

IMMUNIZATION AND RESPIRATORY DISEASES

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$602.593	\$611.384	\$607.942	-\$3.442
PHS Evaluation Transfer	\$12.864	\$12.864	\$12.864	\$0.000
ACA/PPHF	\$90.883	\$160.300	\$127.260	-\$33.040
PHSSEF Transfer	\$11.829	\$0.000	\$0.000	\$0.000
Total Request	\$718.169	\$784.548	\$748.066	-\$36.482
FTEs	626	626	626	0
Immunization Program Level	\$552.043	\$611.990	\$560.508	-\$51.482
-Immunization Program - BA	\$448.296	\$438.826	\$420.384	-\$18.442
-National Immunization Survey - PHS Evaluation Transfer	\$12.864	\$12.864	\$12.864	\$0.000
-Immunization Program - PPHF	\$90.883	\$160.300	\$127.260	-\$33.040
Influenza/Influenza Planning and Response	\$166.126	\$172.558	\$187.558	+\$15.000
-Influenza Planning and Response - BA	\$154.297	\$172.558	\$187.558	+\$15.000
-Influenza Planning and Response – PHSSEF Transfer	\$11.829	\$0.000	\$0.000	\$0.000

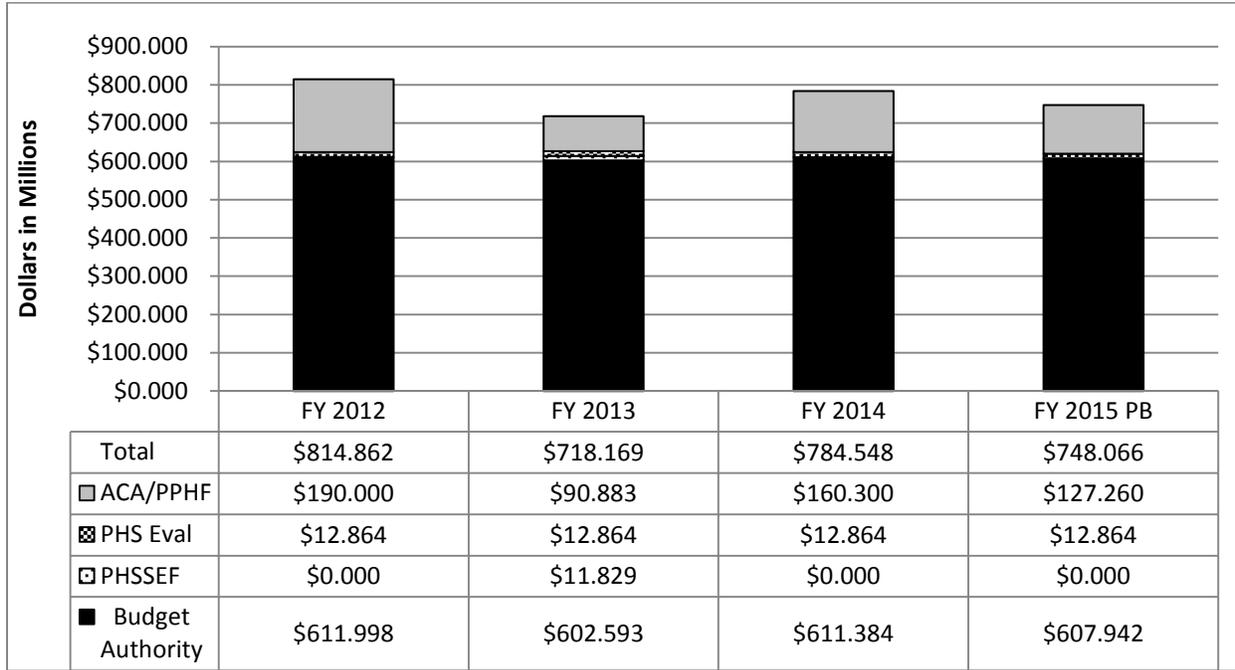
¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Summary

CDC prevents disease, disability, and death of children, adolescents, and adults through immunization and control of respiratory and related diseases. Through the discretionary Section 317 Immunization Program and mandatory Vaccines for Children (VFC) Program, CDC improves access to immunization services for underinsured and uninsured populations in the United States and supports the scientific evidence base for vaccine policy and practices. CDC also provides critical epidemiology and laboratory capacity to detect, prevent, and respond to vaccine-preventable, respiratory, and related infectious disease threats as well as preparedness planning for pandemic influenza.

