Congressional Research Service
Informing the legislative debate since 1914

U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress

March 11, 2021

Congressional Research Service
https://crsreports.congress.gov
R46711

CRS REPORT
Prepared for Members and
Committees of Congress

Congressional Research Service
Informing the legislative debate since 1914

SUMMARY

R46711

March 11, 2021

Kavya Sekar, Coordinator
Analyst in Health Policy

Agata Bodie
Analyst in Health Policy

Ada S. Cornell
Senior Research Librarian

Johnathan H. Duff
Analyst in Health Policy

Elayne J. Heisler
Specialist in Health Services

Isaac A. Nicchitta
Research Assistant

U.S. Public Health Service: COVID-19 Supplemental Funding in the 116th Congress

Within the Department of Health and Human Services (HHS), eight agencies and two offices are designated components of the U.S. Public Health Service (PHS). Some of these agencies and offices—for example, the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA)—have played a major role in the federal response to the Coronavirus Disease 2019 (COVID-19) pandemic.

PHS agencies are funded primarily by annual discretionary appropriations. As such, many of these agencies have received additional supplemental discretionary appropriations for pandemic-related activities. In addition, one-time appropriations have been made to the Public Health and Social Services Emergency Fund (PHSSEF) account, which funds emergency preparedness and response activities and is often used for one-time and pass-through funding to address health emergencies. As part of the federal response to the pandemic, PHSSEF appropriations have been used to fund activities such as purchasing medical products and supplies (e.g., vaccines and syringes) and supporting health care providers.

This CRS report summarizes COVID-19 supplemental funding for the public health service agencies and to PHSSEF in the 116th Congress. It also includes resources to track COVID-19 supplemental spending provided across five supplemental appropriations measures:

- **First Measure:** Division A of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123), enacted on March 6, 2020.
- **Second Measure:** Division A of the Families First Coronavirus Response Act (FFCRA, P.L. 116-127), enacted on March 18, 2020.
- **Third Measure:** Division B of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136), enacted on March 27, 2020.
- **Fourth Measure:** Division B of the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA, P.L. 116-139), enacted on April 24, 2020.
- **Fifth Measure:** Division M of Consolidated Appropriations Act, 2021 (P.L. 116-260), enacted on December 27, 2020.

Across the five measures, a total of $305.6 billion has been provided to the PHS agencies and PHSSEF, much of which is available for multiple years or until expended. In some cases, amounts were appropriated to one account with instructions to transfer a portion of the funds to another account or agency. Except as noted, amounts shown in the tables and figures throughout this report typically present funds in the account to which they were appropriated, as final data on transfers are not universally available for all accounts. The following amounts were appropriated to each PHS agency:

- **CDC**, the federal government's lead public health agency, received a total of $15.3 billion.
- The **Agency for Toxic Substances and Disease Registry** (ATSDR), which is headed by the CDC director and investigates the public health impact of exposure to hazardous substances, received a total of $12.5 million.
- **FDA**, which regulates medical products such as vaccines, treatments, and tests, received a total of $196 million.

- The **Health Resources and Services Administration (HRSA)**, which funds programs and systems that provide health care services to the uninsured and medically underserved, received a total of $1.3 billion.
- The **Indian Health Service (IHS)**, which supports a health care delivery system for Native Americans, received a total of $1.1 billion.
- The **National Institutes of Health (NIH)**, the nation's lead medical and health research agency, received a total of $3.0 billion.
- The **Substance Abuse and Mental Health Services Administration (SAMHSA)**, which funds mental health and substance abuse prevention and treatment services, received a total of $4.7 billion.

PHSSEF received a total of $280 billion (including amounts directed as transfers to the above agencies) for a broad set of purposes. Some of the funded activities are carried out by the Office of the Assistant Secretary for Preparedness and Response (ASPR; a component of the Public Health Service). In particular, the account funds the Biomedical Advanced Research and Development Authority (BARDA) which supports the development and procurement of medical countermeasures (e.g., vaccines, treatments), as well as the deployment of certain operational response assets such as the Strategic National Stockpile and medical workforce assistance to states. Some PHSSEF funding has since been transferred from PHSSEF or administered by other agencies, in addition to the transfers directed by the laws. HHS transfer authorities allow for transfers between accounts as specified in each law.

Some of the supplemental funding has been provided broadly, "to prevent, prepare for and respond to coronavirus, domestically or internationally." Other funding was provided for specific purposes, for example, for testing and vaccine distribution. Further, appropriations in different laws are available for different time periods. This report summarizes appropriations by agency, account, availability, and purpose as directed across the measures.

Contents

Introduction 1
Understanding PHS COVID-19 Supplemental Appropriations 2
PHS Agency and PHSSEF Appropriations: A Snapshot 3
Report Roadmap 4
Agency Overview 5
Centers for Disease Control and Prevention (CDC) 6
U.S. Food and Drug Administration (FDA) 8
Health Resources and Services Administration (HRSA) 10
Indian Health Service (IHS) 12
Funding for Tribal Entities 14
National Institutes of Health (NIH) 15
Substance Abuse and Mental Health Services Administration (SAMHSA) 16
Office of the Secretary 19
Public Health and Social Services Emergency Fund 19
Funding Overview 22
Resources for Tracking PHS Spending 34
USAspending.gov 34
Pandemic Response Accountability Committee 34
HHS TAGGS 34
GAO Reports 35
PHS Agency Websites 35
Nongovernment Sources 36

Figures

Figure 1. PHS Agencies: COVID-19 Supplemental Appropriations 5
Figure 2. PHSSEF: Major Categories of COVID-19 Supplemental Appropriations 19

Tables

Table 1. Summary of COVID-19 Supplemental Appropriations to Public Health Service 23
Table 2. Detailed COVID-19 Supplemental Appropriations to Public Health Service 25

Contacts

Author Information 37

Introduction

The Coronavirus Disease 2019 (COVID-19) pandemic continues to have a significant impact on communities throughout the United States and around the world. The federal response to this crisis has included multiple waves of supplemental appropriations for various agencies, programs, and accounts to help prevent, prepare for, and respond to the pandemic.

Within the Department of Health and Human Services (HHS), eight agencies and two offices are designated components of the U.S. Public Health Service (PHS).[1] Some of these agencies and offices—such as the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA)—have played a major role in the federal public health response to the COVID-19 pandemic. Others have played a role in providing community health support services, for example, the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

PHS agencies are primarily funded by annual discretionary appropriations. As such, many of these agencies have received additional supplemental discretionary appropriations for pandemic-related activities. In addition, one-time appropriations have been made to the Public Health and Social Services Emergency Fund (PHSSEF) account, which funds emergency preparedness and response activities and is often used for one-time and pass-through funding to address health emergencies. As part of the federal response to the pandemic, PHSSEF appropriations have been made to fund activities such as purchasing medical products and supplies (e.g., vaccines and syringes) and supporting health care providers. Some of these activities are carried out by the Office of the Assistant Secretary for Preparedness and Response (ASPR, a PHS component). PHSSEF appropriations also include a number of transfers to PHS agencies, as directed in the response measures.

This report summarizes coronavirus supplemental funding for the public health service agencies and to the PHSSEF in the 116th Congress. It also includes resources for tracking spending. Funding has been provided across five supplemental appropriations measures:

- **First Measure:** Division A of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123), enacted on March 6, 2020.
- **Second Measure:** Division A of the Families First Coronavirus Response Act (FFCRA, P.L. 116-127), enacted on March 18, 2020.
- **Third Measure:** Division B of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136), enacted on March 27, 2020.[2]
- **Fourth Measure:** Division B, of the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA, P.L. 116-139), enacted on April 24, 2020.

[1] The two HHS offices that are a part of the Public Health Service (PHS) include 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) has responsibilities 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] In addition, Division A of the CARES Act provides the supplemental mandatory funding for HRSA that is included in the budgetary calculations in this report. Information on this mandatory funding is included to provide a more complete account of the additional funding provided to HRSA for pandemic response.

- **Fifth Measure:** Division M of Consolidated Appropriations Act, 2021 (P.L. 116-260), enacted on December 27, 2020.

This report provides an overview of each of the PHS agencies, as well as the PHSSEF. The funding tables (**Table 1** and **Table 2**) display supplemental funding as appropriated to these accounts across the measures. In addition, this report provides an overview of resources for tracking spending; however, it does not provide a comprehensive overview of allocations, outlays, and awards because available funding data are incomplete.

Understanding PHS COVID-19 Supplemental Appropriations

The above appropriations measures provided additional budgetary resources to PHS accounts to address the pandemic. In these measures, discretionary funding was appropriated to PHS accounts pursuant to an "emergency requirement" and directed to be used for various pandemic-related activities.[3] Additionally, the measures directed that certain amounts of appropriations funding be transferred from one account to another. In several instances, these transfers were directed as "not less than" or "not more than" a certain amount.

In addition, the measures included several authorities that allow the HHS Secretary to transfer certain funds between certain accounts, as specified in each measure. This transfer authority is in addition to the directed transfers specified in the laws.

The first measure broadly allowed for HHS to transfer funds among accounts at CDC, NIH, and PHSSEF. The third measure allowed for transfers among accounts at CDC, PHSSEF, the Administration for Children and Families (ACF), the Administration for Community Living (ACL), and NIH. The fourth measure allowed for transfers among accounts at CDC, NIH, PHSSEF, and FDA, but limited the amounts available for such transfers (e.g., it excluded from this authority $75 billion provided to the PHSSEF for the "Provider Relief Fund"). The fifth measure allowed for transfers among accounts at CDC, NIH, SAMHSA, ACF, and PHSSEF, but again limited the amounts available for such transfers (e.g., it excluded from this authority $22.4 billion provided to the PHSSEF for COVID-19 testing, contact tracing, surveillance, containment, and mitigation). The acts require HHS to notify the House and the Senate appropriations committees 10 days in advance of such transfers.

Moreover, in several instances, one agency administers a program funded by appropriations that were made to another agency's or office's account. Unless otherwise noted, the budgetary figures in this report do not reflect transfers between accounts pursuant to these authorities, nor do they reflect allocations and spending of agency appropriations below the level of detail specified in the supplemental appropriations measures.

Several of the other divisions in the above measures include either regular discretionary appropriations to these agencies' accounts or mandatory appropriations to support ongoing programs and operations. These regular, annual funds are not reflected in this report because they were not appropriated specifically to address the pandemic. However, this report does include the mandatory appropriations for the HRSA Health Centers program that were provided in Division A of the third measure, because these funds were specifically directed as supplemental awards for pandemic-related activities at HRSA-funded health centers.

[3] For further information about the emergency requirements designation, see CRS Report R45778, *Exceptions to the Budget Control Act's Discretionary Spending Limits*.

A Note About Funding Amounts in This Report

Funding amounts in each section of this report are presented in different ways. The "Agency Overview" section discusses agency funding accounting for *directed* transfers to and from the agency accounts in the laws. As a result, the funding totals based on these CRS calculations differ from **Table 1** and **Table 2** (in the "Funding Overview" section), because those tables show funds *as appropriated* in each account and prior to any transfers. Websites that track federal spending may include various breakdowns and presentations of funds in these agency accounts that do not match numbers in this report.

In addition, the report does not include an overview of funding by category, such as funding totals for vaccine, testing, or contact tracing-related purposes. Questions such as "How much funding was appropriated for testing, contact tracing, or vaccines?" often defy a clear answer. Several agencies that support related programs and activities received broad appropriations "to prevent, prepare for, and respond to coronavirus," or similar broad language. Agencies generally have discretion to allocate such funding for specific purposes and may not do so in ways that are easy to categorize. For example, CDC has used its appropriations to award several broad and flexible grants to states and other jurisdictions that can be used for a variety of purposes, including expanding testing, laboratory, and contact tracing programs, among others. In addition, health care services programs, such as those administered by HRSA and IHS, provide many kinds of care, including testing and vaccination services. Further, categories such as "testing" and "vaccines" may include a wide set of activities—research and development; regulation; testing and vaccination programs and infrastructure; testing, vaccine, and related supply manufacturing; procurement of tests, vaccines, and related supplies; health education programs about testing and vaccination; and the provision and financing of testing and vaccination services, among others. Many accounts at PHS agencies and across the federal government may support similar or related activities.

Some sources, such as reports published by the Government Accountability Office (GAO), provide views of funding allocations by various categories. GAO uses data provided by HHS and the Office of Management and Budget (OMB). These reports are inherently subject to categorization choices made by HHS, OMB, and GAO.

