

**IMMUNIZATION AND RESPIRATORY DISEASES**

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	\$479.049	\$576.083	\$583.855	+\$7.772
PHS Evaluation Transfer	\$12.864	\$12.864	\$13.765	+\$0.901
PHSSEF Transfer	\$156.344	\$0.000	\$51.049	+\$51.049
ACA/PPHF	\$100.000	\$190.000	\$72.460	-\$117.540
<b>Total</b>	<b>\$748.257</b>	<b>\$778.947</b>	<b>\$721.129</b>	<b>-\$57.818</b>
FTEs	669	666	666	0

**Authorizing Legislation:** PHSA §§ 301, 307, 310, 311, 317, 317(a), 317(j), 317(k), 317(l), 317(m), 317N, 317S, 319, 319C, 319E, 319F, 322, 325, 327, 340C, 352, 2102(a)(6), 2102(a)(7), 2125, 2126, 2127, 2821; Immigration and Nationality Act §§ 212 (8 U.S.C. 1182), 232 (8 U.S.C. 1222); Social Security Act § 1928 (42 U.S.C. 1396s); Pandemic and All-Hazards Preparedness Act of 2006 (P.L. 109-417)

**FY 2013 Authorization**.....Expired/Indefinite

**Allocation Methods:** Direct Federal/Intramural; Competitive Cooperative Agreements/Grants, including Formula Grants; Contracts; and Other

**SUMMARY**

CDC's FY 2013 request of \$721,129,000 for immunization and respiratory diseases, including \$72,460,000 from the Affordable Care Act Prevention and Public Health Fund, \$51,049,000 from the Public Health and Social Services Emergency Fund, and \$13,765,000 in PHS Evaluation resources, is an overall decrease of \$57,818,000 below the FY 2012 level. The FY 2013 request includes a decrease of \$57,986,000 for the Section 317 Immunization Program.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Section 317 Immunization	\$425.571	\$367.870	\$426.839	+\$58.969
Program Implementation	\$63.005	\$62.302	\$62.887	+\$0.585
PHS Eval Transfer (non-add)	\$12.864	\$12.864	\$13.765	+\$0.901
Influenza Planning and Response	\$159.681	\$158.775	\$158.943	+\$0.168
PHSSEF Transfer (non-add)	\$156.344	\$0.000	\$51.049	+\$51.049
ACA/PPHF	\$100.000	\$190.000	\$72.460	-\$117.540
<b>Total</b>	<b>\$748.257</b>	<b>\$778.947</b>	<b>\$721.129</b>	<b>-\$57.818</b>

CDC focuses on the prevention of disease, disability, and death of children, adolescents, and adults through immunization and by control of respiratory and related diseases. Childhood vaccination coverage rates are at near record high levels, and as a result, cases of most vaccine-preventable diseases in the United States are at or near record lows. Maintaining and enhancing high vaccination coverage is critical for preventing recurrent epidemics of diseases that could result in preventable illness, disability, and death. For example, the over 200 measles cases in 2011 that were primarily import-related and the outbreaks of pertussis in the United States serve as reminders that we must maintain high coverage rates in order to keep disease rates low. In addition, acute respiratory infections are a critical public health, humanitarian, and security concern. CDC provides technical expertise in implementing immunization programs; preparedness planning for pandemic influenza; and epidemiology and laboratory capacity to detect, prevent, and respond to vaccine-preventable, respiratory, and related infectious disease threats.

- CDC administers the two primary federal programs that support immunization for the underinsured and uninsured populations in the United States—the discretionary Section 317 Immunization Program and the mandatory Vaccines for Children (VFC) Program.
- CDC ensures a safe and effective vaccine delivery system by providing core support for state and local program operations and infrastructure via Section 317 funding. This infrastructure is critical to support successful VFC Program implementation.
- CDC invests in disease surveillance, laboratory capacity, and scientific studies to evaluate vaccine effectiveness and program impact to provide essential information to inform the nation’s immunization policies and programs.
- CDC is the nation’s lead public health agency for maintaining a safe, effective vaccine supply for all children, adolescents, and adults in the United States by monitoring vaccine safety and conducting research to address gaps in scientific knowledge about vaccine-associated adverse events.
- CDC’s public health surveillance, laboratory infrastructure, and response capacity protect against existing and emerging respiratory diseases, including influenza and pneumonia, that threaten the health and safety of every person in the country.

Through these investments, CDC aims to prevent vaccine-preventable diseases by assuring high immunization coverage levels, and to control respiratory and related diseases such as influenza.

**FUNDING HISTORY<sup>1</sup>**

<b>Section 317 Immunization</b>	
<b>Fiscal Year</b>	<b>Dollars (in millions)</b>
2003	\$502.765
2004	\$468.789
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	\$430.172
2012 (ACA/PPHF)	\$190.000

<b>Immunization and Respiratory Diseases</b>	
<b>Fiscal Year</b>	<b>Dollars (in millions)</b>
2008	\$684.634
2009 <sup>2</sup>	\$716.048
2010	\$721.180
2011	\$648.257
2011 (ACA/PPHF)	\$100.000
2012	\$588.947

<b>Immunization and Respiratory Diseases</b>	
<b>Fiscal Year</b>	<b>Dollars (in millions)</b>
2012 (ACA/PPHF)	\$190.000

<sup>1</sup>Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

<sup>2</sup>Amount does not include \$200,000,000 for Pandemic Influenza from the Public Health and Social Services Emergency Fund.

The table below reflects the sources of VFC funding and estimates of total VFC obligations. The FY 2013 estimate is a net increase of \$261,955,000 above the FY 2012 estimate. The FY 2013 estimate includes an increase for vaccine purchase and a decrease for vaccine management business improvement plan contractual support. The increase in vaccine purchase is based on price and forecast changes for vaccines.

