Americans, as well as research, training, and demonstration activities.

The act establishes statutory funding formulas to determine allotments to states and U.S. territories for programs under Title III, Grants for State and Community Programs on Aging, and Title VII, Allotments for Vulnerable Elder Rights Protection Activities. Annual grants awarded to states, the District of Columbia, and U.S. territories are distributed based on a statutory funding formula that takes into account each state or territory's relative share of the total U.S. population

[161] Generations United, *2020 State of Grandfamilies Report*, October 2020, p. 19, https://www.gu.org/app/uploads/2020/10/2020-Grandfamilies-Report-Web.pdf.

[162] E-Shien Chang and Becca R. Levy, "High Prevalence of Elder Abuse During the COVID-19 Pandemic: Risk and Reslience Factors," *The American Journal of Geriatric Psychiatry*, January 19, 2021, https://doi.org/10.1016/j.jagp.2021.01.007.

[163] For further background on the OAA, see CRS Report R43414, *Older Americans Act: Overview and Funding*.

aged 60 and older (aged 70 and older for the Title III-E, National Family Caregiver Support Program). Under Title VI, Grants for Native Americans, funding is provided to eligible tribal organizations for nutrition, supportive services, and family caregiver services and supports.

Provision

Section 2921 appropriates $1.434 billion to the HHS Secretary, to remain available until expended, for certain OAA statutory formula grant programs in the following amounts:

- $460.0 million for Supportive Services and Senior Centers (Title III-B);
- $750.0 million for Congregate and Home-Delivered Nutrition Services (Title III-C);
- $44.0 million for Preventive Services (Title III-D);
- $145.0 million for National Family Caregiver Support Program (Title III-E);
- $25.0 million for Grants for Native Americans (Title VI); and
- $10.0 million for Long-Term Care Ombudsman Program (Title VII).

For funding provided for Supportive Services and Senior Centers, the provision specifies funding is available for services made available in the previous fiscal year; efforts related to COVID-19 vaccination outreach and education; and activities to address social isolation among older individuals. Such activities may include investments in technological equipment and other solutions to alleviate the negative health effects of social isolation due to stay-at-home orders during the public health emergency.

Section 2922. National Technical Assistance Center on Grandfamilies and Kinship Families

Background

In 2018, an estimated 2.7 million children were living with grandparents or other kin householders (including relatives and nonrelatives) and without their parents.[164] A grandparent or a family member may have to care for a relative child for many reasons, such as death of the child's parents. For example, parental substance abuse and incarceration are often cited as reasons why a grandparent or family member provides care.[165] Furthermore, when compared with the general population, grandparents in these settings are more often female, non-White, unemployed, and living in poverty.[166]

Congress passed the Supporting Grandparents Raising Grandchildren Act (P.L. 115-196, enacted July 7, 2018), in response to the increasing role grandparents play as primary caretakers to grandchildren. This act established the Advisory Council to Support Grandparents Raising Grandchildren. The advisory council first met in August 2019 and published its first annual report in November 2020.[167] Around the same time, the advisory council finalized 22 recommendations

[164] U.S. Government Accountability Office, *Child Welfare and Aging Programs: HHS Could Enhance Support for Grandparents and Other Relative Caregivers*, gao-20-434, July 2020, p. 11, https://www.gao.gov/assets/gao-20-434.pdf.

[165] Ibid., p. 20.

[166] Ibid., p. 15.

[167] Administration for Community Living, Advisory Council to Support Grandparents Raising Grandchildren, *Year One Progress Report: Supporting Grandparents Raising Grandchildren Act*, November 2020, https://acl.gov/sites/

intended to advance change and improve supports to kinship families and grandfamilies of all ages.[168] The recommendations touched on several areas, including awareness and outreach; caregiver engagement; services and supports; financial and workspace security; and research, data, and evidence-based practices. Recommendations 5.1, 5.2, and 5.3 are particularly relevant to this provision:

> **Recommendation 5.1:** Establish a national approach for obtaining, analyzing, and disseminating relevant data on kinship families and grandfamilies.
>
> **Recommendation 5.2:** Increase, support, and sustain research and development, including adequate investments for evaluating programs that support kinship families and grandfamilies.
>
> **Recommendation 5.3:** Increase the promotion, translation, and dissemination of promising practices, model approaches, and evidence-informed and evidence-based practices to support kinship families and grandfamilies.