PHS Agency and PHSSEF Appropriations: A Snapshot

Across the five measures, a total of $305.6 billion was provided to the PHS agencies and PHSSEF. Much of this funding is available for multiple years or until expended. These measures include the following amounts by PHS agency (as appropriated to agency accounts):

- **CDC**, the federal government's lead public health agency, received a total of $15.3 billion.
- The **Agency for Toxic Substances and Disease Registry** (ATSDR), which is headed by the CDC director and investigates the public health impact of exposure to hazardous substances, received a total of $12.5 million.
- **FDA**, which regulates medical products such as vaccines, treatments, and tests, received a total of $196 million.
- **HRSA**, which funds programs and systems that provide health care services to the uninsured and medically underserved, received a total of $1.3 billion.
- The **Indian Health Service (IHS)**, which supports a health care delivery system for Native Americans, received a total of $1.1 billion.
- The **National Institutes of Health (NIH)**, the nation's lead medical and health research agency, received a total of $3.0 billion.
- **SAMHSA**, which funds mental health and substance abuse prevention and treatment services, received a total of $4.7 billion.

The PHSSEF received a total of $280 billion for a broad set of purposes, including funding directed as transfers to the above agencies. This funding was generally provided for four main purposes:

- **Medical Countermeasures and Surge Capacity** (approximately $53.4 billion), including the development, manufacture, and purchase of medical countermeasures such as tests, treatments, vaccines, and other medical supplies, as well as supporting a surge in demand for health care (e.g., health care workforce supports, distribution of medical supplies, and alternative care sites).
- **COVID-19 Testing for the Uninsured** ($1 billion), provided in the second measure. Accounting for a transfer in the fourth measure of not more than $1 billion of the amount for COVID-19 Testing, Surveillance, Contact Tracing, Containment and Mitigation (last bullet below), a total of not more than $2 billion has been provided for this fund.
- **Provider Relief Fund** ($178 billion) to reimburse eligible health care providers for health care-related expenses or lost revenues attributable to the pandemic.
- **COVID-19 Testing, Surveillance, Contact Tracing, Containment and Mitigation** ($47.4 billion). Much of this funding has been awarded as grants to states and other jurisdictions by CDC, while other amounts have been transferred to other PHS agencies or used for related purposes, such as purchasing testing-related supplies, or transferred to the uninsured fund listed above.

Some of the funded activities are carried out by ASPR, particularly BARDA for medical countermeasure development and procurement. Some PHSSEF funding has since been transferred from PHSSEF and is administered by other agencies (though these transfers were not explicitly directed in the laws).

An eighth PHS agency, the Agency for Healthcare Research and Quality (AHRQ) did not receive COVID-19 supplemental appropriations in any of the measures.

Report Roadmap

This report provides an overview of COVID-19 supplemental appropriations to PHS accounts in three main sections:

Agency Overviews. This section provides a high-level overview of each PHS agency and its role in the pandemic response. The discussion includes total supplemental appropriations and additional budgetary resources made available to each agency for pandemic response, accounting for both appropriations made to agency accounts and transfers to the agency directed from other accounts. The section discusses the purposes for which funds were appropriated, as well as programs administered by the agency for which funding was appropriated to another account. Finally, the section discusses PHSSEF, the largest account covered in this report, and the major categories of its appropriations.

Funding Overview. This section includes two tables of COVID-19 supplemental appropriations for PHS agencies *as appropriated*, with information on availability of funds. **Table 1** provides a high-level summary of appropriations by agency and includes information about transfers specifically directed to another agency account. **Table 2** provides a more detailed view of these appropriations, including overviews of all appropriations for accounts, programs, and specified purposes within an agency, as well as directed transfers outside of agency accounts. In at least one case, transfers are directed to "other federal agencies" without specifying the specific agency or account.

Resources to Track Spending. This section provides an overview of available resources to track spending from PHS accounts, with a discussion of data limitations and relevant caveats for

interpreting these sources. The section includes both general federal spending and department and agency-specific resources.

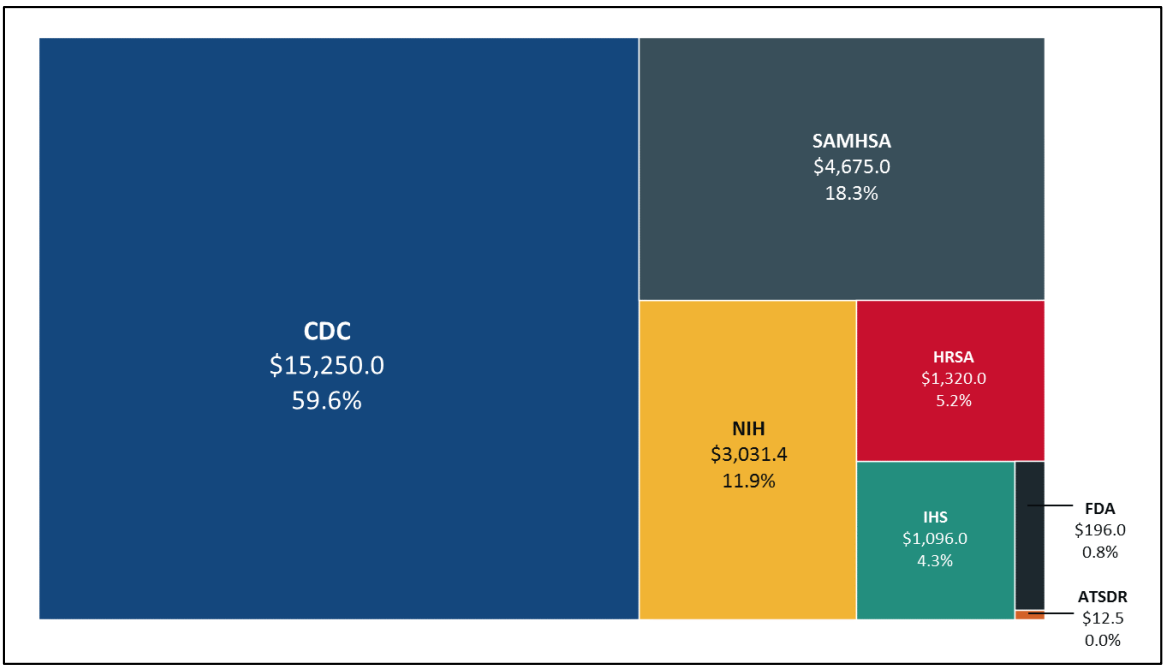
As a general caveat, the PHS agencies are not the only agencies within the federal government that have conducted public health activities for pandemic response. The federal public health response to the COVID-19 pandemic has been "whole-of-government" and has involved departments and agencies outside of HHS, such as the Federal Emergency Management Agency (FEMA), the Department of Defense (DOD), and others. These entities and their appropriations are outside the scope of this report.

Agency Overview

Seven PHS agencies received COVID-19 supplemental appropriations across the five measures. As shown in **Figure 1**, CDC received the largest amount of appropriations at $15.3 billion (59.6% of all PHS agency appropriations), followed by SAMHSA ($4.7 billion; 18.3%), NIH ($3.0 billion; 11.9%), HRSA ($1.3 billion; 5.2%), IHS ($1.1 billion; 4.3%), FDA ($196.0 million; 0.8%); and ATSDR ($12.5 million; less than 1%).

Figure 1. PHS Agencies: COVID-19 Supplemental Appropriations

(Dollars in millions; amounts shown as appropriated)



Source: Compiled by CRS from amounts specified in P.L. 116-123 (Title III, Division A), P.L. 116-127 (Title V, Division A), P.L. 116-136 (Division A and Title VIII, Division B), P.L. 116-139 (Title I, Division B), and P.L. 116-260 (Division M).

Notes: These amounts reflect discretionary supplemental appropriations to agency accounts, as well as additional mandatory appropriations for pandemic response made available to HRSA. These amounts do *not* reflect transfers directed into and from agency accounts in the laws; therefore these amounts may differ from those in the discussion below about transfers. Other sources that track federal spending, such as USASpending.gov, may include various breakdowns and presentations of funds in these agency accounts that do not match numbers in this figure.

This section discusses agency funding accounting for *directed* transfers to and from the agency accounts in the laws. As such, the funding totals based on these calculations differ from **Figure 1**,

as well as **Table 1** and **Table 2** in the "Funding Overview" section, as those figures and tables show funds *as appropriated* in each account and prior to any transfers.

Centers for Disease Control and Prevention (CDC)

As the nation's lead public health agency, CDC's mission is to "to protect America from health, safety and security threats, both foreign and in the United States."[4] To fulfill its mission, CDC supports various activities related to a wide array of illnesses and injuries, including developing expertise and best practices in disease prevention and control; conducting and supporting public health research; supporting health education; developing laboratory capacity; and conducting surveillance (i.e., data collection), among others. A large portion of CDC's annual budget is awarded as external financial assistance (typically in the form of grants)—especially to state health departments.[5]

During the COVID-19 pandemic, CDC has played major roles in supporting the nation's public health response. The agency has produced and disseminated health information on COVID-19, conducted research, awarded funding, and provided technical assistance to public health agencies at the state, local, territorial, and tribal level (SLTT). These activities include (1) supporting surveillance, epidemiology, and contact tracing; (2) supporting laboratory testing and diagnostics development; (3) coordinating across public health agencies; (4) providing health education and guidance for a variety of stakeholders; (5) providing travel health advisories and notices; (6) supporting international public health responses to the pandemic; and (7) coordinating, setting requirements, and providing assistance for the COVID-19 vaccination program.[6]

Across four of the five supplemental appropriations measures, CDC received appropriations of nearly $15.3 billion to the CDC-Wide Activities and Program Support account, along with an additional directed transfer in the fourth measure of not less than $1 billion to CDC from PHSSEF. In addition, the fifth measure directed a transfer of $210 million from CDC to IHS. Accounting for transfers, total budgetary resources available to CDC are not less than $16.0 billion. In addition, CDC has administered grants funds for testing-related activities initially appropriated to the PHSSEF account (as explained in the **text box** below).

In general, appropriations to CDC have been provided for three major purposes:

Broadly Available Funding. The first and third measures made available a total of $6.5 billion to CDC "to prevent, prepare for, and respond to coronavirus," including $2.2 billion in the first measure and $4.3 billion in the third measure, with amounts set aside or transferred for the following purposes:

- **Grants to state, local, territorial, tribal governments, and other tribal health organizations (SLTT agencies):** Not less than $2.45 billion total, including not less than $950 million in the first measure and not less than $1.5 billion in the third measure. As specified in the laws, the funding was directed "to carry out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities." CDC has since awarded the funding through several grant mechanisms and programs (see the

[4] CDC, "Mission, Role, and Pledge," https://www.cdc.gov/about/organization/mission.htm.

[5] CDC, "Office of Financial Assistance: FY2019 Assistance Snapshot," https://www.cdc.gov/funding/documents/fy2019/fy-2019-ofr-assistance-snapshot-508.pdf.

[6] CDC, "CDC in Action: Working 24/7 to the Stop the Threat of COVID-19," https://www.cdc.gov/budget/documents/covid-19/CDC-247-Response-to-COVID-19-fact-sheet.pdf.

text box below). The measures specify that, at a minimum, every grantee that received a Public Health and Emergency Preparedness (PHEP) grant for FY2019 must receive no less than 90% of that grant level from the first measure, and no less than 100% of that grant level from the third measure.[7] A portion of funds in each measure is designated for tribal entities (as detailed in "Funding for Tribal Entities" section).

- **Global disease detection and emergency response:** Not less than $800 million total is for global disease detection and emergency response, including not less than $300 million in the first measure and not less than $500 million in the third measure.
- **Public health data modernization:** The third measure set aside not less than $500 million of the total appropriation to CDC for "public health data surveillance and analytics infrastructure modernization."
- **Transfers to the Infectious Disease Rapid Response Reserve Fund (IDRRRF):** Not less than $600 million total was directed to IDRRRF, including not less than $300 million in the first measure and not less than $300 million in the third measure. The IDRRRF is a reserve account for CDC used for infectious disease emergencies, with funding generally available until expended.[8]

Testing-Related Funding. The fourth measure directed a transfer of not less than $1 billion from PHSSEF to CDC for "surveillance, epidemiology, laboratory capacity expansion, contact tracing, public health data surveillance and analytics infrastructure modernization, disseminating information about testing, and workforce support necessary to expand and improve COVID-19 testing."