<b>VFC</b>	<b>FY 2011 Actual</b>	<b>FY 2012 Estimate</b>	<b>FY 2013 Estimate</b>
Unobligated Balances Brought Forward/Recoveries	\$7M	\$3M <sup>2</sup>	N/A
Non-expenditure Transfer from CMS	\$3,937M	\$4,006M	\$4,271M
<b>Total VFC Obligations<sup>1</sup></b>	<b>\$3,953M</b>	<b>\$4,009M</b>	<b>\$4,271M</b>

<sup>1</sup>In FY 2011, total VFC obligations did not equal total available resources.

<sup>2</sup>Unobligated balances were returned to the Centers for Medicare & Medicaid Services (CMS). Amount reflects prior year recoveries and refunds. The FY 2013 net increase of estimated total obligations, inclusive of prior year recoveries and refunds brought into FY 2012, totals \$261,955,000; the FY 2013 net increase of the non-expenditure transfer from CMS, exclusive of prior year recoveries and refunds brought into FY 2012, totals \$265,074,280.

**SECTION 317 IMMUNIZATION PROGRAM AND PROGRAM IMPLEMENTATION AND ACCOUNTABILITY BUDGET REQUEST**

<b>(dollars in millions)</b>	<b>FY 2011 Appropriation</b>	<b>FY 2012 Enacted</b>	<b>FY 2013 President's Budget</b>	<b>FY 2013 +/- FY 2012</b>
Budget Authority	\$475.712	\$417.308	\$475.961	+\$58.653
PHS Evaluation Transfer	\$12.864	\$12.864	\$13.765	+\$0.901
ACA/PPHF	\$100.000	\$190.000	\$72.460	-\$117.540
<b>Total</b>	<b>\$588.576</b>	<b>\$620.172</b>	<b>\$562.186</b>	<b>-\$57.986</b>

**Program Overview:** The Section 317 Immunization Program aims to improve access to immunization services by funding the purchase and delivery of vaccines to vulnerable populations, including underinsured children and adolescents, underinsured and uninsured adults, and special populations at high risk for vaccine-preventable diseases. Section 317 provides evidence-based recommendations, technical assistance, capacity-building, and infrastructure support for 64 grantees, including the 50 states, six large cities (including Washington, D.C.), and eight territories and former territories to implement immunization programs.

The passage and implementation of the Affordable Care Act (ACA) includes new prevention provisions that create health insurance reforms. Since September 23, 2010, new health plans are required to cover recommended preventive services without charging a deductible, copayment, or coinsurance. This reform includes coverage of vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) when these services are provided by an in-network provider. In 2011, HHS estimated that 41 million people enrolled in new health plans benefitted from these new prevention provisions. This estimate is expected to increase to 88 million by 2013. As health reform expands prevention services, the

size of the uninsured and underinsured populations served by Section 317 is expected to be reduced and cost savings to Section 317 Vaccine Purchase are likely to occur. Savings will also be realized from Section 317 billing projects that will fund additional state and local health department clinics to develop the capacity to bill health insurance plans for services provided to insured members. These savings will be used by states to increase outreach to at-risk populations with unmet needs, as prioritized by each state.

A strong public health infrastructure is vital to ensuring high vaccination coverage levels and low incidence of vaccine-preventable diseases, as well as maintaining adequate public health preparedness for response to a vaccine-preventable national emergency, such as a pandemic or biologic attack. Regardless of whether a vaccine is publically or privately purchased, public health at the federal, state, and local levels plays a critical role in ensuring a safe and effective national immunization system. Ongoing safety monitoring, vaccine effectiveness studies, and coverage assessments help to ensure maximum impact of immunization policies, programs, and investments.

CDC's post-licensure immunization safety activities include: monitoring adverse events following immunization, evaluating adverse events that result in a safety concern to assess the possibility of causal association with immunization, assessing risk factors for specific adverse events, and communicating vaccine risks and benefits to health care providers and the public. A robust and transparent immunization safety monitoring and research system must exist to ensure safe and effective vaccines and maintain public confidence in immunizations.

Recent accomplishments:

- Documented increases in adolescent vaccination coverage rates through the National Immunization Survey-Teen. Vaccination coverage among adolescents aged 13 through 15 years increased for all three of the routinely administered adolescent vaccines from 2009 to 2010: Tetanus, Diphtheria, Pertussis (Tdap) from 62 percent to 74 percent; meningococcal conjugate vaccine (MCV) from 55 percent to 65 percent; and for girls who received at least one dose of human papillomavirus (HPV) vaccine from 41 percent to 46 percent.
- Enhanced interoperability of Electronic Health Records (EHRs) and Immunization Information Systems (IIS) by funding 20 Section 317 immunization grantees with Health Information Technology for Economic and Clinical Health (HITECH) and American Recovery and Reinvestment Act (ARRA) funds, which allowed more than 80 percent of grantees to reach full compliance with Health Level Seven (HL7) messaging standards for immunization data transactions. HL7 messaging standards are recommended by the National Vaccine Advisory Committee as one of the core IIS functions or minimum functional standards for data exchange.
- Documented that in the 2007–2009 timeframe, after introduction of rotavirus vaccine in 2006, there was a reduction of nearly 65,000 hospitalizations from diarrhea and direct medical savings of approximately \$280 million. The sustained declines in diarrhea hospitalizations and costs reaffirm the benefits of the U.S. rotavirus vaccination program.
- Provided critical scientific evidence that informed the ACIP's new adolescent recommendation for a booster dose of meningococcal conjugate vaccine (MCV4) at age 16 to assure protection through the high-risk college years. CDC's vaccine effectiveness study demonstrated declining effectiveness of MCV4 within three years of vaccination.
- Assessed a potential safety concern regarding increased risk of febrile seizures in young children associated with the 2010–2011 trivalent inactivated influenza vaccine; preliminary findings of this rapid assessment were presented at the February 2011 ACIP meeting for discussion and consideration of next steps.