Grandfamilies and kinship families face a number of challenges that make them particularly vulnerable during the COVID-19 pandemic. Advocates have cited the disparate impact of COVID-19 on communities of color as one such challenge, given the high proportion of non-White grandfamilies. Moreover, a survey of caregivers showed that the COVID-19 pandemic has created a significant potential for food and housing insecurity.[169] Caregivers responding to this survey noted a reduction in available services in general during the COVID-19 pandemic.[170] The advisory council published an emergency preparedness resource list for grandfamilies and kinship families specifically in response to the pandemic.[171]

Provision

Section 2922 appropriates $10 million to the ACL Administrator,[172] to remain available through September 30, 2025, to establish a National Technical Center on Grandfamilies and Kinship Families to provide training, technical assistance, and resources for government programs, nonprofit and other community-based organizations, and Indian Tribes, tribal organizations, and urban Indian organizations. This section requires the center to focus primarily on serving grandfamilies and kinship families in which the primary caregiver is an adult aged 55 or older, or in which a child has one or more disabilities. It requires the center to conduct the following activities:

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default/files/RAISE_SGRG/SGRGProgressReport2020_Final.pdf.

[168] Administration for Community Living, Advisory Council to Support Grandparents Raising Grandchildren, *Final Recommendations*, October 20, 2020, https://acl.gov/sites/default/files/programs/2020-12/SGRG%20Recommendations%20Final%20Web.pdf.

[169] Generations United, *2020 Grandfamilies Infographic*, October 2020, Generations United, *2020 State of Grandfamilies Report*, October 2020, p. 19, https://www.gu.org/app/uploads/2020/10/2020-Grandfamilies-Report-Web.pdf.

[170] Rosenthal, M., Littlewood, K., and Cooper, L., (2020, October 5-9). "Lifting Up the Voices of 600 Caregivers in the Pandemic: GrOW's Grand-families during COVID-19 Study," conference presentation, A Call to Action to Change Child Welfare, Kempe Center International Virtual Conference, October 5-9, 2020, https://www.grandfamilieswork.org/s/GrOWs-Lifting-Up-the-Voices-of-600-Caregivers-in-the-Pandemic-Kempe-Conference-citation.pdf.

[171] Administration for Community Living, Advisory Council to Support Grandparents Raising Grandchildren, *COVID-19/Emergency Preparedness Resources*, August 25, 2020, https://acl.gov/sites/default/files/programs/2020-08/8-25-2020_Emergency%20Preparedness%20for%20Kinship%20Families%20and%20Grandfamilies_shorterTOC_508accessible_FINAL.pdf.

[172] Section 2922 appropriates funding to the HHS Secretary "acting through" the ACL Administrator.

- to engage experts regarding the development and identification of evidence-based, evidence-informed, and exemplary practices or programs related to a range of health, social, and economic issues;
- to encourage and support the implementation of evidence-based, evidence-informed, and exemplary practices or programs to support families and to promote coordination of services;
- to facilitate learning across certain specified entities for providing technical assistance, resources, and training to individuals and entities across systems that directly work with grandfamilies and kinship families;
- to help certain specified entities plan and coordinate responses to assist grandfamilies and kinship families during emergencies and disasters; and
- to help certain specified entities promote equity and implement culturally and linguistically appropriate approaches as the programs and organizations serve grandfamilies and kinship families.

The funds appropriated under this provision can be used to establish the center either directly, through grants, or through contracts.

Section 9301. Additional Funding for Aging and Disability Services Programs

Background

Elder abuse and neglect, also referred to as elder mistreatment, are considered to be "intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm." Such actions may involve physical or psychological abuse, financial exploitation, neglect, or abandonment.[173]

Elder abuse is a complex issue. As such, it often leads to calls for a multifaceted policy response that combines public health interventions, social services programs, and law enforcement. To address this complexity, the Elder Justice Act (EJA) was enacted as part of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and contained certain public health and social services approaches to the prevention, detection, and treatment of elder abuse. Several of the Elder Justice Act provisions amended the Social Security Act (SSA), which incorporated elder justice into a renamed Title XX, Block Grants to States for Social Services and Elder Justice, and added a new Subtitle B, Elder Justice.