In addition, a large portion of the general testing-related funds in the PHSSEF account made available by the fourth and fifth measures has been administered as CDC grants (see the **text box** below).

Vaccine-Related Funding. The fifth measure made available $8.75 billion to CDC for "activities to plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines to ensure broad-based distribution, access, and vaccine coverage." Of this total, at least $4.5 billion was for SLTT grants (or cooperative agreements), of which $210 million is to be transferred to the Indian Health Service (IHS) and a separate amount of not less than $300 million is for "high-risk and underserved populations, including racial and ethnic minority populations and rural communities."

Public Health Grant Funding for States, Localities, Territories, and Tribes (SLTTs)

CDC has used funding made available to the CDC-Wide Activities and Program Support account, as well as several appropriations to the PHSSEF account for "COVID-19 Testing, Surveillance, Contact Tracing, Containment and Mitigation" to support public health grant programs. CDC has primarily awarded this funding using some of its existing grant relationships with states, territories, and a few localities and tribal entities. For some of the funding for tribes, CDC created new grant mechanisms (as explained in the "Funding for Tribal Entities" section).

According to funding data published by CDC, as of January 8, 2021, CDC has awarded a total of $34.7 billion in grants to SLTT governments and tribal entities. Of this amount, the three grant mechanisms described below

[7] 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].

[8] 42 U.S.C. §247d-4a.

were used to award most of the funding. Although these grant mechanisms were used to award the funding, the exact terms of each grant and the purposes for which the awards can be used vary by funding allocation:

- **Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement.** The majority of the funds ($30.2 billion) have been awarded using the Epidemiology and Laboratory Capacity cooperative agreement mechanism, drawing from appropriations in the first, third, fourth, and fifth measures (from both CDC and PHSSEF accounts). This program generally awards annual funding to 64 state, local, and territorial health departments to facilitate capacity for infectious disease control and prevention. For the pandemic, ELC has been used as a mechanism to support expanding testing capacity (including by expanding laboratory capacity and supporting public health department testing programs), surveillance, contact tracing, health communication, and infection control programs in health care and other high-risk settings (e.g., long-term care facilities, prisons), among other functions.
- **Immunization Cooperative Agreements (Section 317 Program).** CDC has awarded a total of $3.3 billion using its Immunization Cooperative agreement ("Section 317" program) funding mechanism, which annually funds 64 state, territorial, and local jurisdictions for immunization-related programs. These awards, using funds from the third and fifth measures, support planning and implementation of the COVID-19 vaccine program, including supporting distribution efforts, data systems, vaccine safety and effectiveness monitoring, and related health education, among other activities.
- **Crisis Response Cooperative Agreement.** Initially, CDC used its Crisis Response funding mechanisms to award a total of $755 million to 65 jurisdictions using funds from the first measure. This grant mechanism was designed specifically to allow for rapid grant awards to jurisdictions in the event of a public health emergency.

CDC also awarded several other smaller grant awards using its COVID-19 supplemental funds, as outlined in the table linked in the source note below.

Sources: Funding Table: CDC COVID-19 State, Tribal, Local, and Territorial (STLT) Funding Update, January 8, https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/funding-update.pdf.

CDC, "Budget," https://www.cdc.gov/budget/index.html. This website includes several factsheets on the agency's COVID-19 response funding efforts.

The Agency for Toxic Substances and Disease Registry (ATSDR), which is headed by the CDC Director, investigates the public health impact of exposure to hazardous substances. The third measure made available $12.5 million to ATSDR, designated for two purposes:

- $7.5 million for the Geospatial Research, Analysis and Services Program "to support spatial analysis and Geographic Information System mapping of infectious disease hot spots, including cruise ships."
- $5 million to Pediatric Environmental Health Specialty Units and state health departments "to provide guidance and outreach on safe practices for disinfection for home, school, and daycare facilities."

U.S. Food and Drug Administration (FDA)

FDA regulates the safety of foods (including dietary supplements), cosmetics, and radiation-emitting products; the safety and effectiveness of medical products (e.g., drugs, biologics, and devices); and public health aspects of tobacco products.[9]

During the pandemic, FDA has engaged in premarket regulatory activities to facilitate the availability of medical products for the treatment, prevention, mitigation, and diagnosis of COVID-19, as well as postmarket activities such as monitoring of medical product safety and supply chain issues.[10] With respect to its premarket work, FDA has granted approval or

[9] CRS Report R44576, *The Food and Drug Administration (FDA) Budget: Fact Sheet*.

[10] CRS Report R46507, *FDA's Role in the Medical Product Supply Chain and Considerations During COVID-19*.

emergency use authorization (EUA) to COVID-19 therapeutics, vaccines, diagnostics, and other medical devices (e.g., respirators and ventilators).[11] FDA has issued guidance to facilitate COVID-19 vaccine development, clarifying its expectations for licensure and EUA.[12] As part of its postmarket work, the agency has monitored medical product shortages and issued policies of enforcement discretion to increase availability of certain medical products, including hand sanitizer, surgical gowns, and face masks. To further address potential supply chain disruptions, FDA has worked with the pharmaceutical industry and federal partners to accelerate the adoption of advanced manufacturing technologies (i.e., technologies that may improve medical product quality, reduce shortages, and speed time to market).[13]

Across four of the five measures, FDA has received a total of $218 million, including $196 million to the agencies' accounts and a directed transfer from the PHSSEF to FDA of $22 million in the fourth measure. This funding was provided in two categories:

Broadly Available Funding. In the first, third, and fifth measures, funding was made available to FDA to "prevent, prepare for, and respond to coronavirus domestically and internationally." The supplemental funds were to be used for activities such as pre- and postmarket work on medical countermeasures (e.g., therapeutics, vaccines, and diagnostics), EUAs, monitoring of medical product supply chains, advanced manufacturing, and related administrative activities. In the first and third measures, amounts were not designated for specific activities.

However, the fifth measure specified that FDA was to spend the total supplemental appropriation of $55 million as follows:

- $9 million for the development of necessary medical countermeasures and vaccines,
- $30.5 million for advanced manufacturing of medical products,
- $1.5 million for the monitoring of medical product supply chains,
- $7.6 million for other public health research and response investments,
- $1.4 million for data management operation tools, and
- $5 million for after action review activities.

Testing Activities. The fourth measure provided $22 million to FDA, as a transfer from the PHSSEF account, to support activities associated with "diagnostic, serological, antigen, and other tests, and related administrative activities."

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

[12] FDA, "Development and Licensure of Vaccines to Prevent COVID-19," Guidance for Industry, June 2020, https://www.fda.gov/media/139638/download. FDA, "Emergency Use Authorization for Vaccines to Prevent COVID-19," Guidance for Industry, October 2020, https://www.fda.gov/media/142749/download.

[13] 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.

Health Resources and Services Administration (HRSA)

HRSA provides health care to individuals who are geographically isolated, economically or medically vulnerable, or both. HRSA programs target specific populations, including pregnant women and their children and individuals with HIV/AIDS. In addition, HRSA supports the health care workforce; oversees organ, bone marrow, and cord blood donation; and administers the National Vaccine Injury Compensation program. HRSA currently awards funding to more than 3,000 grantees, including community-based organizations; colleges and universities; hospitals; state, local, and tribal governments; and private entities. These funds support health services projects, such as training health care workers and providing specific health services.[14]

COVID-19 prevention, treatment, and response has involved a number of HRSA programs. For example, the health centers program, HRSA's largest program, provides grants to support more than 12,000 sites in underserved areas that provide primary care to disadvantaged populations regardless of their ability to pay.[15] Because of their scope, health centers have been an important part of COVID-19 response.[16] They have provided testing to underserved and largely minority populations. The Biden Administration has included health centers in its vaccine program beginning in February 2021 as a way of reaching underserved populations.[17]

The Ryan White HIV/AIDS program (Ryan White) provides HIV/AIDS health care and related health and social support services to individuals with HIV or AIDS. Individuals with HIV/AIDS may be particularly vulnerable to serious COVID-19 infections.[18] Ryan White sites have undertaken prevention efforts and increased certain services (e.g., meal delivery) to facilitate program participants' ability to self-isolate to reduce their risk of infection.

During the pandemic, health care providers have increasingly used telehealth services to reduce the spread of COVID-19 and conserve health care workforce time and supplies (e.g., personal protective equipment). HRSA has made long-standing investments in increasing telehealth in rural areas, which may have less access to technology and infrastructure needed to effectively deliver telehealth, and has increased this support during the pandemic.[19]

HRSA received a total of $1.3 billion in COVID-19 supplemental mandatory funding for its Health Centers program in Division A of the CARES Act (P.L. 116-136). In addition, the first, third, and fourth measures directed HHS to transfer a combined total of $975 million to HRSA from PHSSEF. These transfers are estimated to increase HRSA's total budgetary resources for pandemic-related activities to nearly $2.3 billion. Moreover, HRSA administers several pandemic response programs funded by the PHSSEF account: (1) the Uninsured Fund for testing, which received funds in two of the measures, (2) the Provider Relief Fund, which received funds in

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

[15] See https://data.hrsa.gov/.

[16] CRS Insight IN11367, *Federal Health Centers and COVID-19*.

[17] "President Biden Announces Community Health Centers Vaccination Program to Launch Next Week and Another Increase in States, Tribes, & Territories' Vaccine Supply," press release, February 9, 2021, https://www.whitehouse.gov/briefing-room/statements-releases/2021/02/09/fact-sheet-president-biden-announces-community-health-centers-vaccination-program-to-launch-next-week-and-another-increase-in-states-tribes-territories-vaccine-supply/, and HRSA, "Ensuring Equity in COVID-19 Vaccine Distribution," https://www.hrsa.gov/coronavirus/health-center-program.

[18] HIV.gov, "Coronavirus (COVID-19) and People with HIV," press release, December 30, 2020, https://www.hiv.gov/hiv-basics/staying-in-hiv-care/other-related-health-issues/coronavirus-covid-19.

[19] CRS Report R44437, *Telehealth and Telemedicine: Description and Issues*.

three of the measures, and (3) testing programs at rural health clinics, which received funds in one of the measures. HRSA funding and programs are described in greater detail below.

Health Centers. The Health Centers program received funding in the first, third, and fourth measures. In the first and fourth measures, funding was provided as transfers from the PHSSEF account, including $100 million in the first measure and $600 million specified for testing-related activities in the fourth measure. Funding in the fourth measure was specifically made available to federally qualified health center look-alikes.[20] Health centers received $1.3 billion as a mandatory appropriation in the third measure to supplement existing health center grant awards. The law directed these funds specifically for supplementary awards to health centers for "the detection of SARS–CoV–2 [the virus that causes COVID-19] or the prevention, diagnosis, and treatment of COVID–19."[21] All told, the Health Centers program has received additional budgetary resources totaling roughly $2 billion.

Additional Support for Existing HRSA Programs. The third measure included a transfer of $275 million from the PHSSEF to HRSA to support three agency programs:

- $90 million to supplement grants awarded as part of the Ryan White HIV/AIDS program to support pandemic response,
- $5 million transfer to "improve the capacity of poison control centers to respond to increased calls," and
- $180 million for telehealth and rural health activities, of which not less than $15 million was reserved for Indian Tribes (ITs), Tribal Organizations (TOs), Urban Indian health organizations (UIOs), and health service providers to tribes. These funds were provided to support small rural hospitals in their pandemic response and were awarded to telehealth resource centers to provide technical assistance to rural areas to aid with pandemic response.[22]

New Funds that HRSA Administers. The various measures created two new funding streams, from PHSSEF funds, to support health care providers in responding to the pandemic:

- **The Uninsured Fund:** The Uninsured Fund, which was created to pay for health care expenses of the uninsured during the pandemic, received a total of not more than $2 billion to pay for costs associated with testing the uninsured. The second measure appropriated $1 billion to the PHSSEF to reimburse providers for uninsured testing. Though no administering agency was specified, the language in the second measure stated that reimbursements were to be made in "in coordination with the Assistant Secretary for Preparedness and Response and the Administrator of the Centers for Medicare & Medicaid Services." HHS elected to have HRSA administer these funds as part of the Uninsured Fund.[23] Uninsured testing subsequently received an additional not more than $1 billion transfer in the fourth measure.

[20] CRS Report R46325, *Fourth COVID-19 Relief Package (P.L. 116-139): In Brief*.

[21] §3211 of P.L. 116-136.