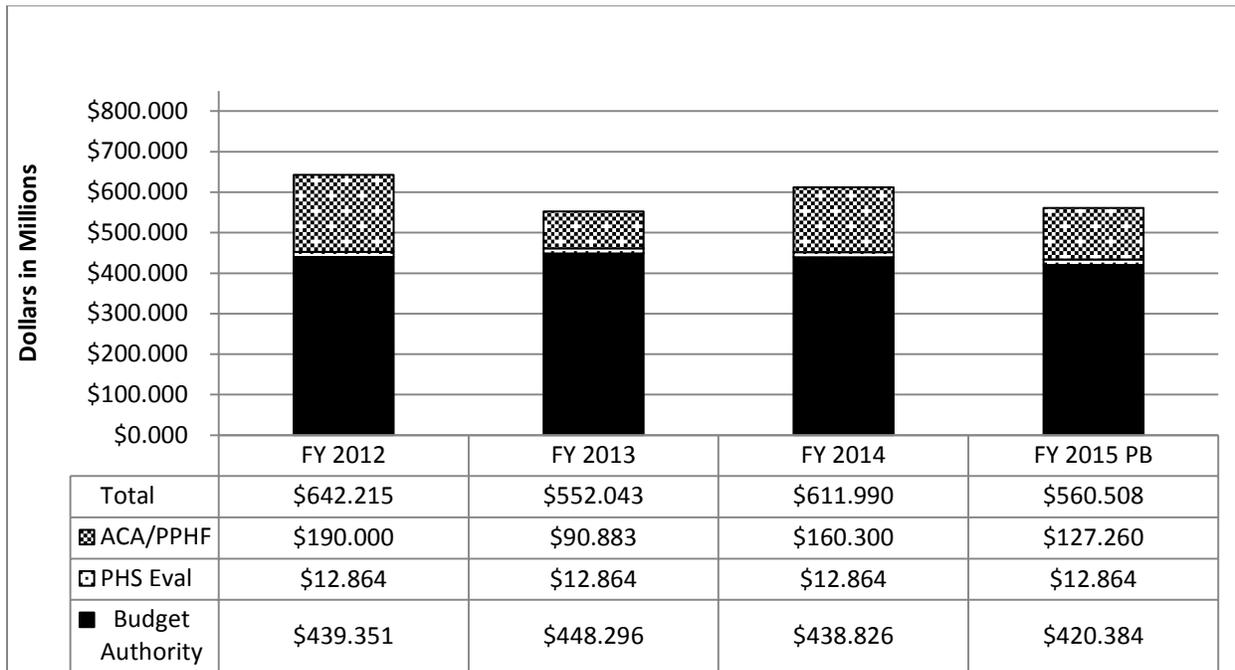
CDC's FY 2015 request of **\$748,066,000** for immunization and respiratory diseases, including \$127,260,000 from the Affordable Care Act Prevention and Public Health Fund (PPHF) and \$12,864,000 in PHS Evaluation funding, is \$36,482,000 below the FY 2014 Enacted level. The reductions to the 317 Immunization Program reflect an expectation of increased insurance coverage for immunization services through public and private health insurance expansion.

Figure: Immunization and Respiratory Diseases Funding History¹



¹FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Figure: 317 Immunization Program Funding History¹



¹FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Table: Immunization Program Funding History¹

Immunization Program ¹	
Fiscal Year	Dollars (in millions)
2005	\$493.032
2006	\$517.199
2007	\$512.804
2008	\$527.359
2009	\$557.359
2009 (ARRA)	\$300.000
2010	\$561.459
2011	\$488.576
2011 (ACA/PPHF)	\$100.000
2012	\$452.215
2012 (ACA/PPHF)	\$190.000
2013	\$461.160
2013 (ACA/PPHF)	\$90.883
2014	\$451.690
2014 (ACA/PPHF)	\$160.300

¹FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Immunization Program Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$448.296	\$438.826	\$420.384	-\$18.442
PHS Evaluation Transfer	\$12.864	\$12.864	\$12.864	\$0.000
ACA/PPHF	\$90.883	\$160.300	\$127.260	-\$33.040
Total	\$552.043	\$611.990	\$560.508	-\$51.482

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC's national immunization recommendations currently provide guidance for the prevention of 17 vaccine-preventable diseases (VPDs) across the lifespan. The Section 317 Program plays a fundamental role in the achievement of national immunization goals and aims to achieve and sustain high vaccination coverage rates to prevent death and disability from VPDs. The Section 317 Program provides funds to support the essential public health functions and to ensure program effectiveness and scientifically sound immunization policy. A strong public health infrastructure at the national, state, and local levels is vital to sustaining high vaccination coverage levels, low incidence of VPDs, and for maintaining public health preparedness for a response to a vaccine-preventable national emergency, such as a pandemic or biologic attack. The Section 317 Program also purchases routinely recommended vaccines to protect at-risk and vulnerable populations not eligible for VFC and to meet urgent public health needs such as controlling VPD outbreaks. The flexibility of the Section 317 Program is critical—allowing states to use their Section 317-purchased vaccine to meet their unique needs and priorities and fulfilling needs in responding to VPD outbreaks. The Affordable Care Act health insurance-related provisions will improve access to immunization services by requiring new private health plans and most public insurance to cover routinely recommended vaccines without cost-sharing. However, these health insurance provisions do not address the public health functions that must be in place to ensure safe and effective national immunization policies and programs—making the Section 317 Immunization cooperative agreements critical in FY 2015 and beyond.

Budget Request

CDC's FY 2015 request of **\$560,508,000** for the Immunization Program, including \$127,260,000 from the Affordable Care Act Prevention and Public Health Fund and \$12,864,000 in PHS Evaluation funding, is \$51,482,000 below the FY 2014 Enacted level. This decrease will be targeted to vaccine purchases. Health insurance expansion will further increase access to immunizations and is expected to decrease the number of uninsured and underinsured individuals in need of Section 317 vaccine for routine immunizations. Since September 2010, new health plans have been required to cover vaccines routinely recommended by the Advisory Committee on Immunization Practices (ACIP) without charging a deductible, copayment, or coinsurance. This request includes \$8,000,000 to expand the capacity of public health departments to bill health insurers for immunization services.

For FY 2015, CDC's priorities for the Section 317 Immunization Program are to:

- Preserve core public health immunization infrastructure at the local, state, and federal levels
- Maintain an adequate amount of vaccine purchase to provide a vaccination safety net for uninsured adults, and for response to VPD outbreaks and other vaccine urgent needs
- Make strategic investments to enhance the immunization infrastructure and evidence base and improve efficiency

Preserving Core Public Health Immunization Infrastructure

In FY 2015, the Section 317 Immunization Program will remain responsible for the essential public health workforce and systems at the national, state, and local levels that protect all Americans, regardless of health insurance status, from disability and death from VPDs.

In FY 2015, CDC will conduct scientific studies that provide the evidence base for national immunization policy, including burden of disease, vaccine effectiveness and safety, economic analyses, and program feasibility.

- For example, CDC's vaccine effectiveness research provided critical scientific evidence of waning immunity that informed the ACIP's recommendation for a booster dose of meningococcal conjugate vaccine at age 16 to assure protection through the high-risk college years.