**Budget Proposal:** CDC's FY 2013 request of \$562,186,000 for the Section 317 Immunization Program and immunization program implementation and accountability, including \$72,460,000 from the

Affordable Care Act Prevention and Public Health Fund and \$13,765,000 in PHS Evaluation resources, is an overall decrease of \$57,986,000 below the FY 2012 level. This represents reductions from one-time investments supported by the Prevention and Public Health Fund (PPHF). The FY 2013 budget request will continue to provide vaccine purchase for at-need populations, immunization program operations—including support for implementing billing systems for immunization services at public health clinics to sustain high levels of vaccine coverage, and support for the scientific evidence base informing immunization policies. Health reform expansion will further increase access to immunizations and decrease the number of uninsured and underinsured individuals served by the Section 317 Program, resulting in cost savings. FY 2011 and FY 2012 funding supported activities to assist with the transition to full implementation of the health insurance reforms, such as IIS and adult immunization. FY 2013 PPHF funding includes \$25,000,000 to continue progress with public health departments directly billing insurers for immunization services. The FY 2013 request also includes an increase of \$901,000 in PHS Evaluation resources for the National Immunization Survey.

In FY 2013, CDC will:

- Support immunization for priority populations served in non-traditional venues, such as pharmacies and retail-based clinics where providers can appropriately bill insurers.
- Expand the billables program to allow public health departments to have the capacity to bill private insurers for immunization services. This will help public health departments in transitioning to health reform by 2014.
- Continue to provide funding and technical assistance to immunization grantees to 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.
- Increase national public awareness and provider knowledge about vaccine-preventable diseases and immunization recommendations using an array of media and culturally appropriate tools and resources to support informed decision-making about vaccination.
- Improve methods to assess vaccination coverage levels across the lifespan to identify groups at risk of vaccine-preventable diseases, monitor racial and ethnic disparities in vaccine coverage, evaluate the effectiveness of programs designed to increase coverage levels, monitor uptake of new vaccines, assess differential impact of vaccine shortages, measure performance by various types of providers, and provide greater understanding of socio-demographic and attitudinal factors associated with vaccination.
- Strengthen the scientific evidence base for the nation's immunization policies and programs through investments in disease surveillance, laboratory capacity, outbreak response, and scientific studies to evaluate vaccine effectiveness and program impact.
- Continue to ensure a safe immunization program through the implementation of CDC's vaccine safety priority studies, strengthening vaccine safety surveillance capacity for rare, immunization-associated vaccine adverse events, improvement of adverse-event reporting through electronic reporting, and the development of vaccine safety profiles for each newly licensed vaccine in collaboration with the Food and Drug Administration (FDA) to support FDA's mandates.

**Section 317 Immunization Grant Table** <sup>1,2</sup>

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	64	64	64
Average Award	\$7.477	\$8.032	\$7.188
Range of Awards	\$0.404–\$54.582	\$0.484–\$63.099	\$0.433–\$56.457

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of New Awards	0	0	0
Number of Continuing Awards	64	64	64

<sup>1</sup>This table includes Section 317 budget authority and Prevention and Public Health Funds.

<sup>2</sup>Includes immunization operations grants and vaccine direct assistance.

**INFLUENZA PLANNING AND RESPONSE BUDGET REQUEST**

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	\$3.337	\$158.775	\$107.894	-\$50.881
PHSSEF Transfer	\$156.344	\$0.000	\$51.049	+\$51.049
<b>Total</b>	<b>\$159.681</b>	<b>\$158.775</b>	<b>\$158.943</b>	<b>+\$0.168</b>

Program Overview: Seasonal influenza remains a formidable public health challenge due to the substantial health and economic burden throughout the world and the potential for rapid emergence and spread of new influenza virus strains. Influenza seasons are unpredictable in timing and severity. Over a period of 30 years, between 1976 and 2006, annual estimates of influenza-associated deaths in the United States range from a low of about 3,000 to a high of about 49,000 people, with an average of more than 200,000 hospitalizations per year. A study published in 2007 estimated that seasonal influenza contributed an estimated \$10.4 billion annually in direct medical costs in the United States.<sup>1</sup>

The 2009 H1N1 influenza pandemic demonstrated that threats of pandemics from novel influenza viruses against which few people have natural immunity represent a critical on-going public health hazard. The United States was fortunate in 2009. Systems in the United States and substantial international investments in influenza surveillance and diagnostics, put in place largely with U.S. Government funding, discovered the disease and identified the virus quickly, produced an effective vaccine in record time, and made antiviral medications widely available. Public health measures substantially mitigated the health impact of the pandemic, particularly among those younger than 65 years of age, including pregnant women. The United States was also fortunate that many older adults had existing immunity to the virus. However, influenza viruses are constantly evolving, and the next pandemic could present more serious challenges and could occur at any time.

CDC maintains a wide, diverse network that supports core capabilities to protect the public from influenza, including international partners, policymakers, tribal leaders, state and local health departments, the medical community, private sector partners, academic institutions, and other parts of the federal government. The program supports influenza prevention and control in all U.S. states, the Global Influenza Surveillance and Response System, the United Nations Global Initiative to Combat Avian Influenza, and the Global Initiative on Sharing All Influenza Data. Funding supports activities in CDC's global health, public health scientific services, vaccine coverage and safety monitoring, vaccine distribution, health care surge planning, and quarantine programs.

---

<sup>1</sup>Molinari NA, Ortega-Sanchez IR, Messonnier ML, Thompson WW, Wortley PM, Weintraub E, et al. "The Annual Impact of Seasonal Influenza in the US: Measuring Disease Burden and Costs". *Vaccine* 2007 Jun 28;25(27):5086-96. Epub 2007 Apr 20.