The EJA authorizes entities to address the federal coordination of elder abuse prevention activities, such as establishment of the Elder Justice Coordinating Council. It also authorizes the administration of new grant activities and other specified reports and studies.[174] Specifically, SSA Section 2042(b) requires the HHS Secretary to establish a grants program to enhance state and U.S. territories Adult Protective Services (APS) programs, which are social services programs established through legislation enacted in all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. APS programs serve seniors and adults with disabilities by offering a system for reporting and investigating abuse, as well as by providing social services to

[173] Richard J. Bonnie and Robert B. Wallace, eds., *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America*, National Research Council (Washington, DC: National Academy Press, 2003).

[174] §6703(a) through (c) of the ACA.

victims. Annual grants awarded to states, the District of Columbia, and U.S. territories are to be distributed based on a statutory funding formula that takes into account each state's or territory's relative share of the total U.S. population aged 60 years and older. For each of FY2011 through FY2014, it authorized to be appropriated $100.0 million for annual grants to enhance APS programs.

Elder Justice and Adult Protective Services activities receive some annual funding through the discretionary appropriations process under the Labor-HHS-Education account, "Aging and Disability Services Programs," administered by ACL. Since FY2015, Congress has instructed HHS to use a portion of the department's annual appropriations for Elder Justice and Adult Protective Services. For FY2021, the joint explanatory statement accompanying the Consolidated Appropriations Act, 2021 (P.L. 116-260), directed HHS to reserve $12 million to the Elder Justice and Adult Protective Services program and an additional $2 million to grants to address state guardianship laws and procedures as authorized under SSA Section 2042(c)(3).[175] In prior years, ACL funding under the Elder Justice and Adult Protective Services program has also been used for related activities authorized under OAA.[176] With respect to COVID-19 relief, the Consolidated Appropriations Act, 2021, also provided $100 million in discretionary supplemental funding for the COVID-19 response.[177] This amount is available for EJA activities, of which no less than $50 million is designated for SSA Section 2042(b) grants to enhance state APS programs.[178]

Provision

Section 9301 amends SSA Title XX to add a new Section 2010 entitled "Additional Funding for Aging and Disability Services Programs." It appropriates $276 million, to remain available until expended, to carry out EJA activities under SSA Title XX, Subtitle B. From this total, $88 million is available for FY2021 and $188 million is available for FY2022. The provision seeks to ensure that not less than $100 million in total funds is made available to carry out activities authorized under SSA Section 2042(b) to enhance state APS programs for each fiscal year. For FY2021, this $100 million threshold would be met by a combination of the new $88 million made available by this provision and funds previously provided for this purpose.

[175] Explanatory statement submitted by Rep. Lowey, Chairwoman of the House Committee on Appropriations, regarding the House Amendment to the Senate Amendment to H.R. 133, Consolidated Appropriations Act, 2021, *Congressional Record*, December 21, 2020, pp. H8632, H8640, H8679-H8681, https://www.congress.gov/116/crec/2020/12/21/CREC-2020-12-21.pdf-bk4.

[176] Specifically, OAA Section 411, which authorizes the Assistant Secretary to make available research, demonstration, and training grants or contracts with states and other entities on a range of aging-related activities, and OAA Section 752, which authorizes competitive grants to states to promote comprehensive elder justice systems.

[177] Division M of P.L. 116-260.

[178] Of the $100.0 million appropriated for activities authorized under the Elder Justice Act, ACL announced that $93.9 million would be available for "Grants to Enhance Adult Protective Services to Respond to COVID-19," 86 *Federal Register* 7726, February 1, 2021, https://www.federalregister.gov/d/2021-02091/. Another $4.0 million of that amount would be available for "Grants to Enhance Capacity of Long-Term Care Ombudsman Programs to Respond to Complaints of Abuse and Neglect of Residents in Long-Term Care Facilities During the COVID-19 Public Health Emergency," 86 *Federal Register* 7728, February 1, 2021, https://www.federalregister.gov/d/2021-02092. ACL also announced two new elder justice funding opportunities, Grants to Enhance State Adult Protective Services and Elder Justice Innovation Grants, on April 7, 2021, https://acl.gov/news-and-events/announcements/new-elder-justice-funding-opportunities.