In addition, CDC collects, analyzes, and reports scientific data about the effectiveness and safety of vaccines as they are used in the real-world setting and with larger populations to ensure the effectiveness and safety of our national vaccine programs and policies, and inform changes. This includes:

- Implementing vaccine safety priority studies by strengthening vaccine safety surveillance for rare vaccine adverse events
- Improving adverse-event reporting through electronic reporting
- Developing vaccine safety profiles for each newly licensed vaccine in collaboration with other federal agencies

Ongoing monitoring of immunization coverage rates is critical to identify and reach populations at greater risk for VPDs. The National Immunization Survey (NIS) is essential to assess national progress, document programmatic achievements, and identify disparities in immunization coverage rates. The NIS documented increases in adolescent vaccination rates from 2010 to 2012 for all three routinely recommended adolescent vaccines, and also identified the need for targeted efforts to improve human papillomavirus (HPV) vaccination coverage among adolescent girls. Based on this information, CDC provided FY 2013 funding from the PPHF to 11 immunization programs to conduct several activities to increase HPV vaccination, including using Immunization Information Systems (IIS) for reminder/recall for girls 11-18 years of age and a comprehensive communications campaign. In FY 2015, CDC will fund the NIS to monitor progress and inform programmatic strategies.

CDC supports efforts to communicate the benefits of vaccine to the public—through science-based communications campaigns and tools—as an aid in making informed vaccine decisions to protect themselves and their loved ones. CDC also conducts outreach to educate healthcare providers about current immunization policy and clinical best practices to help them protect their patients and communities from VPDs. CDC developed and will maintain a [dynamic provider toolkit](#)⁵ for conversations with parents about vaccination which includes evidence-based strategies, print materials, and web-based tools.

CDC will implement health information technologies to give healthcare providers the necessary immunization information to make sure their patients get the vaccines they need, when they need them, and CDC will manage vaccine supply disruptions and shortages to ensure the best public health outcomes until restoration of vaccine supply. Funds will also be used to respond to disease outbreaks by:

- Rapidly identifying and investigating cases
- Conducting surveillance and laboratory testing
- Implementing targeted vaccination efforts and other measures to control the spread of disease and prevent future outbreaks

⁵ <http://www.cdc.gov/vaccines/hcp.htm>

Maintaining an Adequate Amount of Vaccine Purchase

In FY 2015, the Section 317 Immunization Program will continue to be responsible for providing federally purchased vaccines to protect uninsured Americans from preventable diseases—and thus protecting communities from the dangers of low vaccination rates. CDC estimates, that although it is expected these populations will begin to decrease as implementation of expanded health insurance coverage provisions begin, there will continue to be a need for Section 317-purchased vaccines to serve uninsured adults and to provide rapid vaccination response to disease outbreaks and other urgent public health needs. It will be important to maintain a safety net for immunization services. And, unlike the federal VFC Program which has very specific eligibility requirements, Section 317 vaccine can be used to vaccinate non-VFC-eligible populations, such as adults or the fully-insured, in a public health emergency. A recent example where it became necessary to use Section 317 vaccine to vaccinate some privately-insured children was responding to pediatric influenza vaccine supply shortages in 2012-2013. The shortage was due to pediatricians not buying an adequate supply of privately-purchased pediatric influenza vaccines.

In FY 2015, CDC will work collaboratively with its awardees and partners to sustain record-high childhood immunization coverage rates and increase immunization coverage rates for children and adults by improving access to immunizations. Specifically, CDC will work to establish access points at complementary venues such as schools, pharmacies, and retail-based clinics; expand the network of VFC providers through recruitment efforts; purchase and deliver vaccine for at-risk populations; and ensure those with insurance have access to immunization services through an in-network provider.

Making Strategic Investments

In some communities, such as rural areas, health departments serve as a critical access point. Since 2009, CDC invested funding to expand immunization infrastructure to assist public health clinics that serve fully-insured patients with billing for immunization services in order to preserve access to life-saving immunizations for fully-insured populations. The purpose of billing is to expand access to fully-insured individuals in areas where there is not adequate in-network provider coverage. As of FY 2013, 35 awardees are developing and/or implementing billing systems in targeted areas of their jurisdictions. In FY 2015, CDC will support awardees in this area. However, while expanded billing capacity in public health departments may help to maintain and improve access to immunization services for the fully-insured, it does not replace the need for Section 317 vaccine that provides a critical public health safety net for vaccinating the uninsured and responding to VPD outbreaks and other public health emergencies.

Anticipating the evolving role of public health, CDC strategically directed immunization resources to prepare for the new healthcare environment. CDC made investments in IIS that inform and support clinical decision-making and allow interfacing with electronic health records (EHRs) and vaccine ordering systems—helping more than 95% of 56 awardees to reach full compliance with Health Level Seven (HL7) messaging standards for immunization data transactions. In FY 2015, Section 317 will provide funding to immunization awardees and support scientific and programmatic expertise to further develop, enhance, and maintain IIS capable of identifying individuals in need of immunization, measuring vaccination coverage rates, producing reminder and recall notices, and interfacing with EHRs. CDC's immunization services program and the public health informatics program (refer to the public health scientific services section) collaborate to support Section 317 awardees in enhancing their IIS to be compliant with standards and requirements set by the national Electronic Health Records – Meaningful Use (EHR-MU) program.

Immunization Summary Table

(dollars in millions)		FY 2013	FY 2014	FY 2015	2015
		Final ¹	Enacted	President's Budget	+/-2014
	Immunization Infrastructure ²	\$218.201	\$241.080	\$241.080	\$0.000
	Vaccine Purchase ²	\$121.937	\$123.480	\$85.980	-\$37.500
	Extramural Program Operations	\$161.623	\$188.824	\$176.698	-\$12.126
	Intramural Program Operations	\$50.282	\$58.606	\$56.750	-\$1.856
	Total	\$552.043	\$611.990	\$560.508	-\$51.482

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² See 317 Immunization Grant Table for more information.