[22] HHS, HRSA, "HHS Awards Nearly $165 Million to Combat the COVID-19 Pandemic in Rural Communities," press release, April 22, 2020, https://public3.pagefreezer.com/content/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2020/04/22/hhs-awards-nearly-165-million-to-combat-covid19-pandemic-in-rural-communities.html.

[23] CRS Insight IN11526, *COVID-19 and the Uninsured: Federal Funding Options to Pay Providers for Testing and Treatment*. See also CRS Report R46481, *COVID-19 Testing: Frequently Asked Questions*.

- **Provider Relief Fund:** The Provider Relief Fund (PRF), which was created to reimburse health care providers for lost revenues and increased expenses during the pandemic, received a total of $178 billion across three measures. The third measure provided the PHSSEF with $100 billion "to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus." This fund was later termed the Provider Relief Fund and is administered by HRSA, though the third measure did not use this term, nor did it specify an administering agency for the fund.[24] Subsequent measures increased PRF to a total of $178 billion—with $75 billion provided in the fourth measure and $3 billion provided in the fifth measure. The Trump Administration elected to use an unspecified amount of the third measure appropriation to reimburse providers for uninsured treatment, which is administered in conjunction with the appropriation for uninsured testing as the Uninsured Fund. This fund was subsequently expanded to enable reimbursement of costs for vaccination services for the uninsured and underinsured.[25]

In addition to these larger funds, HRSA administers the $225 million transferred from the PHSSEF in the fourth measure for testing at rural health clinics (RHCs)—small outpatient clinics located in rural areas. As directed in the law, funds are to be awarded through grants or other mechanisms "for building or construction of temporary structures, leasing of properties, and retrofitting facilities as necessary to support COVID–19 testing." Although RHCs are similar to health centers, a dedicated grant program for RHCs did not exist prior to the pandemic. As such, unlike health centers, where grants can be supplemented, RHCs required a new funding process to receive funds—a process that was undertaken by HRSA.[26] The law did not specify which agency is to administer these funds.

Indian Health Service (IHS)

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 by providing grants to Urban Indian Health Organizations (UIOs) to provide care to American Indians and Alaska Natives in urban areas.[27] IHS generally provides services free of charge to approximately 2.6 million eligible American Indians and Alaska Natives in 37 states.[28] 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

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

[25] CRS communication with CDC, March 1, 2021.

[26] 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.

[27] 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*.

[28] 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.

or compact for services that IHS would have otherwise provided by entering into a funding agreement that delineates the services funded under the agreement.

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 directly 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.[29] IHS, like other health systems, experienced increased demand for intensive COVID-19 related services, while seeing declining revenue from cancelled or delayed routine and elective care.[30] In addition to providing health services related to COVID-19, IHS supports certain public health and health education activities (similar to those of CDC).

Across four of the five measures, IHS received $1.1 billion in supplemental appropriations to the 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 have been made available either to IHS accounts or at the direction of the IHS Director. In addition, a total of not less than $320 million has been reserved for tribal entities (i.e., ITs/TO/UIOs) from funds that were appropriated to other HHS accounts but were not specifically directed to IHS.

Funding has been provided to IHS in three categories: (1) funding for testing, (2) funding for health services and infrastructure, and (3) funding for vaccines. In addition, funds have been provided to tribal entities (i.e., ITs/TO/UIOs), but not specifically to IHS, for public health activities and telehealth and behavioral health.

Funding for Testing. IHS received funding for testing-related activities in the second, fourth, and fifth measures. In the second measure, $64 million was provided directly to IHS for COVID-19 testing, test administration, and related items and services.[31] In the fourth measure, of the not less than $11 billion in that measure set aside for SLTT grants for testing-related activities, not less than $750 million was provided in the PHSSEF account to be allocated in consultation with the IHS director. The law did not specify that these funds be transferred to IHS; however, HHS eventually did so.[32] The fifth measure directed that $790 million be transferred to IHS from the PHSSEF for testing, contact tracing, surveillance, and containment, among other purposes. The law specified that funds were to be allocated, at the discretion of the IHS Director, to IT/TOs through ISDEAA contracts and compacts, and to UIOs through grants or contracts. In total, IHS has been provided not less than $1.6 billion for testing-related purposes.

Funding for Health Services and Infrastructure. The third measure appropriated $1.032 billion to the IHS Indian Health Services account. Specifically, funds were provided to

[29] 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.

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

[31] The law waived cost sharing for testing provided to Indian Health Service (IHS) beneficiaries who receive services outside of IHS facilities, but authorized payment with IHS funding. For more information, see CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127*.

[32] Letter from Michael D. Weahkee, Director, Indian Health Service, to Tribal Leader and Urban Indian Organization Leader:, May 19, 2020, https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_DUIOLL_05192020.pdf.

> respond to coronavirus, domestically or internationally, including for public health support, electronic health record modernization, telehealth and other information technology upgrades, Purchased/Referred Care, Catastrophic Health Emergency Fund, Urban Indian Organizations, Tribal Epidemiology Centers, Community Health Representatives, and other activities to protect the safety of patients and staff.

Purchased/Referred Care and the Catastrophic Health Emergency Fund are both mechanisms used to pay for care provided to beneficiaries at non-IHS facilities. Tribal Epidemiology Centers (TEC) and Community Health Representatives perform public health activities for the IHS system. TECs conduct surveillance and epidemiology activities for IHS service areas. Community Health Representatives are generally paraprofessionals involved in activities such as health education and disease prevention. Further, the law specified that not less than $450 million was for ITs/TOs to supplement their existing ISDEAA contracts and compacts, and that not more than $125 million was for the Indian Health Facilities account and to be allocated at the discretion of the IHS Director.[33] The Indian Health Facilities account is used for facility and equipment-related expenses.

Funding for Vaccine Distribution. In the fifth measure, CDC was directed to transfer $210 million to IHS "for activities to plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines to ensure broad-based distribution, access, and vaccine coverage." The law specified that these funds were to be allocated at the discretion of the IHS Director, to IT/TOs through ISDEAA contracts and compacts, and to UIOs through grants or contracts.

Funding for Tribal Entities

As discussed elsewhere in this report, some of the measures directed that funding in certain accounts (e.g., CDC, SAMHSA) be made available to tribal entities (ITs, TOs, UIOs, and health service providers to tribes); however, the measures did not specify that these funds be transferred to IHS.

Funding for Public Health Activities. Several CDC appropriations have been directed to tribal entities in the first and third measures. The first and third measure required that not less than $40 million and not less than $125 million, respectively, in CDC funds for SLTT grants be made available to ITs/TOs, UIOs, and health providers to Indian Tribes for "surveillance, epidemiology, laboratory capacity, and other preparedness and response activities." CDC awarded much of this funding using new noncompetitive grant mechanisms to tribal nations, consortia, and organizations, as well as through some of its existing grant relationships with regional tribal organizations.[34] As noted above, some of the funds provided directly to the Indian Health Services account in the third measure were to be used for public health activities conducted by IHS.

Funding for Telehealth and Behavioral Health. The third and fifth measures included set-aside funding for tribal entities in both HRSA and SAMHSA appropriations. For HRSA, the third measure specified that of the amount transferred from PHSSEF to HRSA's Office of Rural Health for telehealth and rural health activities, not less than $15 million was to be allocated to ITs/TOs, UIOS, or health service providers to tribes. These funds were subsequently provided to facilitate

[33] For more information about IHS's budget accounts, see CRS Report R46490, *Indian Health Service (IHS) FY2021 Budget Request and Funding History: In Brief*.

[34] CDC, "CDC COVID-19 Funding for Tribes," https://www.cdc.gov/budget/documents/covid-19/CDC-COVID-19-Funding-for-Tribes-508.pdf.

the ability of ITs/TOs to provide telehealth to their service populations.[35] In addition, SAMHSA appropriations included set-asides for tribal entities for behavioral health activities in two of the measures, specifically not less than $15 million in the third measure and not less than $125 million in the fifth measure. As directed in the measures, these appropriations were to be allocated to ITs/TOs/UIOS and to behavioral health service providers to tribes.

National Institutes of Health (NIH)

NIH is the nation's lead medical and health agency. It supports much of the basic biomedical research in the United States and some development of new medical products. NIH is made up of 27 institutes and centers (ICs) and the Office of the Director (OD). Of the ICs, 24 ICs and OD support research programs; each IC has broad responsibilities to support research, scientific training, information dissemination and health and medical science as related to its respective mission. In general, about 80% of NIH's budget supports extramural research through grants, contracts, and other awards to research institutions (e.g., universities, medical centers) and 10% supports intramural research at NIH-operated laboratories and facilities.[36] During the pandemic, NIH has supported scientific research on the virus and disease, as well as the development of vaccines, therapeutics, and diagnostics. It has also published and maintained treatment guidelines and other health information.

Across four of the five measures, NIH received a total of $3.0 billion to NIH IC accounts, along with directed transfers from the PHSSEF account to NIH accounts totaling not less than $1.8 billion. Accounting for transfers, NIH is to receive a total of at least $4.8 billion. This funding was primarily provided in three categories:

Broadly Available Funding. In the first and third measure, funding was made available to several NIH IC accounts "to prevent, prepare for and respond to coronavirus, domestically and internationally." Uses of the funds would be governed by the mission and authority of the ICs receiving funds. For example, the National Institute of Allergy and Infectious Diseases (NIAID) supports research, training, and information dissemination related to "allergic and immunologic diseases and disorders and infectious diseases, including tropical diseases."[37] The National Heart, Lung, and Blood Institute (NHLBI) supports research, training, and information dissemination related to "heart, blood vessel, lung, and blood diseases."[38] NIH IC accounts that received broadly available funds and their totals include the following:

- **NIAID:** $1.5 billion, including $836 million in the first measure and $706 million in the third measure. Some transfers or set-asides were directed for specific purposes in the NIAID appropriations. The first measure directed a transfer of not less than $10 million to the National Institute of Environmental Health Sciences (NIEHS) for "worker-based training to prevent and reduce exposure of hospital employees, emergency first responders, and other workers who are at risk of exposure to coronavirus through their work duties." The third measure set aside not less than $156 million of the total for "the study of, construction of, demolition of, renovation of, and acquisition of equipment for,

[35] For information on these awards, see HHS, HRSA, "HHS Awards $15 Million to Combat the COVID-19 Pandemic in Rural Tribal Communities," press release, May 28, 2020, https://public3.pagefreezer.com/content/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2020/05/28/hhs-awards-15-million-to-combat-covid19-pandemic-in-rural-tribal-communities.html.

[36] CRS Report R41705, *The National Institutes of Health (NIH): Background and Congressional Issues*.

[37] Public Health Service Act (PHSA) Section 446, 42 U.S.C. §285f.

[38] Public Health Service Act (PHSA) Section 419, 42 U.S.C. §285b-1.

vaccine and infectious diseases research facilities of or used by NIH, including the acquisition of real property."

- **NHLBI:** $103.4 million in the third measure.
- **National Institute of Biomedical Imaging and Bioengineering (NIBIB):** $60 million in the third measure.
- **National Library of Medicine (NLM):** $10 million in the third measure.
- **National Center for Advancing Translational Sciences (NCATS):** $36 million in the third measure.
- **Office of the Director (OD):** $30 million in the third measure.

Diagnostic Testing Research and Development (R&D). In the fourth and fifth measure, NIH received funding for specific purposes related to diagnostic test R&D. This funding was directed to NIH as "not less than" transfers from the PHSSEF account in the fourth measure, and directly to the OD account in the fifth measure. These amounts include the following:

- **National Cancer Institute (NCI):** Transfer of not less than $306 million from PHSSEF to NCI "to develop, validate, improve, and implement serological testing and associated technologies."
- **NIBIB:** Transfer of not less than $500 million from PHSSEF to NIBIB "to accelerate research, development, and implementation of point of care and other rapid testing related to coronavirus."
- **OD:** Transfer of not less than $1 billion from PHSSEF to OD "to develop, validate, improve, and implement testing and associated technologies; to accelerate research, development, and implementation of point of care and other rapid testing; and for partnerships with governmental and non-governmental entities." In the fifth measure, not less than $100 million of the $1.25 billion total provided to the OD account is for "the Rapid Acceleration of Diagnostics."

NIH's Rapid Acceleration of Diagnostics (RADx) initiative is a prize competition for diagnostics development. As communicated to CRS, the $1.5 billion total for NIBIB and OD in the fourth measure was used to support RADx initially, with additional funds in the fifth measure as specified above.[39]

Long-Term Studies of COVID-19. The fifth measure directed $1.15 billion of the total $1.25 billion provided to the OD account "for research and clinical trials related to long-term studies of COVID-19." The fifth measure also allows the total $1.25 billion appropriation to OD to be transferred to other IC accounts (in addition to other HHS transfer authorities in the law).