CDC works to improve influenza prevention, control, monitoring, and response by developing and deploying vaccines to prevent disease and antiviral medications to treat illness, using its surveillance and laboratory capabilities to determine which viruses pose a pandemic threat, what viruses are causing disease, and the effectiveness of these interventions. CDC evaluates interventions and educates health care providers and the public to improve acceptance of public health interventions. The impact of CDC's focus on influenza to build generic international health capacity is substantial. Globally, public health is applying these influenza accomplishments to support diagnosis, response, and surveillance for other infectious diseases, as well as disaster events. For example, in building capacity for influenza, CDC has helped develop capacity and technical competence in the same laboratories that have also been activated to support work during Ebola outbreaks and anthrax diagnoses.

Recent accomplishments:

- Data from surveys with pregnant women have shown that the most significant motivator for women to be vaccinated against influenza is the recommendation and offer of vaccine by their obstetricians. During the 2009 H1N1 pandemic, CDC worked closely with professional obstetric provider groups to encourage vaccination of pregnant women. As a result, vaccination among pregnant women increased from less than 15 percent before the pandemic to nearly 50 percent during the 2009–2010 (pandemic) season, and these gains were sustained during the 2010–2011 season. During the 2011–2012 influenza season, CDC is building on this successful effort by continuing to work with these professional organizations with the goal of making influenza vaccination a part of routine obstetric care.
- Utilized new systems during the 2010–2011 and 2011–2012 influenza seasons to monitor vaccine coverage. These systems have allowed public information about vaccine knowledge and coverage among the U.S. population to be shared in early December—earlier than information has been available in past seasons—resulting in opportunities for increased awareness in local areas and with important groups such as pregnant women and health care personnel.
- Distributed influenza test reagents to record numbers of state public health laboratories, Department of Defense laboratories, and over 100 National Influenza Centers globally during the 2011–2012 influenza season in the Northern and Southern Hemispheres to monitor influenza disease, develop new vaccine candidates, and detect emerging influenza viruses with pandemic potential.
- Enhanced preparedness and response capabilities globally through activities in more than 40 countries, including cooperative agreements with in-country and international partners, intramural research, and technical support. Assessment and review tools show that significant improvements from 2008–2010 continue for 2011 for critical capabilities such as clinical management guidance, resource management for antiviral treatment and personal protective equipment, and communicating surveillance information. Assessment and review tools include: the International Influenza Laboratory Capacity Review Tool, the International Influenza Surveillance Assessment Tool, and the National Inventory of Core Capabilities for Pandemic Influenza Preparedness and Response which will be formally reported next in FY 2012.

Budget Proposal: CDC's FY 2013 request of \$158,943,000 for influenza planning and response, including \$51,049,000 from the Public Health and Social Services Emergency Fund, is an increase of \$168,000 above the FY 2012 level.

### ***Influenza Prevention and Response to Outbreaks***

In FY 2013, CDC will:

- Continue promotion of the 2010–2011 ACIP influenza season recommendation that every American six months and older be vaccinated. Vaccination is the primary means of preventing influenza.
- Determine optimal vaccine strategies that incorporate new vaccine approaches.
- Promote vaccination through traditional primary care settings and clinics, while expanding support for school-located vaccination activities. CDC will continue special efforts to reach high-risk individuals, such as pregnant women, and provide further outreach to subspecialty medical providers to increase vaccination of persons at especially high risk of severe illness or death from influenza.
- Extend the reach of vaccination by working with partners to promote non-traditional venues as vaccination sites. CDC is accomplishing this through initiatives with non-traditional vaccine providers, such as retail pharmacies and other commercial sites, to extend the efforts of clinicians and to increase access to vaccine services outside of typical clinic hours.
- Capitalize on the progress made since FY 2010 in increasing influenza vaccination among vulnerable and special populations, including expanded efforts to increase influenza vaccination among minority populations. In addition, CDC will work to capitalize on influenza vaccination efforts and systems to improve the coverage of recommended vaccines for other diseases.
- Improve U.S. health security by providing support to other countries and international partners to expand influenza immunization globally in conjunction with increased global vaccine production capacity and supply.
- Refine and implement recommended interventions and countermeasures in addition to vaccines and antiviral medications to protect individuals from influenza, such as promoting hand washing and covering coughs and sneezes. Interventions and countermeasures for an influenza pandemic also could include promoting social distancing when one is sick with influenza-like symptoms, and developing a nationwide system of nurse triage/call centers to reduce burden on hospitals, health care facilities, and public health facilities.
- Sustain the nation’s ability to respond to influenza pandemics by ensuring that well-trained staff are in place for pandemic response, and by providing technical assistance where feasible to help CDC’s Public Health Emergency Preparedness (PHEP) Cooperative Agreement and HHS’ Hospital Preparedness Program (HPP) Cooperative Agreement grantees meet all hazard requirements of the Pandemic and All Hazards Preparedness Act.

### ***Detection and Monitoring of Influenza***

In FY 2013, CDC will:

- Improve CDC's ability as a World Health Organization (WHO) Collaborating Center to rapidly detect, identify, and characterize emerging influenza viruses so that seed strains used to produce vaccines for seasonal and novel viruses can be selected rapidly and with precision. A crucial ingredient of effective influenza control is to shorten the interval between the identification of novel influenza viruses and the delivery of effective vaccines. CDC will accomplish this by:
  - Improving the use of new diagnostics at public health laboratories;
  - Working with the FDA to bring new point-of-care influenza virus detection tests to clinician offices; and
  - Promoting use of national electronic messaging standards for automated reporting of influenza laboratory data.