Table: Advancing Public Health Immunization Priorities

Funding Category	FY 2015 Section 317 Funding
Immunization Infrastructure	Will be awarded to support essential public health immunization workforce and systems at the state and local levels to recruit and educate networks of immunization providers, provide continual quality assurance, promote public awareness of new and expanded vaccine recommendations, manage vaccine shortages, and respond to VPD outbreaks. These awards only include core infrastructure/operations funding that goes to all awardees.
Vaccine Purchase	Will be allocated through direct assistance to provide federally purchased vaccines to vaccinate non-VFC-eligible uninsured populations and to meet urgent public health needs such as VPD outbreaks.
Extramural Program Operations	Will support national immunization policies and programs, including disease surveillance, vaccine coverage assessment, post-marketing evaluation of vaccine effectiveness and safety, immunization information technologies, centralized vaccine ordering and distribution systems, payor of last resort, public awareness campaigns and resources, and provider education and tools. Some of these funds go to awardees for work beyond the scope of core grants.
Intramural Program Operations	Will provide national public health expertise in immunization and VPDs that supports national, state, and local vaccination program efforts, including expertise in epidemiology and surveillance, laboratory methods and science, immunology, immunization policy, health communications science, vaccine management, and program implementation.

Supporting State and Territorial Immunization Programs

In FY 2015, CDC will provide infrastructure funding to 64 awardees—including all 50 states, Washington, D.C., five large cities, five territories, and three Pacific Freely Associated States—through a non-competitive, formula-based, discretionary cooperative agreement program that provides financial assistance for state and local

immunization operations. Through population-based awards and collaboration, the Section 317 Program established a comprehensive immunization system providing:

- Public sector vaccine ordering and distribution
- Continual quality assurance
- Provider recruitment and enrollment in the VFC Program
- Provider education and public awareness focused on new and expanded vaccine recommendations
- Management of vaccine shortages

In addition, CDC will provide its 64 awardees with direct assistance for vaccine purchased from the federal contracts. As part of the new five-year funding cycle that began in FY 2013, CDC adopted a vaccine use policy that Section 317–purchased vaccines cannot be used for routine vaccination of fully insured individuals. Assuring that public funds are not subsidizing insured benefits allows CDC to target its resources more effectively to meet public health priorities. In alignment with the vaccine use policy and to assure that public funds are not subsidizing insured benefits, the FY 2015 budget continues to allocate vaccine direct assistance based on the estimated number of uninsured adults within each awardee’s jurisdiction. Beginning in FY 2014, vaccine direct assistance will be allocated to the 64 Section 317 Immunization Programs based on a formula that takes into account the percentage of uninsured adults ages 19 to 64 years in their jurisdictions. The final allocation to awardees is adjusted as necessary to minimize large fluctuations. This will support an orderly transition to the new vaccine allocation formula, limit disruption to the Section 317 Immunization Program, and ensure that all awardees receive some amount of discretionary Section 317 vaccine to provide a safety net. For the FY 2014 allocation of vaccine direct assistance to U.S state and city awardees, CDC used the 2012 U.S. Census data for uninsured adults ages 19 to 64 years as its base population and allocated vaccine to each awardee based on their proportion of the uninsured adult population. The allocation of vaccine to the five U.S. Territories and three Pacific Freely Associated States was not changed.

CDC provides national public health expertise in VPDs that supports the 64 awardees, including expertise in:

- Epidemiology and surveillance
- Laboratory methods and science
- Immunology
- Immunization policy
- Health communications science
- Vaccine management
- Program implementation

Table: Section 317 Immunization Cooperative Agreements^{1, 2}

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final	Enacted	President’s Budget	2015 +/-2014
Number of Awards	64	64	64	0
- New Awards	0	0	0	0
- Continuing Awards	64	64	64	0
Average Award	\$5.315	\$5.696	\$5.110	-\$0.586
Range of Awards	\$0.572–\$37.773	\$0.624–\$40.527	\$0.600–\$36.500	N/A
Total Awards	\$340.138	\$364.560	\$327.060	-\$37.500

¹This table includes Section 317 budget authority and Prevention and Public Health Funds. It does not include funds from the former program implementation line.

²Immunization operations awards and vaccine direct assistance are included in the table. In FY 2013, CDC awarded a new five-year cooperative agreement for Section 317 immunization funding.

Influenza Planning and Response Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$154.297	\$172.558	\$187.558	+\$15.000
PHSSEF Transfer	\$11.829	\$0.000	\$0.000	\$0.000
Total	\$166.126	\$172.558	\$187.558	+\$15.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC's influenza planning and response activities ensure a comprehensive response for seasonal influenza as well as the ability to respond to an influenza pandemic. CDC's influenza program works to detect, respond to, and prevent influenza disease that can cause mild to severe illness, and at times can lead to death. Some people, such as older adults, young children, and people with certain health conditions, are at higher risk for serious influenza complications. Over a period of 30 years, between 1976 and 2006, estimates of influenza-associated deaths in the United States ranged from a low of about 3,000 to a high of about 49,000 people. On average, influenza causes more than 200,000 hospitalizations annually, and a [study](#)⁶ published in 2007 estimated more than \$10 billion annually in direct medical costs for hospitalizations and outpatient visits from seasonal influenza-related complications. Not only can influenza infections be severe, but also, influenza seasons are unpredictable—requiring constant vigilance from CDC and its domestic and international public health partners. CDC provides leadership and a cutting-edge scientific and programmatic foundation for the diagnosis, prevention, and control of influenza domestically and internationally. CDC's annual seasonal influenza activities improve preparedness by:

- Strengthening surveillance and diagnostic capacity
- Improving public awareness and provider knowledge about influenza and the importance of vaccination, other prevention measures, and early treatment
- Enhancing our international, Federal, State, and local partnerships to respond quickly to influenza epidemics

Prevention of seasonal influenza requires an annual reassessment of virus strains contained in the vaccine; the assessment is based on CDC surveillance data. The vaccine must be produced and administered annually to account for seasonal variations. Since 2010, the Advisory Committee on Immunization Practices (ACIP) has recommended influenza vaccine for all Americans six months and older. To implement this recommendation, CDC works to educate providers and raise public awareness. CDC makes special efforts to reach high-risk individuals, such as pregnant women, and provides further outreach to subspecialty medical providers to increase vaccination of persons at especially high risk of severe illness or death from influenza. CDC also promotes vaccination at non-traditional venues, such as retail pharmacies, to increase access to vaccine services outside of clinic settings and hours.