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA is the federal agency primarily responsible for supporting community-based mental health and substance abuse treatment and prevention services. SAMHSA provides federal funding to states, local communities, and private entities by administering block grants and other formula and discretionary grants. Some grants allow broad uses of funds, whereas others target specific behavioral health issues or populations. Through such grants, SAMHSA supports activities that include education and training, prevention programs, early intervention activities, treatment

[39] CRS communication with NIH, July 24, 2020.

services, and technical assistance. SAMHSA does not provide mental health or substance abuse treatment. Rather, the agency supports states' efforts in providing community-based behavioral health services. In addition, SAMHSA conducts surveillance and data collection of national behavioral health issues, provides statistical and analytic support to grantees, and administers other agency-wide initiatives.

SAMHSA has continued to support community-based behavioral health treatment and prevention services throughout the COVID-19 pandemic. Circumstances surrounding the pandemic—including lifestyle changes instituted to prevent spread of the virus—appear to have negatively affected the mental health of many Americans.[40] Studies show elevated levels of emotional distress, anxiety, depression, substance use, and drug-related overdoses in 2020 compared with the same time period in previous years.[41] 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."[42] In addition, physical distancing measures and temporary stay-at-home orders associated with the pandemic have required changes to service delivery for mental health and substance use treatment. Many behavioral health service providers have increased their use of telehealth modalities to deliver treatment.[43] 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.[44] Emergency financial support for behavioral health activities provided in two of the supplemental COVID-19 funding measures may address the high demand for mental health and substance use disorder treatment services and decreased capacity in the system.

SAMHSA received a total of $4.7 billion in supplemental appropriations in the third ($425 million) and fifth ($4.25 billion) measures. Funding was designated for specific purposes as follows (organized by size of appropriation):

Block Grant Programs. Of the total $4.25 billion in the fifth measure, $1.65 billion was designated for each of SAMHSA's two main block grants: the Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG)—SAMHSA's two largest grant programs. Both block grant programs distribute funds to states (including the District of Columbia and territories) according to a statutory formula.[45]

---

[40] See, for example, Colin Planalp, Giovann Alacron, 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.

[41] 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/.

[42] 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.

[43] 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.

[44] 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/.

[45] 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*.

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. The law maintained a 20% set-aside for prevention-related activities.

Certified Community Behavioral Health Clinic (CCBHC) Expansion Grant Program. A total of not less than $850 million was made available to the Certified Community Behavioral Health Clinic (CCBHC) Expansion grant program. The third measure included not less than $250 million of the total appropriation for SAMHSA, and the fifth measure included not less than $600 million.

Certified Community Behavioral Health Clinics (CCBHCs)

In 2014, the Protecting Access to Medicare Act of 2014 (P.L. 113-193) created a program to improve community-based behavioral health services through a demonstration program. Certified community behavioral health clinics (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.[46] 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 (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.[47] Two additional states were added to the demonstration program in 2020.[48]

A CCBHC Expansion grant program was authorized as a part of FY2020 appropriations (P.L. 116-94). CCBHC Expansion Grants 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 rate.) In 2020, 33 states were participating in the CCBHC Demonstration and Expansion Grant programs.[49]

Emergency Substance Abuse or Mental Health Needs. A total of not less than $340 million was made available for emergency substance abuse or mental health needs, including not less than $100 million in the third measure and not less than $240 million in the fifth measure. 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.[50] SAMHSA gave states significant flexibility in how they use these funds to support behavioral health-related activities.

Suicide Prevention. A total of not less than $100 million was provided for suicide prevention, including not less than $50 million in the third measure and not less than $50 million in the fifth measure.

---

[46] §223 of P.L. 113-93, Protecting Access to Medicare Act of 2014.

[47] SAMHSA, *Section 223 Demonstration Program for Certified Community Behavioral Health Clinics*, Last updated October 11, 2018, https://www.samhsa.gov/section-223.

[48] §3814 of P.L. 116-136, the Coronavirus Aid, Relief, and Economic Security Act.

[49] The National Council for Behavioral Health, *CCBHCs: A New Model for Behavioral Health Gaining Momentum in States*, webinar, Washington, DC, January 29, 2021, https://www.thenationalcouncil.org/webinars/ccbhcs-a-new-model-for-behavioral-health-gaining-momentum-in-states.

[50] 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.

Project AWARE. Of the total amount in the fifth measure, $50 million was directed to SAMHSA's Project AWARE program, which supports school-based mental health training and referral services in elementary and secondary education.

National Child Traumatic Stress Network. Of the total funding amount in the fifth measure, $10 million was designated for the National Child Traumatic Stress Network, which was established to improve behavioral health services for children exposed to traumatic events. Grant funding supports development and promotion of effective community practices, mostly through information and trainings by a network of centers.

Office of the Secretary

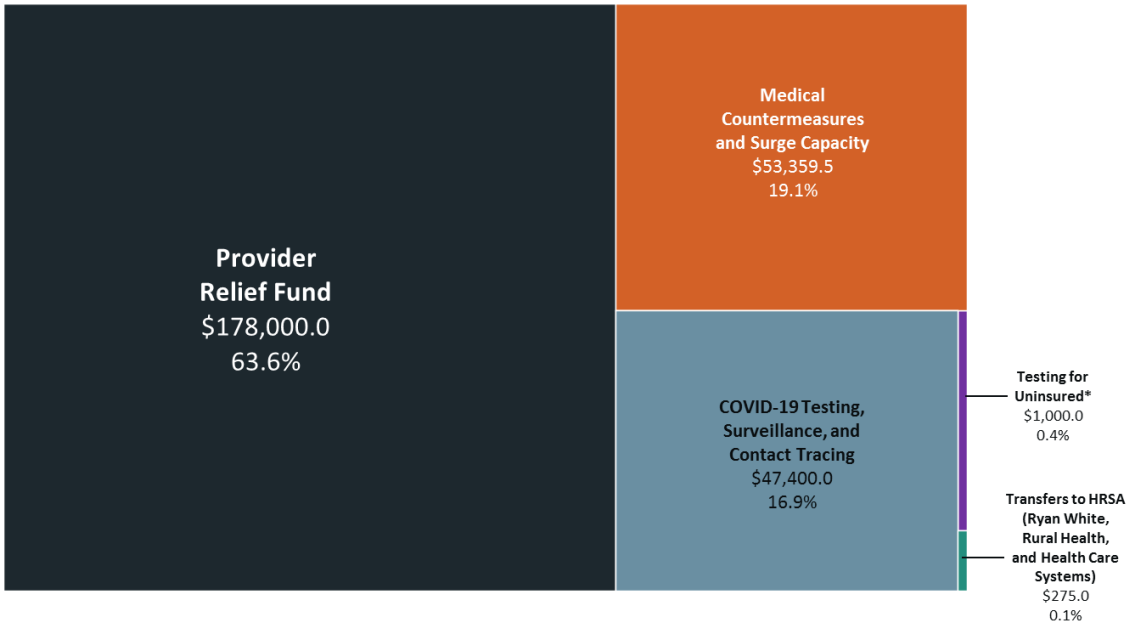
Under the HHS Office of the Secretary (OS), the PHSSEF account is often used for one-time or short-term funding, such as emergency supplemental appropriations. PHSSEF receives annual appropriations for the routine operations of several HHS offices, including the Office of the HHS Assistant Secretary for Preparedness and Response (ASPR), the lead office at HHS for health emergency preparedness and response strategy and coordination and a component of the Public Health Service.

Public Health and Social Services Emergency Fund

PHSSEF received about $280 billion in supplemental funding across the five measures. These funds may support various activities, including health care surge capacity and the development and purchase of medical countermeasures (including vaccines), as well as provider reimbursement through the Provider Relief Fund and Uninsured Fund. In general, PHSSEF supplemental funding has been provided for certain activities and programs as shown in **Figure 2**.

Figure 2. PHSSEF: Major Categories of COVID-19 Supplemental Appropriations

Dollars in millions; amounts shown as appropriated. All transfers and set-asides are not shown.



Sources: Compiled by CRS from amounts specified in P.L. 116-123 (Title III, Division A), P.L. 116-127 (Title V, Division A), P.L. 116-136 (Title VIII, Division B), P.L. 116-139 (Title I, Division B), and P.L. 116-260 (Division M).

Notes: These amounts reflect discretionary supplemental appropriations to PHSSEF. They *do not* reflect directed transfers out of PHSSEF to other agency accounts or set-aside amounts within the account. PHSSEF appropriations include many transfer and set-aside amounts as detailed below and in the tables in the next section. Other sources that track federal spending, such as USASpending.gov, may include various breakdowns and presentations of funds in these agency accounts that do not match numbers in this figure.

*Additionally, a total of not more than $1 billion of funding for "COVID-19 Testing, Surveillance, and Contact Tracing" in the fourth measure was set aside for Testing for the Uninsured.

PHSSEF appropriations include four major categories:

Medical Countermeasures and Surge Capacity. The first, third, and fifth measures each provided funding to support (1) the development, manufacturing, and, in some cases, federal purchase of COVID-19 medical countermeasures (e.g., diagnostic tests, treatments, vaccines, and medical supplies), and (2) other response activities, such as for health care workforce and surge capacity (e.g., health care workforce supports, distribution of medical supplies, and alternative care sites). In total, approximately $53.4 billion (prior to transfers) has been provided for these activities. The measures specify that some of these funds are to be transferred elsewhere (e.g., to other federal agencies for the care of persons under federal quarantine) or reserved for specific purposes or activities (e.g., provided to grantees of the Hospital Preparedness Program). These activities may be carried out by various ASPR components, especially the Biomedical Advanced Research and Development Authority (BARDA) for countermeasure development and procurement.[51] Two major set-aside categories are described below.

- **BARDA:** Under ASPR, BARDA specifically supports the development of medical countermeasures for health emergencies, such as emerging infectious diseases and other threats (i.e., chemical, biological, radiological, and nuclear threat agents). A total of not less than $24.2 billion has been set aside for BARDA in the third, fourth, and fifth measures. This includes $23.2 billion of the total for Medical Countermeasures and Surge Capacity in the third and fifth measures, including not less than $3.5 billion in the third measure and $19.7 billion in the fifth measure. Funding in the third measure was designated for "necessary expenses of manufacturing, production, and purchase … of vaccines, therapeutics, diagnostics, and small molecule active pharmaceutical ingredients, including the development, translation, and demonstration at scale of innovations in manufacturing platforms." Funding in the fifth measure was designated for "necessary expenses of manufacturing, production, and purchase … of vaccines, therapeutics, and ancillary supplies." An additional set-aside of not less than $1 billion was directed to BARDA in the fourth measure from the total for "COVID-19 Testing, Surveillance, Contact Tracing, Containment, and Mitigation" in that measure. This transfer was directed for "necessary expenses of advanced research, development, manufacturing, production, and purchase of diagnostic, serologic, or other COVID–19 tests or related supplies, and other activities related to COVID–19 testing."
- **Strategic National Stockpile (SNS),** under ASPR, provides select medicines and medical supplies during public health emergencies that overwhelm local availability. PHSSEF funding in the first, third, fourth (of the total $25 billion for COVID-19 Testing, Contact Tracing and Surveillance), and fifth measures can be used for SNS supply purchases. The third and fifth measures specify that a total of not more than $19.25 billion may be allocated for the SNS from the total

[51] For information on the ASPR activities, see HHS, ASPR, "COVID-19: 2019 Novel Coronavirus Disease," https://www.phe.gov/emergency/events/COVID19/Pages/default.aspx.

appropriations for Medical Countermeasures and Surge Capacity in those laws, including not more than $16 billion in the third measure and not more than $3.25 billion in the fifth measure.

COVID-19 Testing for the Uninsured. The second measure included $1 billion to provide reimbursements for COVID-19 testing and related services for persons who are uninsured. In addition, the fourth measure specified that up to $1 billion of the amounts appropriated for broader COVID-19 testing purposes (discussed below) may be used to cover the costs of testing for the uninsured.[52] (See the "Health Resources and Services Administration" section for details about HRSA's administration of this program.)