- Provide support to states, territories, and countries through the Epidemiology and Laboratory Capacity (ELC) grant for enhanced surveillance and laboratory testing capacity of influenza viruses. This activity determines which influenza viruses are circulating, identifies and prepares viruses for use in vaccines, monitors for vaccine mismatch during influenza seasons, detects the emergence of novel influenza strains, and determines the effectiveness of antiviral drug treatment for circulating viruses.
- Enhance the capability of state and local health departments to conduct influenza laboratory testing by increasing the number of public health laboratories that can perform testing for resistance to antiviral medications from 12 in FY 2012 to 15 in FY 2013, and maintaining the number of state and local laboratories that participate in CDC evaluations of new influenza diagnostic tests.
- Continue 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.
- Monitor influenza viruses and infections to:
  - Determine the health security and economic impacts of influenza-associated clinic visits, hospitalizations, and deaths; and
  - Refine methods to demonstrate the health security and economic impacts of annual influenza recommendations.
- Conduct research to better understand the complex factors that determine how influenza is transmitted and causes illness.
- Support the international monitoring of influenza and continue to evaluate countries' core capacities to conduct surveillance, perform laboratory testing, and prepare for and be ready to respond to influenza pandemics that can occur at any time. CDC will place special emphasis on expanded virus sample sharing among countries to produce vaccines and develop tests to detect influenza viruses that have pandemic potential.

### ***Education of Health Care Providers and the Public***

In FY 2013, CDC will:

- Continue effective influenza communication and education that is crucial for successful preparedness for and response to seasonal and pandemic influenza. CDC will lead efforts to improve clinician and public awareness and acceptance of CDC's influenza prevention, testing, and treatment recommendations.
- Strengthen communication and education strategies to reach vulnerable populations, including pregnant women and others with special needs.

**AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND**

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
ACA/PPHF	\$100.000	\$190.000	\$72.460	-\$117.540

The following activities are included:

- Immunization – \$72,460,000 (included in the Immunization narrative)

**PERFORMANCE**

Efficiency Measure for the National Center for Immunization and Respiratory Diseases

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
<u>1.E.1</u> : Make vaccine distribution more efficient and improve availability of vaccine inventory by reducing the number of vaccine inventory depots in the U.S. (Efficiency)	FY 2011: 98% reduction (Target Met)	Maintain 98% reduction in inventory depots	Maintain 98% reduction in inventory depots	Maintain

***Program: Section 317 Immunization Program and Program Implementation and Accountability***

Performance Measures for Long Term Objective: Ensure that children and adolescents are appropriately vaccinated.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
<u>1.2.1c</u> : Sustain immunization coverage in children 19 to 35 months of age for one dose of Measles, Mumps, and Rubella (MMR) vaccine (Intermediate Outcome)	FY 2010: 92% (Target Exceeded)	90%	90%	Maintain
<u>1.2.1h</u> : Achieve immunization coverage of at least 90% in children 19-35 months of age for at least 4 doses pneumococcal conjugate vaccine (Intermediate Outcome)	FY 2010: 83% (Target Not Met but Improved)	90%	87%	-3%
<u>1.2.1i</u> : Achieve immunization coverage of at least 60% in children 19- to 35-months of age for 2-3 doses of rotavirus (Intermediate Outcome)	FY 2010: 59% (Target Exceeded)	60%	60%	Maintain
<u>1.2.2a</u> : Achieve or sustain immunization coverage of at least 70% in adolescents 13 to 15 years of age for 1 dose Tdap (tetanus and diphtheria toxoids and acellular pertussis) (Intermediate Outcome)	FY 2010: 74% (Target Exceeded)	70%	73%	+3%

NARRATIVE BY ACTIVITY  
IMMUNIZATION AND RESPIRATORY DISEASES  
BUDGET REQUEST

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
<u>1.2.2b</u> : Achieve or sustain immunization coverage of at least 70% in adolescents 13 to 15 years of age for 1 dose meningococcal conjugate vaccine (MCV4) (Intermediate Outcome)	FY 2010: 65% (Target Exceeded)	70%	73%	+3%
<u>1.C</u> : Number of states (including the District of Columbia) achieving 65% coverage for 1 birth dose hepatitis B vaccine (19–35 months of age) (Output)	FY 2010: 32 (Target Exceeded)	40	42	+2
<u>1.D</u> : Number of states (including the District of Columbia) achieving 30% coverage for influenza vaccine (6–23 months of age) (Output)	FY 2010: 27 (Target Exceeded)	29	31	+2
<u>1.E</u> : Number of states (including the District of Columbia) achieving 25% coverage for ≥ 3 doses human papillomavirus vaccine (13–17 years of age) (Output)	FY 2010: 45 (Target Exceeded)	40	42	+2
<u>1.F</u> : Number of states (including the District of Columbia) achieving 45% coverage for ≥ 1 dose Tdap vaccine (13–17 years of age) (Output)	FY 2010: 49 (Target Exceeded)	46	48	+2
<u>1.G</u> : Number of states (including the District of Columbia) achieving 45% coverage for ≥ 1 dose meningococcal conjugate vaccine (13–17 years of age) (Output)	FY 2010: 44 (Target Exceeded)	40	42	+2

**Performance Measures for Long Term Objective: Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.**

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
<u>1.3.1a</u> : Increase the rate of influenza vaccination in persons 65 years of age and older (Intermediate Outcome)	FY 2010: 66% (Target Not Met)	75%	78%	+3%
<u>1.3.1b</u> : Increase the rate of pneumococcal vaccination in persons 65 years of age and older (Intermediate Outcome)	FY 2010: 60% (Target Not Met)	67%	70%	+3%
<u>1.3.2a</u> : Increase the rate of influenza vaccination among adults ages 18 to 64 (Intermediate Outcome)	FY 2010: 28% (Target Not Met but Improved)	36%	40%	+4%
<u>1.3.2b</u> : Increase the rate of pneumococcal vaccination among non-institutionalized high-risk adults ages 18 to 64 (Intermediate Outcome)	FY 2010: 28% (Target Not Met but Improved)	31%	34%	+3%

**Performance Trends:** Immunization continues to be one of the most cost-effective public health interventions. CDC supports the implementation of state-based immunization programs making vaccines available to vulnerable children, adolescents, and adults. Since the adoption of this strategy, the U.S. experienced record high childhood vaccination levels and record low levels of vaccine-preventable diseases. For each 2009 birth cohort vaccinated against 13 diseases (diphtheria, haemophilus influenzae type b, hepatitis A, hepatitis B, measles, mumps, pneumococcal, pertussis, polio, rotavirus, rubella, tetanus, and varicella) in accordance with the routine childhood immunization schedule, the U.S. saved \$13.6 billion in direct medical costs and 42,000 lives and prevented 20 million cases of disease. Overall, an estimated \$10.20 for every \$1 invested (Table 1).