Budget Request

CDC's FY 2015 request of **\$187,558,000** for influenza planning and response is \$15,000,000 above the FY 2014 Enacted level, reflecting a realignment of funding to CDC previously funded through pandemic influenza balances, to sustain critical international influenza activities.

⁶ <http://download.thelancet.com/flatcontentassets/H1N1-flu/epidemiology/epidemiology-14.pdf>

Influenza Prevention

In FY 2015, CDC will support efforts to prevent influenza through vaccination. CDC focuses on increasing demand with healthcare providers for influenza vaccination each season through investments in health communication with providers and the general public, targeted outreach to high-risk populations, and partnerships with pharmacists as a means to extend the reach of influenza vaccination. Annual vaccination campaigns help reach the Healthy People 2020 influenza vaccination goals, including those for minority and high-risk populations, and they also help build capacity for vaccination efforts in the event of an influenza pandemic.

To complement national efforts, resources will be available to all 64 immunization awardees to increase demand for seasonal influenza, including school-located vaccination clinics, and to improve influenza coverage rates among priority populations (school-aged children, high-risk adults, and racial and ethnic groups). CDC will measure vaccination coverage, with particular attention to racial and ethnic minority populations with historically low coverage rates. These surveys guide outreach efforts that result in improvement of influenza vaccination rates, particularly among children.

Detection and Monitoring of Influenza

Detection and monitoring of influenza involves a network of laboratories at the state level and internationally that are routinely testing samples to:

- Determine severity of the [influenza season](#)⁷
- Identify viruses that are causing disease and may pose a pandemic threat
- Determine the effectiveness of the influenza vaccine and other interventions

Ongoing work to improve laboratory and surveillance methods ensures that CDC can adequately respond to unusual cases. To build capacity for influenza surveillance, CDC continues to train public health laboratory workers at state laboratories that have similar responsibilities during foodborne outbreaks.

In FY 2015, CDC will serve as a World Health Organization (WHO) Collaborating Center to rapidly detect, identify, and characterize emerging influenza viruses so vaccine-candidate viruses used to produce vaccines for seasonal and novel viruses are rapidly selected. CDC receives and characterizes approximately 11,000 influenza virus specimens each year. The number of influenza virus specimens received and characterized fluctuates by year depending on the severity and burden of the disease. Worldwide characterization of these specimens is essential to the production of each season's influenza vaccine. It also aids in informing vaccine policies and recommendations as well as decisions regarding potential vaccines for novel viruses with pandemic potential. Effective influenza control depends on shortening the time between identification of novel influenza viruses and delivery of effective vaccines.

CDC will work with domestic and international partners in the intersection of human and animal health to improve surveillance, conduct swift outbreak responses, and complete threat assessments for emerging influenza viruses with pandemic potential. Pandemics emerge when a virus that is predominantly transmitted among animals develops the ability to be transmitted among humans. Each human case of infection with an animal influenza virus represents the potential for a pandemic. CDC will conduct research to understand better the complex factors that determine how and when these novel influenza viruses develop the ability to be transmitted from person to person.

Because novel influenza viruses can emerge anywhere in the world, CDC will support the international monitoring of influenza and evaluate countries' core capacities to conduct surveillance, perform laboratory testing, and prepare to respond to influenza pandemics. CDC's influenza program funds WHO regional offices as

⁷ <http://www.cdc.gov/flu/weekly/fluactivitysurv.htm>

well as partner nations through cooperative agreements. CDC will continue this support by funding 36 countries, with emphasis on countries that continue to experience animal outbreaks and human cases of H5N1 and H7N9 influenza. Core activities funded through these agreements include:

- Helping establish, expand, and maintain influenza surveillance and laboratory capacity
- Helping develop global and local pandemic plans and influenza prevention policies
- Supporting targeted research projects to address critical needs
- Building the evidence base for decisions on influenza vaccine program expansion

CDC's international support resulted in twice as many countries reporting to WHO FluNet since 2005 when the number of countries from which specimens were processed was 59; as of 2013, 121 countries report to WHO FluNet. CDC will work on expanding virus sample sharing among countries so that vaccines and diagnostic tests for viruses with pandemic potential can be produced.

Domestically, CDC will support the capability of state and local health departments to conduct influenza laboratory testing. CDC will provide training and consultation to maintain the number of public health laboratories able to perform testing for resistance to antiviral medications and to participate in CDC evaluations of new influenza diagnostic tests.

Supporting State/Municipality/Territorial Laboratory Capacity

The Epidemiology and Laboratory Capacity for Infectious Diseases cooperative agreement (ELC) assists states and eligible local public health agencies to strengthen their basic epidemiologic and laboratory capacity to address infectious disease threats. CDC funds 50 states, five municipalities, and one territory through the ELC to conduct influenza surveillance and diagnostic activities with funding from the Influenza Planning and Response budget line.

In FY 2015, public health departments will be funded to improve detection of novel human influenza virus infections, such as the H3N2v and H7N9 influenza virus. Rapid and thorough investigations determined the H3N2v virus caused 308 human cases in the United States in 2012. Collaboration between the state and local health authorities and CDC is essential for risk assessment and response to similar novel viruses. In addition, these funds support seasonal influenza surveillance consisting of eight different systems. This network of systems provides data on:

- Influenza viruses
- Outpatient influenza-like illness
- Influenza-associated hospitalizations
- Influenza-associated deaths
- Geographic distribution of the viruses

The network also forms the foundation for pandemic influenza surveillance.