Provider Relief Fund (PRF). The third, fourth, and fifth measures each provided funding for a "Provider Relief Fund" to assist health care providers and facilities affected by the COVID-19 pandemic.[53] These funds are intended to reimburse eligible health care providers for health care-related expenses or lost revenues attributable to the pandemic. The measures define eligible providers broadly as any that provide "diagnoses, testing, or care for individuals with possible or actual cases of COVID-19." In total, $178 billion has been appropriated for the PRF.[54] (See the "Health Resources and Services Administration" section for more details about HRSA's administration of this program.)

COVID-19 Testing, Surveillance, Contact Tracing, Containment, and Mitigation. As specified in the bullets below, the fourth and fifth measures provided $47.4 billion to augment national capacity for COVID-19 containment, including expanded testing capacity and workforce and technical capacity for disease surveillance and contact tracing.

- The fourth measure provided $25 billion total and directed HHS to reserve some of these funds for specific purposes. For example, not less than $11 billion is for states, localities, territories, tribes, tribal organizations, urban Indian health organizations, and health service providers to tribes. Of this total for SLTT grantees, not less than $2 billion was to be allocated according to the formula that applied to the PHEP cooperative agreement in 2019,[55] and $4.25 billion must be allocated according to a formula that is based on the relative number of COVID-19 cases. In addition, the law specified that certain amounts of these funds are to be transferred to other agencies and accounts (e.g., $22 million is to be transferred to the FDA to support activities related to diagnostic, serological, antigen, and other tests). See **Table 2** for a detailed accounting of all transfers and set-asides.
- The fifth measure provided a total of $22.4 billion and directed that funds shall be for states, localities, territories, and tribal entities, and that funding may be awarded as grants or cooperative agreements. Of the total, $790 million was designated to be transferred to IHS, and a separate amount of not less than $2.5 billion is for "strategies for improving testing capabilities and other purposes ...

[52] Both measures provide for these payments to be made according to the National Disaster Medical System (NDMS) definitive care reimbursement mechanism. As mentioned, this testing program is administered by HRSA. HRSA, "COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured," https://www.hrsa.gov/CovidUninsuredClaim.

[53] For more information on the Provider Relief Fund, see HHS, "CARES Act Provider Relief Fund" (the name given to this fund by HHS), April 22, 2020, https://www.hhs.gov/provider-relief/index.html.

[54] For further information about these appropriations, see CRS Report R46325, *Fourth COVID-19 Relief Package (P.L. 116-139): In Brief*, and HHS news releases at https://www.hhs.gov/about/news/index.html.

[55] See footnote 7 for explanation of the PHEP program.

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." The funding, except for the transfer to IHS, is to be awarded according to the formula that applied to the PHEP cooperative agreement in FY2020.

CDC has administered several grant awards using these appropriations (as described in the **text box** in the "Centers for Disease Control and Prevention (CDC)" section).

In addition to the activities specified above, PHSSEF appropriations in the first, third, and fourth measures called for some portion of the funds to be transferred to other agencies or accounts for particular activities. For instance, some PHSSEF funds are to be transferred to HRSA for health centers, rural health, the Ryan White HIV/AIDS program, and health care systems.[56] (See the "Health Resources and Services Administration (HRSA)" section for more details.)

Funding Overview

The following tables provide overviews of COVID-19 supplemental appropriations for PHS agencies *as appropriated.*

- **Table 1** provides a high-level summary of appropriations by agency and includes information about transfers specifically directed to another agency account. It also provides information on the period of availability for these funds, listed as a specified date when they are no longer available for obligation (i.e., "expire"), or that they are "no year" funds (i.e., available until expended).
- **Table 2** provides a more detailed view of these appropriations, including overviews of all appropriations for accounts, programs, and specified purposes within an agency, as well as directed transfers outside of agency accounts. It also provides information on the availability of the funds for obligation, as above.

The tables present accounts in the order in which they appear in the five appropriations laws. Transfers are listed in their account of origin, not the receiving account. In at least one case, transfers are directed to "other federal agencies" without specifying the agency or account. Several of these transfers are directed as "not less than" (NLT) or "not more than" (NMT).

[56] For further background on HRSA and these activities, see, for example, CRS Report R44054, *Health Resources and Services Administration (HRSA) Funding: Fact Sheet*; CRS Report R46239, *Telehealth and Telemedicine: Frequently Asked Questions*; and CRS Insight IN11238, *Coronavirus Disease 2019 (COVID-19) Poses Challenges for the U.S. Blood Supply*.

Table 1. Summary of COVID-19 Supplemental Appropriations to Public Health Service

All amounts are in U.S. $ millions

Department or Agency, Program or Account	P.L. 116-123 (Division A)		P.L. 116-127 (Division A)		P.L. 116-136 (Division A & B)		P.L. 116-139 (Division B)		P.L. 116-260 (Division M)		
	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Total
FDA; Salaries and Expenses	**61**	**expended**	**—**	**—**	**80**	**expended**	**—**	**—**	**55**	**expended**	**196**
CDC; CDC-Wide Activities and Program Support	**2,200**	**Sep. 30, 2022**	**—**	**—**	**4,300**	**Sep. 30, 2024**	**—**	**—**	**8,750**	**Sep. 30, 2024**	**15,250**
Transfer to IHS	—	—	—	—	—	—	—	—	*(210)*	*(as above)*	
NIH	**836**	**Sep. 30, 2024**	**—**	**—**	**945**	**Sep. 30, 2024**	**—**	**—**	**1,250**	**Sep. 30, 2024**	**3,031**
SAMHSA; Health Surveillance and Program Support	**—**	**—**	**—**	**—**	**425**	**Sep. 30, 2021**	**—**	**—**	**4,250**	**Sep. 30, 2021**	**4,675**
HRSA	**—**	**—**	**—**	**—**	**1,320**	**Sep. 30, 2020**	**—**	**—**	**—**	**—**	**1,320**
PHSSEF; HHS OS	**3,400** (including contingent of 300)	**varies**	**1,000**	**expended**	**127,290**	**varies**	**100,000**	**expended**	**48,345**	**varies by appropria tion**	**280,035**
NMT Transfer to HHS OIG	*(2)*	*expended*	—	—	*(4)*	*expended*	*(6)*	*(as above)*	*(2)*	*expended*	*(14)*
Transfers to HRSA (Ryan White, Rural Health, and Health Care Systems)	—	—	—	—	*(275)*	*Sep. 30, 2022*	—	—	—	—	*(275)*
Provider Relief Fund	—	—	—	—	*(100,000)*	*expended*	*(75,000)*	*(as above)*	*(3,000)*	*expended*	*(178,000)*
Medical Countermeasures and Surge Capacity	*(3,400)*	*Sep. 30, 2024*	—	—	*(27,015)*	*Sep. 30, 2024*	—	—	*(22,945)*	*Sep. 30, 2024*	*(53,360)*

Department or Agency, Program or Account	P.L. 116-123 (Division A)		P.L. 116-127 (Division A)		P.L. 116-136 (Division A & B)		P.L. 116-139 (Division B)		P.L. 116-260 (Division M)		
	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Total
Transfer to HRSA, Primary Health Care (Health Centers Program)	*(100)*	*Sep. 30, 2024*	—	—	—	—	—	—	—	—	*(100)*
COVID-19 Testing, Surveillance, and Contact Tracing	—	—	—	—	—	—	*(25,000)*	*(as above)*	*(22,400)*	*Sep. 30, 2022*	*(47,400)*
NLT for grants to states, localities, territories, and tribal entities[a]	—	—	—	—	—	—	*(11,000)*	*(as above)*	—	—	*(11,000)*
NLT allocated in coordination with IHS Director	—	—	—	—	—	—	*(750)*	*(as above)*	—	—	*(750)*
NLT transfer to CDC-Wide Activities and Program Support	—	—	—	—	—	—	*(1,000)*	*(as above)*	—	—	*(1,000)*
NLT transfer to NIH NCI	—	—	—	—	—	—	*(306)*	*(as above)*	—	—	*(306)*
NLT transfer to NIH NIBIB	—	—	—	—	—	—	*(500)*	*(as above)*	—	—	*(500)*
NLT transfer to NIH OD	—	—	—	—	—	—	*(1,000)*	*(as above)*	—	—	*(1,000)*
Transfer to FDA (Salaries and Expenses)	—	—	—	—	—	—	*(22)*	*(as above)*	—	—	*(22)*
Transfer to HRSA (Health Centers)	—	—	—	—	—	—	*(600)p*	*(as above)*	—	—	*(600)*
Transfer to IHS	—	—	—	—	—	—	—	—	*(790)*	*Sep. 30, 2022*	*(790)*
IHS	**—**	**—**		**64**	**Sep. 30, 2022**	**1,032**	**Sep. 30, 2021**	**—**	**—**	**—**	**—**
ATSDR; Toxic Substances and Environmental Public Health	**—**	**—**	**—**	**—**	**13**	**Sep. 30, 2021**	**—**	**—**	**—**	**—**	**13**

Department or Agency, Program or Account	P.L. 116-123 (Division A)		P.L. 116-127 (Division A)		P.L. 116-136 (Division A & B)		P.L. 116-139 (Division B)		P.L. 116-260 (Division M)		
	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Total
Total	**6,497**	**—**	**1,064**	**—**	**135,404**	**—**	**100,000**	**—**	**62,650**	**—**	**305,615**

Source: Compiled by CRS from amounts specified in P.L. 116-123 (Title III, Division A), P.L. 116-127 (Title V, Division A), P.L. 116-136 (Division A and Title VIII, Division B), P.L. 116-139 (Title I, Division B), and P.L. 116-260 (Division M).

Notes: Values are rounded to the nearest million. Due to rounding, some totals may not equal the sum of their separate components. All funds except for the HRSA health center funds in Division A of P.L. 116-136 are designated as an emergency requirement. Amounts in parenthesis and italics are non-adds. Abbreviations: ATSDR = Agency for Toxic Substances and Disease Registry; CDC = Centers for Disease Control and Prevention; FDA = Food and Drug Administration; HHS = Department of Health and Human Services; HRSA = Health Resources and Services Administration; IHS = Indian Health Service; NCI = National Cancer Institute; NIBIB = National Institute of Biomedical Imaging and Bioengineering; NIH = National Institutes of Health; OD = Office of the Director; OIG = Office of the Inspector General; OS = Office of the Secretary; PHSSEF = Public Health and Social Services Emergency Fund; SAMHSA = Substance Abuse and Mental Health Services Administration.

a. Unlike the other appropriations in this table, this funding was not specifically directed to be transferred to another agency account, though the funding has been since administered by CDC and IHS. It is presented here to comprehensively reflect appropriations made available to IHS.

Table 2. Detailed COVID-19 Supplemental Appropriations to Public Health Service

All amounts are in U.S. $ millions

Department or Agency, Program or Account	P.L. 116-123 (Division A)		P.L. 116-127 (Division A)		P.L. 116-136 (Division A & B)		P.L. 116-139 (Division B)		P.L. 116-260 (Division M)		
	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Total
FDA	**61**	**expended**	**—**	**—**	**80**	**expended**	**—[a]**	**—**	**55**	**expended**	**196**
Salaries and Expenses	61	(as above)	—	—	80	(as above)	—	—	55	(as above)	196
Medical countermeasures and vaccines	—	—	—	—	—	—	—	—	*(9)*	*(as above)*	*(9)*
Advanced manufacturing for medical products	—	—	—	—	—	—	—	—	*(31)*	*(as above)*	*(31)*

Department or Agency, Program or Account	P.L. 116-123 (Division A)		P.L. 116-127 (Division A)		P.L. 116-136 (Division A & B)		P.L. 116-139 (Division B)		P.L. 116-260 (Division M)		Total
	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	
Monitoring of medical product supply chains	—	—	—	—	—	—	—	—	*(2)*	*(as above)*	*(2)*
Public health research and response	—	—	—	—	—	—	—	—	*(8)*	*(as above)*	*(8)*
Data management operation tools	—	—	—	—	—	—	—	—	*(1)*	*(as above)*	*(1)*
After action review activities	—	—	—	—	—	—	—	—	*(5)*	*(as above)*	*(5)*
CDC	**2,200**	**Sep. 30, 2022**	**—**	**—**	**4,300**	**Sep. 30, 2024**	**—**	**—**	**8,750[b]**	**Sep. 30, 2024**	**15,250**
CDC-Wide Program Activities and Support	2,200	(as above)	—	—	4,300	(as above)	—	—	8,750	(as above)	15,250
NLT for states, territories, localities, or tribal entities	*(950)[c]*	*(as above)*	—	—	*(1,500)[d]*	*(as above)*	—	—	*(4,500)*	*(as above)*	*(6,950)*
Transfer to IHS	—	—	—	—	—	—	—	—	*(210)*	*(as above)*	*(210)*
NLT for tribes, tribal organizations, and related entities	*(40)*	*(as above)*	—	—	(125)	*(as above)*	—	—	—	—	*(165)*
NLT for high-risk and underserved populations (e.g., racial and ethnic minority populations and rural communities)	—	—	—	—	—	—	—	—	*(300)*	*(as above)*	*(300)*
Transfer to IDRRRF	*(300)*	*(as above)*	—	—	*(300)*	*(as above)*	—	—	—	—	*(600)*
NLT for global disease detection and response	*(300)*	*(as above)*	—	—	*(500)*	*(as above)*	—	—	—	—	*(800)*