**Table 1: Cost-effectiveness of Childhood Vaccines**

Vaccine:	Cost Savings: for every \$1 spent on an individual vaccine
Diphtheria-Tetanus-acellular Pertussus (DTaP)	saves \$47.80
Measles, Mumps, and Rubella (MMR)	saves \$23.30
Hepatitis B	saves \$2.40
Varicella	saves \$2.00
Inactivated Polio (IPV)	saves \$8.60
Haemophilus influenza type b (Hib)	saves \$4.90
Pneumococcal (PCV7)	saves \$1.50
Childhood series (9 vaccines) <sup>1</sup>	saves \$10

<sup>1</sup> Includes DTaP, Hib, hepatitis A, hepatitis B, MMR, PCV7, IPV, rotavirus, and varicella vaccines; hepatitis A and rotavirus vaccines are cost-effective, but not cost saving..

CDC made significant progress in improving and sustaining immunization coverage of children 19–35 months of age with appropriate vaccinations. In 2010, coverage levels were near or above the national Healthy People 2010 targets of 90 percent or higher among children 19–35 months of age for most of the routinely recommended childhood vaccines. Of the three performance measures for vaccination coverage in children 19-35 months of age, two measures exceeded the 2010 target and one, while very close to meeting the target, showed improvement over the 2009 rate. Coverage for MMR vaccine increased from 90 percent in 2009 to 92 percent in 2010; rotavirus vaccine increased by 15 percentage points from 44 percent in 2009 to 59 percent in 2010; and while coverage with pneumococcal conjugate vaccine did not meet the 2010 target of 84 percent, it increased from 80 percent in 2009 to 83 percent in 2010 (Measures 1.2.1).

Adolescent vaccination coverage rates showed significant progress in meeting immunization targets. Both adolescent performance measures significantly exceeded their targets. Vaccination coverage for Tetanus, Diphtheria, Pertussis (Tdap) increased from 62 percent in 2009 to 74 percent in 2010 and MCV4 coverage increased from 55 percent in 2009 to 65 percent in 2010 (Measures 1.2.2).

During the past decade, vaccination coverage levels among older adults increased slightly as CDC implemented national strategies and worked with state and local public health departments to promote adult immunization among healthcare providers and state and local governments. However, CDC did not meet the 2010 targets for adult vaccination. Influenza vaccination among the adults ages 65 and older remained at 66 percent and pneumococcal vaccination decreased from 61 percent in 2009 to 60 percent (Measures 1.3.1). For adults ages 18 to 64, influenza vaccination increased from 27 percent in 2009 (baseline) to 28 percent and pneumococcal vaccination among high risk populations increased from 17 percent in 2009 to 28 (Measures 1.3.2). Addressing barriers to adult immunization and increasing adult vaccination rates will require a different approach to the ones used to increase childhood coverage. Adult vaccination recommendations are not typically included in the routine adult preventive care schedule. Further, the types of providers where adults receive care are more diverse and may not always be experienced in delivering vaccines. CDC is working on a number of strategies to improve adult vaccination coverage rates, including patient and provider education to increase demand, system changes

in the office setting to reduce missed opportunities, evidence-based communication campaigns to increase public awareness about adult vaccines and recommendations, expanded provider education to reach the diversity of health care venues in which adults receive care, and implementation of vaccination programs in new venues.

***Program: Influenza Planning and Response***

**Performance Measures for Long Term Objective: Protect Americans from infectious diseases – Influenza.**

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
1.6.1: Increase the number of public health laboratories monitoring influenza virus resistance to antiviral drugs (Output)	FY 2011: 9 (Target Met)	12	15	+3
1.6.2: Increase the percentage of corrective actions completed from Public Health Emergency Preparedness (PHEP) Cooperative Agreement grantees pandemic influenza improvement plans (Output)	FY 2010: 37% (Baseline)	60%	70%	+10%
1.6.3: Percentage of countries achieving an increase of five percent over last year's indicator score on CDC's National Inventory of Core Capacities for Pandemic Influenza Preparedness and Response (Output)	FY 2010: 94% (Target Exceeded)	75%	N/A <sup>1</sup>	N/A
1.L: Number of influenza diagnostic kits and virus reference panels distributed domestically and internationally. (Output)	FY 2011: 2,315 (Target Exceeded)	2,100	2,100	Maintain
1.M: Number of virus specimens received and characterized annually from global National Influenza Centers for use in determining vaccine strain selection. received and characterized (Output)	FY 2010: 9,487 (Historical Actual)	11,000	11,000	Maintain

<sup>1</sup>This indicator score is formally assessed every other year, and that the instrument may be reassessed and improved in FY 2013.

**Performance Trends:** CDC met the FY 2011 targets of having nine public health programs monitoring the influenza virus resistance to antiviral drugs and having 37 percent of pandemic influenza improvement plan corrective actions completed by Public Health Emergency Preparedness (PHEP) Cooperative Agreement grantees (Measures 1.6.1 and 1.6.2). Recent evaluation of preparedness and response capabilities of 44 countries participating in CDC's National Inventory of Core Capacities for Pandemic Influenza and Response demonstrated significant improvements for the reporting period 2008–2010 in clinical management guidance, resource management for antiviral treatment, personal protective equipment, and communication of surveillance information. CDC expects to achieve the FY 2011 interim target of 60 percent of countries achieving a five percent increase in indicator scores over the full two-year reporting period ending in FY 2012 (Measure 1.6.3).