CDC provides ELC awardees with the reporting websites and other materials necessary to report influenza surveillance data throughout the year from public health laboratories, outpatient influenza-like illness surveillance sites, and vital statistics offices. CDC updates awardees on the current influenza season and any pertinent developments in influenza surveillance during monthly conference calls, yearly in-person meetings, and individually as needed. Awardees also rely on CDC's epidemiologic, laboratory, and programmatic assistance during investigations of outbreaks or unusual cases of influenza (e.g., pediatric deaths, human infections with novel influenza A viruses, and antiviral resistant influenza infections or outbreaks).

Table: Influenza Planning and Response ELC Grants¹

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President's Budget	2015 +/-2014
Number of Awards	56	56	56	0
- New Awards	0	0	0	0
- Continuing Awards	56	56	56	0
Average Award	\$0.107	\$0.107	\$0.107	\$0.000
Range of Awards	\$0.016–\$0.232	\$0.016–\$0.232	\$0.016–\$0.232	N/A
Total Grant Awards	\$6.000	\$6.000	\$6.000	\$0.000

¹This table only reflects Influenza Planning and Response funding that goes out through the ELC, which also funds other infectious disease activities.

Response to Influenza Pandemics

In FY 2015, CDC will work to ensure the availability and effectiveness of medical countermeasures and equipment in the event of an influenza pandemic. Scientific experts will update or develop guidance that will inform purchasing countermeasure requirements. Examples of countermeasures include antiviral drugs, respirators or masks, and ventilators to assist patients with breathing. CDC will also develop and evaluate solutions to lessen the impact of an influenza pandemic through non-pharmaceutical interventions or actions that people and communities can take to help slow the spread of influenza. In addition, CDC is developing a nationwide system of triage call centers that would be activated during a severe pandemic to provide advice to ill individuals and thereby reduce the burden on hospitals, healthcare facilities, and public health departments. CDC is also collaborating with the National Association of County and City Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), and national associations that represent pharmacies, pharmacists, and pharmaceutical distributors on efforts to improve antiviral distribution and dispensing at the local level during a pandemic.

Domestically, CDC will sustain the nation’s ability to respond to influenza pandemics by ensuring well-trained staff are in place for pandemic response. CDC will also provide scientific and programmatic expertise to help CDC’s Public Health Emergency Preparedness (PHEP) Cooperative Agreement Program and HHS’ Hospital Preparedness Program (HPP) Cooperative Agreement awardees meet all hazard requirements of the Pandemic and All Hazards Preparedness Act of 2006 and the Pandemic and All Hazards Preparedness Reauthorization Act of 2013. CDC collaborates with awardees to determine their jurisdictional priorities for capability development and sustainment, along with related performance measures. The pandemic influenza capabilities include Public Health Surveillance & Epidemiological Investigation, Public Health Laboratory Testing, Medical Countermeasure Dispensing, and Emergency Operations Coordination. In addition, CDC will support planning efforts among health departments, hospitals, and emergency responders. Coordination among these groups will result in more integrated emergency response plans prior to a public health disaster to ensure a rapid, efficient, and effective response at the community level. CDC will test its response capabilities with federal, state, and local partners in FY 2015 with a functional exercise that implements an incident management system to test its response plans and evaluate improvements made based on lessons from previous responses and exercises.

Affordable Care Act Prevention and Public Health Fund

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President's Budget	2015 +/-2014
	ACA/PPHF	\$90.883	\$160.300	\$127.260	-\$33.040

The following activities are included:

Immunization – \$127,260,000

In FY 2015, CDC's request of \$127,260,000 will support immunization activities and advance modernization of CDC's immunization infrastructure and evidence base. CDC will also use these funds to support vaccine purchase, state operations, and communications.