Department or Agency, Program or Account	P.L. 116-123 (Division A)		P.L. 116-127 (Division A)		P.L. 116-136 (Division A & B)		P.L. 116-139 (Division B)		P.L. 116-260 (Division M)		Total
	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	
NLT for health data surveillance modernization	—	—	—	—	*(500)*	*(as above)*	—	—	—	—	*(500)*
NIH	**836**	**Sep. 30, 2024**	**—**	**—**	**945**	**Sep. 30, 2024**	**—**	**—**	**1,250**	**Sep. 30, 2024**	**3,031**
NIH NIAID	836	(as above)	—	—	706	(as above)	—	—	—	—	1,542
NLT Transfer to NIH NIEHS	*(10)*	*(as above)*	—	—	—	—	—	—	—	—	*(10)*
NLT for vaccine and infectious disease research facilities	—	—	—	—	*(156)*	*(as above)*	—	—	—	—	*(156)*
NIH NHLBI	—	—	—	—	103	(as above)	—	—	—	—	103
NIH NIBIB	—	—	—	—	60	(as above)	—	—	—	—	60
NIH NLM	—	—	—	—	10	(as above)	—	—	—	—	10
NIH NCATS	—	—	—	—	36	(as above)	—	—	—	—	36
NIH OD	—	—	—	—	30	(as above)	—	—	1,250	(as above)	1,280
Research and clinical trials related to long-term studies of COVID-19	—	—	—	—	—	—	—	—	*(1,150)*	*(as above)*	*(1,150)*
NLT for Rapid Acceleration of diagnostics	—	—	—	—	—	—	—	—	*(100)*	*(as above)*	*(100)*
SAMHSA	**—**	**—**	**—**	**—**	**425**	**Sep. 30, 2021**	**—**	**—**	***4,250*[e]**	**Sep. 30, 2021**	**4,675**
Health Surveillance and Program Support	—	—	—	—	425[f]	(as above)	—	—	*4,250*[e]	(as above)	4,675

Department or Agency, Program or Account	P.L. 116-123 (Division A)		P.L. 116-127 (Division A)		P.L. 116-136 (Division A & B)		P.L. 116-139 (Division B)		P.L. 116-260 (Division M)		Total
	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	
NLT for Certified Community Behavioral Health Clinics	—	—	—	—	*(250)*	(as above)	—	—	*(600)*	*(as above)*	*(850)*
NLT for suicide prevention	—	—	—	—	*(50)*	*(as above)*	—	—	*(50)*	*(as above)*	*(100)*
NLT for emergency response grants for substance abuse and mental health	—	—	—	—	*(100)*	*(as above)*	—	—	*(240)*	*(as above)*	*(340)*
Substance abuse and prevention treatment block grant	—	—	—	—	—	—	—	—	*(1,650)*	*(as above)*	*(1,650)*
Community mental health services block grant	—	—	—	—	—	—	—	—	*(1,650)*	*(as above)*	*(1,650)*
Project AWARE	—	—	—	—	—	—	—	—	*(50)*	*(as above)*	*(50)*
National Child Traumatic Stress Network	—	—	—	—	—	—	—	—	*(10)*	*(as above)*	*(10)*
HRSA	**—**	**—**	**—**	**—**	**1,320**	**Sep. 30, 2020**	**—**	**—**	**—**	**—**	**1,320**
Supplemental awards for health centers	—	—	—	—	*(1,320)*	*(as above)*	—	—	—	—	*(1,320)*
PHSSEF	**3,400 (including contingent of 300)**	**varies**	**1,000[g]**	**varies**	**127,290[h]**	**Sep. 30, 2024**	**100,000[i]**	**expended**	**48,345[j]**	**varies**	**280,035**
HHS OS	3,400	Sep. 30, 2024	1,000[g]	(as above)	127,290[h]	(as above)	100,000[i]	(as above)	48,345[j]	(as above)	280,035

Department or Agency, Program or Account	P.L. 116-123 (Division A)		P.L. 116-127 (Division A)		P.L. 116-136 (Division A & B)		P.L. 116-139 (Division B)		P.L. 116-260 (Division M)		Total
	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	
HHS OS, additional contingent amount	*(300)*[k]	*Sep. 30, 2024*	—	—	—	—	—	—	—	—	*300*
NMT Transfer to HHS OIG	*(2)*[l]	*expended*	—	—	*(4)*[l]	*expended*	*(6)*[l]	*(as above)*	*(2)*[l]	*expended*	*(14)*
Testing for the Uninsured	—	—	*(1,000)*	*(as above)*	—	—	—[m]	—	—	—	*(1,000)*
Transfers to HRSA (Ryan White, Rural Health, and Health Care Systems)	—	—	—	—	*(275)*[n]	*Sep. 30, 2022*	—	—	—	—	*(275)*
Provider Relief Fund	—	—	—	—	*(100,000)*	*expended*	*(75,000)*	*(as above)*	*(3,000)*	*expended*	*(178,000)*
Medical Countermeasures and Surge Capacity	*(3,400)*	*Sep. 30, 2024*	—	—	*(27,015)*	*Sep. 30, 2024*	—	—	*(22,945)*	*Sep. 30, 2024*	*(53,360)*
Transfer to HRSA, Primary Health Care (Health Centers Program)	*(100)*	*(as above)*	—	—	—	—	—	—	—	—	*(100)*
NMT for Strategic National Stockpile	—	—	—	—	*(16,000)*	*(as above)*	—	—	*(3,250)*	*Sep. 30, 2024*	*(19,250)*
NLT for Hospital Preparedness Program grantees or subgrantees	—	—	—	—	*(250)*	*(as above)*	—	—	—	—	*(250)*
NLT for BARDA	—	—	—	—	*(3,500)*	*(as above)*	—	—	—	—	*(3,500)*
BARDA	—	—	—	—	—	—	—	—	*(19,695)*	*Sep. 30, 2024*	*(19,695)*

Department or Agency, Program or Account	P.L. 116-123 (Division A)		P.L. 116-127 (Division A)		P.L. 116-136 (Division A & B)		P.L. 116-139 (Division B)		P.L. 116-260 (Division M)		Total
	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	
NMT transfer to other federal agencies for care of persons under federal quarantine	—	—	—	—	*(289)*	*(as above)*	—	—	—	—	*(289)*
National Academies Study	—	—	—	—	*(2)*	*(as above)*	—	—	—	—	*(2)*
COVID-19 Testing, Surveillance, and Contact Tracing	—	—	—	—	—	—	*(25,000)*	*(as above)*	*(22,400)*	*Sep. 30, 2022*	*(47,400)*
NLT for grants to states, localities, territories, and tribal entities	—	—	—	—	—	—	*(11,000)*	*(as above)*	—°	—	*(11,000)*
NLT allocated in coordination with IHS Director							*(750)*	*(as above)*			*(750)*
NLT transfer to CDC-Wide Activities and Program Support	—	—	—	—	—	—	*(1,000)*	*(as above)*	—	—	*(1,000)*
NLT transfer to NIH NCI	—	—	—	—	—	—	*(306)*	*(as above)*	—	—	*(306)*
NLT transfer to NIH NIBIB	—	—	—	—	—	—	*(500)*	*(as above)*	—	—	*(500)*
NLT transfer to NIH OD	—	—	—	—	—	—	*(1,000)*	*(as above)*	—	—	*(1,000)*
NLT for BARDA	—	—	—	—	—	—	*(1,000)*	*(as above)*	—	—	*(1,000)*

Department or Agency, Program or Account	P.L. 116-123 (Division A)		P.L. 116-127 (Division A)		P.L. 116-136 (Division A & B)		P.L. 116-139 (Division B)		P.L. 116-260 (Division M)		Total
	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	
Transfer to FDA (Salaries and Expenses)	—	—	—	—	—	—	*(22)*	*(as above)*	—	—	*(22)*
Transfer to HRSA (Health Centers)	—	—	—	—	—	—	*(600)*[p]	*(as above)*	—	—	*(600)*
Rural Health Clinics	—	—	—	—	—	—	*(225)*	*(as above)*	—	—	*(225)*
NMT Testing for the Uninsured	—	—	—	—	—	—	*(1,000)*[m]	*(as above)*	—	—	*(1,000)*
Transfer to IHS	—	—	—	—	—	—	—	—	*(790)*	*Sep. 30, 2022*	*(790)*
NLT improving testing and contract tracing for high-risk and underserved populations	—	—	—	—	—	—	—	—	*(2,500)*	*Sep. 30, 2022*	*(2,500)*
IHS	**—**[c]	**—**	**64**	**Sep. 30, 2022**	**1,032**	**Sep. 30, 2021**	**—**	**—**	**—**	**—**	**1,096**
Indian Health Services	—[c]	—	64	(as above)	1,032	(as above)	—	—	—	—	1,096
NMT Electronic health record stabilization and support	—	—	—	—	*(65)*	*(as above)*	—	—	—	—	*(65)*
NLT Indian Self-Determination and Education Assistance Act programs and tribes	—	—	—	—	*(450)*	*(as above)*	—	—	—	—	*(450)*
NMT transfer to Indian Health Facilities	—	—	—	—	*(125)*	*(as above)*	—	—	—	—	*(125)*
ATSDR	**—**	**—**	**—**	**—**	**13**	**Sep. 30, 2021**	**—**	**—**	**—**	**—**	**13**

Department or Agency, Program or Account	P.L. 116-123 (Division A)		P.L. 116-127 (Division A)		P.L. 116-136 (Division A & B)		P.L. 116-139 (Division B)		P.L. 116-260 (Division M)		Total
	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	Amount	Avail. Until	
Toxic Substances and Environmental Public Health	—	—	—	—	13	(as above)	—	—	—	—	13
Geospatial Research, Analysis and Services Program	—	—	—	—	*(8)*	*(as above)*	—	—	—	—	*(8)*
Awards to Pediatric Environmental Health Specialty Units and state health departments	—	—	—	—	*(5)*	*(as above)*	—	—	—	—	*(5)*
Total (in $U.S. millions)	**6,497**	—	**1,064**	—	**135,404**	—	**100,000**	—	**62,650**	—	**305,615**

Source: Compiled by CRS from amounts specified in P.L. 116-123 (Title III, Division A), P.L. 116-127 (Title V, Division A), P.L. 116-136 (Division A and Title VIII, Division B), P.L. 116-139 (Title I, Division B), and P.L. 116-260 (Division M).