In FY 2010 and FY 2011, CDC enhanced state and local capacity to gather influenza epidemiology and laboratory data essential for systematic, accurate surveillance of seasonal and novel influenza viruses by supporting the assignment of 93 ELC-funded laboratorians and influenza coordinators at state and local

health departments. CDC enhanced global capacity to monitor influenza viruses and to inform vaccine policy and antiviral treatment recommendations by serving as a WHO Collaborating Center for Influenza. In this capacity, CDC provided 2,315 influenza diagnostic kits and virus reference panels to ensure the availability of timely diagnostic resources domestically and globally in FY 2010 (Measure 1.L). In the fall of 2011, the FDA approved revisions configuration of diagnostic kits, which increased the products available and subsequently the number of kits shipped during the reporting timeframe. CDC exceeded the target and targets for future years were adjusted to reflect this change. In addition, CDC received and characterized 9,487 influenza virus specimens and expects to receive about 11,000 influenza virus specimens in FY 2010 (Measure 1.M). Characterization of these specimens from throughout the world is essential to the production of each season's influenza vaccine, as well as informing decisions regarding potential vaccines for novel influenza viruses with pandemic potential and informing vaccine policies and recommendations.

**IT INVESTMENTS**

CDC made several investments in information technology (IT) to improve efficiencies and effectiveness. These systems support various programs in the elimination of vaccine-preventable and respiratory diseases and infections. IT investments are developed to track and order vaccines; monitor the occurrence of vaccine-preventable diseases and disease outbreaks; provide electronic capabilities for gathering, storing, tracking, and analyzing critical surveillance data; support the development and dissemination of public health information; and oversee grants management. These systems improve CDC's understanding of the public health issues related to vaccine-preventable and respiratory diseases, and inform the design, implementation, and evaluation of public health practice for preventing and controlling disease. These systems include: the Grants Information Systems for Immunization (formerly Program Annual Progress Assessment), Administrative Support investments, Public Health Communication for Immunization and Respiratory Diseases, Public Health Monitoring for Immunization and Respiratory Diseases, Public Health Services for Immunization and Respiratory Diseases, Immunization Registries (Extramural), and the Vaccine Tracking System (VTrckS).

VTrckS is an enterprise system used to track federally contracted vaccine orders between manufacturers, distributor, and health care providers. The system went live on December 13, 2010, with four pilot grantees: two external registry system grantees (Michigan and Washington) and two VTrckS Provider Order Pilot (VPOP) grantees (Chicago and Colorado). Since the system went live, VTrckS has successfully processed all vaccine orders (approximately two million as of December 2011) generated from the old legacy system by non-pilot grantees, as well as orders entered directly into VTrckS by the pilot grantees. After go-live, pilot grantees, third party reviewers, and internal users provided significant feedback for the need for enhancements and optimizations before further scale up of the system. These optimizations will be released to the pilot grantees in February 2012. Further rollout to the non-pilot grantees will begin in February 2012, with rollout completion in June 2013.

**STATE TABLES<sup>1,2</sup>**

<b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b>				
<b>FY 2013 DISCRETIONARY STATE/FORMULA GRANTS</b>				
<b>CFDA Number: 93.268/Section 317 Immunization Program<sup>1</sup></b>				
<b>State/City/Territory</b>	<b>FY 2011 Appropriation</b>	<b>FY 2012 Enacted</b>	<b>FY 2013 President's Budget</b>	<b>FY 2013 +/- FY 2012</b>
<b>Alabama</b>	\$8,617,358	\$8,454,623	\$7,565,663	-\$888,960
<b>Alaska</b>	\$4,417,966	\$5,063,654	\$4,527,935	-\$535,719
<b>Arizona</b>	\$11,248,386	\$11,943,137	\$10,688,946	-\$1,254,191

<b>CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA Number: 93.268/Section 317 Immunization Program<sup>1</sup></b>				
State/City/Territory	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Arkansas	\$7,431,098	\$4,535,736	\$4,059,034	-\$476,702
California	\$54,581,732	\$63,098,560	\$56,457,479	-\$6,641,081
Colorado	\$9,348,914	\$8,923,218	\$7,985,780	-\$937,438
Connecticut	\$6,652,851	\$5,903,580	\$5,282,066	-\$621,514
Delaware	\$1,212,411	\$1,453,520	\$1,301,301	-\$152,219
District of Columbia	\$1,526,767	\$1,819,236	\$1,628,457	-\$190,778
Florida	\$24,376,881	\$27,798,394	\$24,874,066	-\$2,924,329
Georgia	\$12,294,516	\$13,373,052	\$11,969,681	-\$1,403,371
Hawaii	\$3,742,549	\$3,339,335	\$2,988,956	-\$350,379
Idaho	\$3,036,563	\$3,572,914	\$3,197,169	-\$375,746
Illinois	\$10,414,741	\$12,211,871	\$10,926,601	-\$1,285,270
Indiana	\$7,816,653	\$8,751,190	\$7,827,851	-\$923,339
Iowa	\$5,288,434	\$5,191,251	\$4,645,971	-\$545,280
Kansas	\$7,527,921	\$5,233,112	\$4,683,764	-\$549,348
Kentucky	\$4,641,112	\$5,510,045	\$4,931,749	-\$578,296
Louisiana	\$5,525,117	\$6,421,128	\$5,743,952	-\$677,177
Maine	\$4,410,056	\$3,796,748	\$3,399,521	-\$397,226
Maryland	\$7,847,550	\$7,814,566	\$6,995,304	-\$819,261
Massachusetts	\$13,974,520	\$13,180,643	\$11,788,862	-\$1,391,782
Michigan	\$15,568,191	\$16,823,961	\$15,053,713	-\$1,770,248
Minnesota	\$9,504,850	\$9,717,704	\$8,696,168	-\$1,021,536
Mississippi	\$5,101,609	\$5,486,825	\$4,911,083	-\$575,743
Missouri	\$9,835,236	\$9,855,129	\$8,816,993	-\$1,038,137
Montana	\$1,756,109	\$2,088,388	\$1,869,287	-\$219,100
Nebraska	\$3,271,984	\$3,323,984	\$2,975,684	-\$348,300
Nevada	\$4,100,914	\$4,177,123	\$3,737,532	-\$439,591
New Hampshire	\$2,237,442	\$2,619,798	\$2,343,982	-\$275,816
New Jersey	\$4,585,748	\$4,584,977	\$4,108,031	-\$476,946
New Mexico	\$3,371,657	\$4,041,972	\$3,618,674	-\$423,297
New York	\$15,727,951	\$15,758,168	\$14,107,615	-\$1,650,553