State Table: Section 317^{1,2,3}

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Alabama	\$5,833,752	\$6,214,445	\$5,443,956	(\$770,489)
Alaska	\$1,863,849	\$2,009,077	\$1,841,630	(\$167,447)
Arizona	\$7,439,410	\$7,982,561	\$7,192,406	(\$790,156)
Arkansas	\$2,506,084	\$2,766,976	\$2,760,734	(\$6,242)
California	\$37,773,438	\$40,526,849	\$36,500,080	(\$4,026,769)
Colorado	\$5,215,590	\$5,596,400	\$5,042,506	(\$553,894)
Connecticut	\$4,275,620	\$4,553,272	\$3,984,026	(\$569,245)
Delaware	\$1,112,984	\$1,222,815	\$1,199,913	(\$22,902)
Florida	\$17,029,018	\$18,255,314	\$16,389,941	(\$1,865,373)
Georgia	\$10,410,735	\$11,122,048	\$9,853,597	(\$1,268,450)
Hawaii	\$1,706,822	\$1,874,057	\$1,834,944	(\$39,113)
Idaho	\$2,020,287	\$2,181,699	\$2,013,527	(\$168,172)
Illinois	\$8,632,443	\$9,260,330	\$8,335,560	(\$924,770)
Indiana	\$6,743,642	\$7,181,727	\$6,284,441	(\$897,285)
Iowa	\$3,473,622	\$3,735,236	\$3,392,997	(\$342,239)
Kansas	\$2,721,914	\$2,967,477	\$2,834,611	(\$132,866)
Kentucky	\$4,625,939	\$4,957,720	\$4,446,514	(\$511,206)
Louisiana	\$3,243,068	\$3,508,628	\$3,260,191	(\$248,437)
Maine	\$1,955,193	\$2,141,652	\$2,079,792	(\$61,860)
Maryland	\$4,678,669	\$5,068,235	\$4,731,341	(\$336,893)
Massachusetts	\$6,419,074	\$6,861,085	\$6,090,417	(\$770,668)
Michigan	\$10,019,759	\$10,707,937	\$9,499,061	(\$1,208,876)
Minnesota	\$6,066,385	\$6,462,180	\$5,660,699	(\$801,481)
Mississippi	\$3,177,308	\$3,444,030	\$3,222,467	(\$221,563)
Missouri	\$5,828,585	\$6,224,851	\$5,508,117	(\$716,734)
Montana	\$1,258,699	\$1,362,957	\$1,270,498	(\$92,459)
Nebraska	\$1,514,099	\$1,669,130	\$1,656,712	(\$12,418)
Nevada	\$3,360,632	\$3,576,504	\$3,121,200	(\$455,304)
New Hampshire	\$1,820,095	\$1,971,282	\$1,839,019	(\$132,264)
New Jersey	\$6,995,636	\$7,542,446	\$6,919,705	(\$622,740)
New Mexico	\$3,316,702	\$3,554,566	\$3,187,984	(\$366,582)
New York	\$10,648,034	\$11,425,742	\$10,295,774	(\$1,129,968)
North Carolina	\$9,513,696	\$10,140,830	\$8,905,326	(\$1,235,505)
North Dakota	\$1,226,769	\$1,325,557	\$1,226,020	(\$99,536)
Ohio	\$7,545,709	\$8,240,110	\$7,917,307	(\$322,803)
Oklahoma	\$4,572,731	\$4,887,083	\$4,336,344	(\$550,738)
Oregon	\$4,146,886	\$4,451,616	\$4,017,721	(\$433,895)
Pennsylvania	\$10,325,708	\$10,993,573	\$9,609,931	(\$1,383,642)
Rhode Island	\$2,444,430	\$2,573,801	\$2,150,399	(\$423,402)
South Carolina	\$3,991,840	\$4,327,064	\$4,049,123	(\$277,941)
South Dakota	\$1,967,913	\$2,086,848	\$1,795,298	(\$291,550)
Tennessee	\$5,700,561	\$6,156,546	\$5,683,800	(\$472,746)
Texas	\$26,586,167	\$28,275,887	\$24,613,711	(\$3,662,176)
Utah	\$2,622,318	\$2,866,876	\$2,765,492	(\$101,384)
Vermont	\$1,651,286	\$1,755,316	\$1,524,789	(\$230,527)
Virginia	\$6,524,259	\$7,037,689	\$6,468,471	(\$569,218)
Washington	\$11,164,084	\$11,683,913	\$9,513,226	(\$2,170,687)
West Virginia	\$2,495,875	\$2,659,060	\$2,330,460	(\$328,601)
Wisconsin	\$4,741,318	\$5,136,778	\$4,797,633	(\$339,145)
Wyoming	\$1,025,361	\$1,111,413	\$1,039,834	(\$71,578)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Cities				
Chicago	\$4,413,665	\$4,753,587	\$4,343,778	(\$409,808)
District of Columbia	\$1,889,359	\$2,024,612	\$1,814,968	(\$209,644)
Houston ⁴	\$2,093,920	\$2,313,468	\$2,313,468	\$0
New York City	\$11,293,512	\$12,018,910	\$10,488,686	(\$1,530,224)
Philadelphia	\$2,334,242	\$2,513,544	\$2,295,238	(\$218,306)
San Antonio	\$1,614,984	\$1,784,315	\$1,784,315	\$0
Territories				
American Samoa	\$571,757	\$624,324	\$599,698	(\$24,626)
Guam	\$1,443,584	\$1,562,581	\$1,454,627	(\$107,954)
Marshall Islands	\$2,602,083	\$2,729,450	\$2,244,218	(\$485,232)
Micronesia	\$3,289,921	\$3,438,943	\$2,785,374	(\$653,569)
Northern Mariana Islands	\$990,066	\$1,076,144	\$1,016,998	(\$59,145)
Puerto Rico	\$4,131,722	\$4,425,048	\$3,958,418	(\$466,630)
Republic Of Palau	\$657,388	\$686,369	\$553,117	(\$133,252)
Virgin Islands	\$877,964	\$969,518	\$967,849	(\$1,670)
Subtotal States	\$301,933,998	\$323,639,188	\$290,439,246	(\$33,199,941)
Subtotal Cities	\$23,639,682	\$25,408,436	\$23,040,454	(\$2,367,981)
Subtotal Territories	\$14,564,484	\$15,512,377	\$13,580,300	(\$1,932,077)
Total States/Cities/Territories	\$340,138,164	\$364,560,000	\$327,060,000	(\$37,500,000)
Total Resources ⁵	\$340,138,164	\$364,560,000	\$327,060,000	(\$37,500,000)

¹CFDA NUMBER: 93.268, Discretionary

²This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial awardees). For a more comprehensive view of grant and cooperative agreement funding to awardees by jurisdiction, visit <http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

³Includes vaccine direct assistance and immunization infrastructure/operations grant funding.

⁴Immunization infrastructure/operations grant funding only; vaccine direct assistance for Houston is included with Texas.

⁵FY 2013 does not include American Recovery and Reinvestment Act funding.