Appendix. Abbreviations Used in This Report

Acronym	Definition
ACA	Patient Protection and Affordable Care Act (P.L. 111-148, as amended)
ACL	Administration for Community Living
AIDS	Acquired Immunodeficiency Syndrome
APS	Adult Protective Services
ARPA	American Rescue Plan Act (P.L. 117-2)
ASPR	Assistant Secretary for Preparedness and Response (HHS)
ASTHO	Association of State and Territorial Health Officials
BARDA	Biomedical Advanced Research and Development Authority (HHS)
BHWET	Behavioral Health Workforce Education and Training
CARES Act	Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136)
CCBHC	Certified Community Behavioral Health Clinic
CCP	Crisis Counseling Assistance and Training Program
CDC	Centers for Disease Control and Prevention (HHS)
CHCF	Community Health Center Fund
CHIP	State Children's Health Insurance Program
COVID-19	Coronavirus Disease 2019
DOD	Department of Defense
DPA	Defense Production Act of 1950 (P.L. 81-774)
DTAC	Disaster Technical Assistance Center (SAMHSA)
EJA	Elder Justice Act
EUA	Emergency Use Authorization (FDA)
FDA	Food and Drug Administration (HHS)
FEMA	Federal Emergency Management Agency
FFCRA	Families First Coronavirus Response Act (P.L. 116-127)
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
GAO	U.S. Government Accountability Office
GLS	Garrett Lee Smith Suicide Prevention Grants (SAMHSA)
GME	Graduate Medical Education
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration (HHS)
IC	NIH Institute and Center
IHS	Indian Health Service (HHS)
ISDEAA	Indian Self-Determination and Education Assistance Act (P.L. 93-638)

Acronym	Definition
IT	Indian Tribe
JSI	John Snow, Inc.
KFF	Kaiser Family Foundation
LHD	Local Health Department
MCM	Medical Countermeasures
MHBG	Community Mental Health Services Block Grant (SAMHSA)
MHFA	Mental Health First Aid
MMWR	Morbidity and Mortality Weekly Report (CDC)
MRC	Medical Reserve Corps (HHS)
MUA	Medically Underserved Area
NACCHO	National Association of County and City Health Officials
NAM	National Academy of Medicine
NHSC	National Health Service Corps (HRSA)
NHSPI	National Health Security Preparedness Index
NIH	National Institutes of Health (HHS)
OAA	Older Americans Act of 1965 (P.L. 89-73, as amended)
OWS	Operation Warp Speed
PHEP	Public Health Emergency Preparedness
PHSA	Public Health Service Act
PHSSEF	Public Health and Social Services Emergency Fund
PPE	Personal Protective Equipment
PPPHCEA	Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139)
PRC	Purchased/Referred Care
PRF	Provider Relief Fund
PRNS	Priority Mental Health Needs of Regional and National Significance
(Project) AWARE	Advancing Wellness and Resilience in Education
R&D	Research and Development
ReCAST	Resiliency in Communities After Stress and Trauma
RHC	Rural Health Clinic
SABG	Substance Abuse Prevention and Treatment Block Grant (SAMHSA)
SAMHSA	Substance Abuse and Mental Health Services Administration (HHS)
SEA	State Educational Agency
SHA	State Health Agency
SHADAC	State Health Access Data Assistance Center
SLTT	State, Local, Tribal and Territorial
SSA	Social Security Act

Acronym	Definition
SUPPORT Act	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271)
THC	Teaching Health Center
THCGME	Teaching Health Center Graduate Medical Education
TO	Tribal Organization
UIO	Urban Indian Organization
USDA	U.S. Department of Agriculture

Author Information

Johnathan H. Duff, Coordinator
Analyst in Health Policy

Kavya Sekar, Coordinator
Analyst in Health Policy

Agata Bodie
Analyst in Health Policy

Kirsten J. Colello
Specialist in Health and Aging Policy

Elayne J. Heisler
Specialist in Health Services

Sarah A. Lister
Specialist in Public Health and Epidemiology

Alyssa R. Casey
Analyst in Agricultural Policy

Victoria R. Green
Analyst in Health Policy

Angela Napili
Senior Research Librarian

Hassan Z. Sheikh
Analyst in Public Health Emergency Management

Jared S. Sussman
Analyst in Health Policy

Taylor R. Wyatt
Analyst in Public Health Emergency Management

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