Notes: Values are rounded to the nearest million. Due to rounding, some totals may not equal the sum of their separate components. All funds except for the HRSA health center funds in Division A of P.L. 116-136 are designated as an emergency requirement. Amounts in parenthesis and italics are non-adds. Abbreviations: ATSDR = Agency for Toxic Substances and Disease Registry; BARDA = Biomedical Advanced Research and Development Authority; CDC = Centers for Disease Control and Prevention; FDA = Food and Drug Administration; HHS = Department of Health and Human Services; HRSA = Health Resources and Services Administration; IDRRRF = Infectious Disease Rapid Response Reserve Fund; IHS = Indian Health Service; NCATS = National Center for Advancing Translational Sciences; NCI = National Cancer Institute; NHLBI = National Heart, Lung, and Blood Institute; NIAID = National Institute of Allergy and Infectious Diseases; NIBIB = National Institute of Biomedical Imaging and Bioengineering; NIEHS = National Institute of Environmental Health Sciences; NIH = National Institutes of Health; NLM = National Library of Medicine; OD = Office of the Director; OIG = Office of the Inspector General; OS = Office of the Secretary; PHSSEF = Public Health and Social Services Emergency Fund; SAMHSA = Substance Abuse and Mental Health Services Administration.

a. A $22 million transfer was directed from PHSSEF to FDA for "diagnostic, serological, antigen, and other testing, as well as related administrative activities."

b. This appropriation was directed for vaccine-related activities, specifically for "activities to plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines to ensure broad-based distribution, access, and vaccine coverage."

c. Of the total CDC set-aside for states, territories, localities, or tribal entities, not less than $40 million was to be allocated to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes.

d. Of the total appropriated for the CDC set-aside for states, territories, localities, or tribal entities, not less than $125 million was to be allocated to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes.

e. Of the total appropriated to SAMHSA, not less than $125 million was to be allocated to tribes, tribal organizations, urban Indian health organizations, or health or behavioral health service providers to tribes.

f. Of the total appropriated SAMHSA, not less than $15 million was to be allocated to tribes, tribal organizations, urban Indian health organizations, or health or behavioral health service providers to tribes.

g. To provide reimbursements for COVID-19 testing and related services for persons who are uninsured.

h. Provided in distinct appropriations broadly focused on medical countermeasures and surge capacity ($27 billion), health care provider reimbursement (the Provider Relief Fund, $100 billion), and HRSA transfers ($275 million). Of the total appropriated to the PHSSEF, up to $4 million is to be transferred to the HHS OIG.

i. Provided in distinct appropriations broadly focused on health care provider reimbursement (the Provider Relief Fund, $75 billion) and COVID-19 testing, surveillance, and contact tracing ($25 billion). Of the total appropriated to the PHSSEF, up to $6 million is to be transferred to the HHS OIG.

j. Provided in distinct appropriations broadly focused on medical countermeasures and surge capacity ($23 billion), testing, surveillance, and contact tracing ($22 billion), and health care provider reimbursement (the Provider Relief Fund, $3 billion). Of the total appropriated to the PHSSEF, up to $2 million is to be transferred to the HHS OIG.

k. These funds may be used to purchase medical products (e.g., vaccines, therapeutics, and diagnostics). However, the availability of these appropriations is contingent upon future actions by HHS. Specifically, HHS must certify to the appropriations committees that funds from the initial $3.1 billion in PHHSEF appropriations that had been allotted for purchase of such products will be obligated imminently and that the additional $300 million is necessary to purchase vaccines, therapeutics, or diagnostics to adequately address the public health nee

l. The transfers to the HHS OIG are specified in general provisions (not more than $2 million per Title III, Division A, Section 306 of P.L. 116-123; not more than $4 million per Title VIII, Division B, Section 8113 of P.L. 116-136; not more than $6 million per Title I, Division B, Section 103 of P.L. 116-139; and not more than $2 million per Division M, Section 304 of P.L. 116-260). The amounts transferred to the HHS OIG may come from any funds appropriated to the PHSSEF in the respective appropriations acts. The HHS OIG funds are for oversight of all activities supported with funds appropriated to HHS to prevent, prepare for, and respond to the COVID-19 pandemic (not just funds appropriated to the PHSSEF).

m. P.L. 116-139 did not provide a distinct appropriation for testing for the uninsured, but it specified that up to $1 billion out of the $25 billion appropriated for COVID-19 testing, surveillance, and contact tracing may be used for this purpose.

n. Of the total to be transferred to HRSA, $90 million is for the Ryan White HIV/AIDS program, $180 million is for rural health programs (of which not less than $15 million is for tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes), and $5 million is for health care systems.

o. P.L. 116-260 directed that these funds shall be for "states, localities, territories, tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes" and may be awarded as grants or cooperative agreements.

p. P.L. 116-139 specified that these funds may be awarded to Federally Qualified Health Centers under Section 330 of the Public Health Service Act and to entities that are eligible for but not currently receiving such funds (i.e., Federally Qualified Health Center "look-alikes").

Resources for Tracking PHS Spending

This section provides an overview of federal resources to track Public Health Service spending from COVID-19 supplemental legislation. For further information on tracking COVID-19 spending government-wide, see CRS Report R46491, *Resources for Tracking Federal COVID-19 Spending*.

USAspending.gov

USAspending.gov[57] provides information on federal awards, including grants, contracts, loans, and other assistance. USAspending.gov has a dedicated page for tracking spending from COVID-19 supplemental measures (COVID-19 Spending, https://www.usaspending.gov/disaster/covid-19). There is also an advanced search page (https://www.usaspending.gov/search) with the search option "Disaster Emergency Funding Code," to limit results by COVID-19 supplemental funding law.[58] For the COVID-19 supplemental funding, USAspending.gov provides data on *obligations* (amount promised) and *outlays* (amount paid out). Typically, USAspending.gov provides only obligations data.

Caveats to the data presented in USAspending.gov are outlined on the "Known Data Limitations" page (https://www.usaspending.gov/data/data-limitations.pdf).[59]

Pandemic Response Accountability Committee

The Pandemic Response Accountability Committee (PRAC) website provides visualizations of COVID-19 supplemental appropriations funding data on the "Track the Money" page (https://www.pandemicoversight.gov/track-the-money). This site uses data from USAspending.gov. The "Funding Charts & Graphs" page (https://www.pandemicoversight.gov/track-the-money/funding-charts-graphs) under "Pandemic Response Funding" shows spending by agency, geography, and program ("assistance listing") in interactive charts, graphs, and tables.

HHS TAGGS

The HHS Tracking Accountability in Government Grants System (HHS TAGGS) has a dedicated page for COVID-19 funding (https://taggs.hhs.gov/Coronavirus). This page provides details on HHS grant awards under the first four COVID supplemental measures. Awards can be filtered by HHS operating division (e.g., CDC), program, date, recipient, city, state, and supplemental appropriations law.

Separate tables show data on attested payments[60] made under the Provider Relief Fund (https://taggs.hhs.gov/Coronavirus/Providers), Rural Health Clinic (RHC) COVID-19 Testing

[57] For more information on USAspending.gov, see CRS Report R44027, *Tracking Federal Awards: USAspending.gov and Other Data Sources*, and CRS In Focus IF10231, *Tracking Federal Awards in States and Congressional Districts Using USAspending.gov*.

[58] DEFC Codes are described at USAspending.gov, *COVID-19 Spending: Data Sources & Methodology*, "Disaster Emergency Fund Code (DEFC)," https://www.usaspending.gov/disaster/covid-19/data-sources?section=defc.

[59] Ibid.

[60] For more information about attested payments, see *CARES Act Provider Relief Fund: For Providers*, under "Attest to Payment" (https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html#how-to-attest).

Fund (https://taggs.hhs.gov/Coronavirus/RuralHealthClinics), and the Uninsured Relief Fund (https://taggs.hhs.gov/Coronavirus/Uninsured).

GAO Reports

GAO provides oversight of the federal response to the pandemic and COVID-19-related spending. Information on COVID-19 supplemental funding is available on the "Coronavirus Oversight" page (https://www.gao.gov/coronavirus/). The following GAO reports in particular have detailed information on PHS and COVID-19 related funding:

- *COVID-19: Opportunities to Improve Federal Response and Recovery Efforts* (GAO-20-625, Jun 25, 2020)
- *COVID-19 Contracting: Observations on Federal Contracting in Response to the Pandemic* (GAO-20-632, Jul 29, 2020)
- *COVID-19: Brief Update on Initial Federal Response to the Pandemic* (GAO-20-708, Aug 31, 2020)
- *COVID-19: Federal Efforts Could Be Strengthened by Timely and Concerted Actions* (GAO-20-701, Sep 21, 2020)
- *COVID-19: Federal Efforts Accelerate Vaccine and Therapeutic Development, but More Transparency Needed on Emergency Use Authorizations* (GAO-21-207, Nov 17, 2020)
- *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response* (GAO-21-191, Nov 30, 2020)
- *COVID-19: Critical Vaccine Distribution, Supply Chain, Program Integrity, and Other Challenges Require Focused Federal Attention* (GAO-21-265, Jan 28, 2021)
- *Operation Warp Speed: Accelerated COVID-19 Vaccine Development Status and Efforts to Address Manufacturing Challenges* (GAO-21-319, Feb 11, 2021)

PHS Agency Websites

The following PHS agency websites have information on the distribution of COVID-19 supplemental funding:

- **CDC.** The CDC Budget website (https://www.cdc.gov/budget/index.html) provides CDC COVID-19 State, Tribal, Local, and Territorial (STLT) Funding Fact Sheet (https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/funding-update.pdf) with information on funding by supplemental measure and program by jurisdiction. Additional information is available on the page "Budget Fact Sheets: Novel Coronavirus (COVID-19)" (https://www.cdc.gov/budget/fact-sheets/covid-19/index.html).
- **HRSA.** HRSA provides funding information on various pages for programs that received supplemental funding; for example, "Primary Health Care Coronavirus Related Grants by State Funding Report" (https://data.hrsa.gov/data/reports/datagrid?gridName=COVID19FundingReport); "Coronavirus Disease (COVID-19) Frequently Asked Questions – Federal Office of Rural Health Policy" (https://www.hrsa.gov/rural-health/coronavirus/frequently-asked-questions); and "Ryan White HIV/AIDS Program: FY 2020 CARES Act Awards" (https://hab.hrsa.gov/coronavirus/cares-FY2020-awards). Relevant information

can also be found on the HHS TAGGS pages for the Provider Relief Fund (https://taggs.hhs.gov/Coronavirus/Providers), Rural Health Clinic (RHC) COVID-19 Testing Fund (https://taggs.hhs.gov/Coronavirus/RuralHealthClinics), and the Uninsured Relief Fund (https://taggs.hhs.gov/Coronavirus/Uninsured).

- **IHS.** The IHS website Coronavirus (COVID-19) Resources (https://www.ihs.gov/coronavirus/resources/ https://www.ihs.gov/coronavirus/faqs-federal-response-in-indian-country/) provides details on funding under the section "COVID-19 Funding Guidance for Tribes, Tribal Organizations and Urban Indian Organizations," including "Guidance on Indian Health Service COVID-19 Funding Distribution for Tribes, Tribal Organizations, and Urban Indian Organizations" (https://www.ihs.gov/sites/coronavirus/themes/responsive2017/display_objects/documents/COVID-19_Funding_Guidance_Tribes_UrbanIndianOrganizations.pdf) and "Fiscal Year 2020 Coronavirus (COVID-19) Funding Allocations" (https://www.ihs.gov/sites/coronavirus/themes/responsive2017/display_objects/documents/FY_2020_COVID19_FundingSummary.pdf).
- **NIH.** NIH provides details on research projects funded by COVID-19 supplemental measures, filtered by state and congressional district on the site COVID-19 Research: Funding (https://covid19.nih.gov/funding). Also, the NIH RePORTER database (https://reporter.nih.gov/) provides details on NIH-funded projects with more detailed search capabilities. The "Advanced Projects Search" page (https://reporter.nih.gov/advanced-search) has an option to add the search filter "NIH COVID-19 Response," with choices for "NIH Regular Appropriations Funding Used for COVID-19 Research," which allows users to limit the search to COVID-19 research funded by regular NIH appropriations, COVID-19 supplemental appropriations, or specific supplemental appropriations laws.
- **SAMHSA.** The SAMHSA website Coronavirus (COVID-19) (https://www.samhsa.gov/coronavirus) under "SAMHSA Resources and Information" provides COVID-related grant funding details under "FY 2021 SAMHSA COVID-19 Funded Grants" (https://www.samhsa.gov/sites/default/files/covid19-programs-funded-samhsa-fy21.pdf) and "FY 2020 SAMHSA COVID-19 Funded Grants" (https://www.samhsa.gov/sites/default/files/covid19-programs-funded-samhsa.pdf).

Nongovernment Sources

The following sources are examples of unofficial, nongovernment sources that provide tracking and analysis of COVID-19 supplemental funding:

- COVID Money Tracker (Committee for a Responsible Budget), https://www.covidmoneytracker.org/explore-data/interactive-table
- COVID-19 Relief Spending Tracker (Project on Government Oversight), https://covidtracker.pogo.org/table-view
- Coronavirus Disease 2019 (COVID-19) (Federal Funds Information for States, FFIS), https://ffis.org/COVID-19 (by subscription only)

Author Information

Kavya Sekar, Coordinator
Analyst in Health Policy

Agata Bodie
Analyst in Health Policy

Ada S. Cornell
Senior Research Librarian

Johnathan H. Duff
Analyst in Health Policy

Elayne J. Heisler
Specialist in Health Services

Isaac A. Nicchitta
Research Assistant

Acknowledgments

CRS Visual Information Specialist Jamie Hutchinson provided support for graphics in this report.

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.