State Table: Vaccines for Children^{1,2}

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Alabama	\$56,480,869	\$55,503,655	\$63,908,549	\$8,404,894
Alaska	\$9,635,069	\$9,528,889	\$10,832,058	\$1,303,169
Arizona	\$76,815,180	\$75,503,701	\$86,910,216	\$11,406,515
Arkansas	\$38,776,731	\$38,113,053	\$43,873,392	\$5,760,339
California	\$395,749,600	\$388,903,954	\$447,793,221	\$58,889,267
Colorado	\$38,751,336	\$38,112,510	\$43,835,247	\$5,722,737
Connecticut	\$36,126,110	\$35,556,976	\$40,855,428	\$5,298,452
Delaware	\$10,160,517	\$10,019,996	\$11,483,108	\$1,463,112
Florida	\$190,047,629	\$186,741,648	\$215,047,267	\$28,305,619
Georgia	\$112,149,029	\$110,227,374	\$126,890,299	\$16,662,925
Hawaii	\$13,271,873	\$13,134,327	\$14,981,736	\$1,847,409
Idaho	\$17,253,847	\$16,972,510	\$19,516,241	\$2,543,731
Illinois	\$82,440,747	\$81,061,867	\$93,264,053	\$12,202,185
Indiana	\$56,168,536	\$55,232,545	\$63,541,335	\$8,308,790
Iowa	\$25,459,312	\$25,055,898	\$28,793,121	\$3,737,223
Kansas	\$25,100,585	\$24,691,598	\$28,391,760	\$3,700,162
Kentucky	\$45,329,520	\$44,543,423	\$51,291,412	\$6,747,989
Louisiana	\$59,606,211	\$58,567,700	\$67,447,683	\$8,879,983
Maine	\$13,332,807	\$13,159,597	\$15,064,023	\$1,904,426
Maryland	\$57,260,228	\$56,278,931	\$64,786,777	\$8,507,846
Massachusetts	\$60,097,368	\$59,105,102	\$67,982,329	\$8,877,227
Michigan	\$87,070,772	\$85,611,128	\$98,503,215	\$12,892,087
Minnesota	\$35,413,642	\$34,837,939	\$40,056,548	\$5,218,609
Mississippi	\$38,407,046	\$37,748,990	\$43,455,389	\$5,706,399
Missouri	\$54,529,466	\$53,596,597	\$61,696,442	\$8,099,845
Montana	\$7,945,902	\$7,831,514	\$8,981,951	\$1,150,436
Nebraska	\$15,702,174	\$15,449,711	\$17,759,728	\$2,310,017
Nevada	\$30,580,333	\$30,090,034	\$34,586,935	\$4,496,901
New Hampshire	\$7,844,209	\$7,746,415	\$8,861,166	\$1,114,751
New Jersey	\$65,262,420	\$64,206,747	\$73,816,621	\$9,609,873
New Mexico	\$37,809,847	\$37,188,752	\$42,769,390	\$5,580,637
New York	\$81,509,311	\$80,258,276	\$92,167,058	\$11,908,782
North Carolina	\$97,830,488	\$96,174,862	\$110,681,705	\$14,506,842
North Dakota	\$5,817,870	\$5,737,555	\$6,575,123	\$837,568
Ohio	\$96,605,322	\$94,905,164	\$109,320,757	\$14,415,593
Oklahoma	\$55,506,364	\$54,578,319	\$62,793,436	\$8,215,117
Oregon	\$29,694,871	\$29,232,996	\$33,579,977	\$4,346,981
Pennsylvania	\$75,883,810	\$74,685,452	\$85,818,970	\$11,133,518
Rhode Island	\$11,489,779	\$11,329,972	\$12,985,749	\$1,655,777
South Carolina	\$54,678,305	\$53,770,769	\$61,854,097	\$8,083,328
South Dakota	\$8,884,996	\$8,750,693	\$10,045,956	\$1,295,263
Tennessee	\$67,475,729	\$66,311,935	\$76,347,913	\$10,035,978
Texas	\$341,895,457	\$335,953,207	\$386,867,770	\$50,914,564
Utah	\$23,743,669	\$23,373,740	\$26,850,393	\$3,476,653
Vermont	\$6,444,135	\$6,380,466	\$7,273,156	\$892,690
Virginia	\$56,399,837	\$55,415,767	\$63,820,043	\$8,404,276
Washington	\$77,036,739	\$75,834,244	\$87,117,426	\$11,283,182
West Virginia	\$18,964,144	\$18,656,407	\$21,450,226	\$2,793,819
Wisconsin	\$39,461,011	\$38,805,384	\$44,639,993	\$5,834,609
Wyoming	\$4,852,621	\$4,792,896	\$5,481,439	\$688,543
Cities				

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Chicago	\$47,140,519	\$46,388,826	\$53,315,232	\$6,926,406
District of Columbia	\$9,540,336	\$9,412,395	\$10,780,655	\$1,368,261
Houston ³	\$716,881	\$758,914	\$790,173	\$31,259
New York City	\$119,356,770	\$117,328,255	\$135,039,035	\$17,710,780
Philadelphia	\$25,348,430	\$24,977,664	\$28,655,812	\$3,678,149
San Antonio	\$654,962	\$693,364	\$721,923	\$28,559
Territories				
American Samoa	\$1,444,466	\$1,422,920	\$1,631,131	\$208,210
Guam	\$2,610,984	\$2,589,453	\$2,938,030	\$348,577
Northern Mariana Islands	\$1,377,466	\$1,362,275	\$1,552,269	\$189,994
Puerto Rico	\$45,776,691	\$45,032,857	\$51,778,116	\$6,745,258
Virgin Islands	\$2,179,170	\$2,190,369	\$2,446,898	\$256,528
Subtotal States	\$2,954,753,375	\$2,905,271,184	\$3,342,647,824	\$437,376,640
Subtotal Cities	\$202,757,897	\$199,559,418	\$229,302,831	\$29,743,413
Subtotal Territories	\$53,388,776	\$52,597,874	\$60,346,443	\$7,748,568
Total States/Cities/Territories	\$3,210,900,049	\$3,157,428,477	\$3,632,297,098	\$474,868,621
Other Adjustments ⁴	\$396,115,671	\$405,041,523	\$444,319,902	\$39,278,379
Total Resources⁵	\$3,607,015,720	\$3,562,470,000	\$4,076,617,000	\$514,147,000

¹CFDA Number: 93.268, Mandatory

²This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

³Funding for Houston only includes funding for operations, not the cost of vaccines. Funding for Texas includes the cost of vaccines for Houston.

⁴Other adjustments include vaccine that is in inventory at the centralized distribution center but has not been ordered by immunization providers, funds for centralized vaccine distribution activities, developing a new centralized vaccine ordering system, pediatric stockpile, influenza stockpile, stockpile storage and rotation, and program support services.

⁵Total resources for FY 2013 reflect Actuals; total resources for FY 2014 and FY 2015 are based on the OMB-approved FY 2015 VFC PB 10 Year Table.