<b>CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA Number: 93.268/Section 317 Immunization Program<sup>1</sup></b>				
State/City/Territory	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
<b>North Carolina</b>	\$12,245,952	\$13,160,536	\$11,775,458	-\$1,385,078
<b>North Dakota</b>	\$2,267,034	\$2,377,799	\$2,127,185	-\$250,614
<b>Ohio</b>	\$14,193,018	\$16,164,366	\$14,458,767	-\$1,705,599
<b>Oklahoma</b>	\$6,915,832	\$6,907,641	\$6,181,241	-\$726,399
<b>Oregon</b>	\$5,912,350	\$6,287,161	\$5,627,946	-\$659,215
<b>Pennsylvania</b>	\$12,688,305	\$14,872,326	\$13,306,920	-\$1,565,406
<b>Rhode Island</b>	\$2,377,608	\$2,802,802	\$2,508,170	-\$294,632
<b>South Carolina</b>	\$6,795,174	\$7,230,527	\$6,470,240	-\$760,288
<b>South Dakota</b>	\$2,335,765	\$2,674,766	\$2,391,726	-\$283,040
<b>Tennessee</b>	\$8,070,490	\$9,541,057	\$8,538,742	-\$1,002,314
<b>Texas</b>	\$30,733,189	\$35,484,306	\$31,751,602	-\$3,732,704
<b>Utah</b>	\$5,376,547	\$5,728,690	\$5,126,460	-\$602,230
<b>Vermont</b>	\$3,125,736	\$2,731,991	\$2,444,353	-\$287,638
<b>Virginia</b>	\$10,862,660	\$12,023,827	\$10,753,980	-\$1,269,847
<b>Washington</b>	\$10,531,250	\$10,310,800	\$9,225,574	-\$1,085,226
<b>West Virginia</b>	\$4,419,466	\$3,653,389	\$3,269,253	-\$384,136
<b>Wisconsin</b>	\$8,544,540	\$9,089,063	\$8,131,441	-\$957,623
<b>Wyoming</b>	\$1,952,032	\$1,745,092	\$1,562,044	-\$183,047
<b>Chicago</b>	\$4,661,699	\$5,586,888	\$5,001,761	-\$585,126
<b>Houston<sup>2</sup></b>	\$2,087,960	\$2,476,429	\$2,220,233	-\$256,196
<b>New York City</b>	\$13,212,691	\$15,691,126	\$14,044,406	-\$1,646,720
<b>Philadelphia</b>	\$2,623,676	\$3,156,108	\$2,825,836	-\$330,272
<b>San Antonio</b>	\$2,353,652	\$2,847,982	\$2,550,341	-\$297,640
<b>American Samoa</b>	\$404,308	\$484,024	\$433,319	-\$50,705
<b>Guam</b>	\$957,601	\$1,140,992	\$1,021,338	-\$119,654
<b>Marshall Islands</b>	\$1,697,945	\$1,967,340	\$1,759,720	-\$207,621
<b>Micronesia</b>	\$2,743,502	\$3,220,166	\$2,881,329	-\$338,837
<b>Northern Mariana Islands</b>	\$711,123	\$858,959	\$769,154	-\$89,804
<b>Puerto Rico</b>	\$5,526,764	\$6,530,978	\$5,844,814	-\$686,165
<b>Republic Of Palau</b>	\$551,445	\$639,632	\$572,146	-\$67,486
<b>Virgin Islands</b>	\$641,648	\$800,752	\$717,629	-\$83,123



<b>CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA Number: 93.268/Section 317 Immunization Program<sup>1</sup></b>				
State/City/Territory	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
<b>Total States/Cities/Territories</b>	<b>\$478,516,746</b>	<b>\$514,055,055</b>	<b>\$460,001,999</b>	<b>-\$54,053,056</b>
<b>Other Adjustments<sup>3</sup></b>	\$47,054,254	\$43,814,945	\$39,297,001	-\$4,517,944
<b>Total Resources<sup>4,5</sup></b>	<b>\$525,571,000</b>	<b>\$557,870,000</b>	<b>\$499,299,000</b>	<b>-\$58,571,000</b>

<sup>1</sup>Includes vaccine direct assistance and immunization infrastructure/operations grant funding.

<sup>2</sup>Immunization infrastructure/operations grant funding only; vaccine direct assistance for Houston is included with Texas.

<sup>3</sup>Other 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, vaccine safety data link, PHS evaluation, special projects, and program support services.

<sup>4</sup>FY 2011 does not include American Recovery and Reinvestment Act funding.

<sup>5</sup>FY 2011 includes Section 317 request of \$425,571,000 and Prevention and Public Health Fund (PPHF) request of \$100,000,000. PPHF operations funding was awarded by a competitive funding opportunity announcement (not all Section 317 grantees applied or were awarded funds); FY 2012 includes Section 317 request of \$367,870,000 and PPHF request of \$190,000,000; FY 2013 includes Section 317 request of \$426,813,000 and PPHF request of \$72,460,000.

<b>CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2013 MANDATORY STATE/FORMULA GRANTS CFDA Number: 93.268/Vaccines for Children (VFC) Program<sup>1</sup></b>				
State/City/Territory	FY 2011 Appropriation	FY 2012 Appropriation	FY 2013 President's Budget	FY 2013 +/- FY 2012
<b>Alabama</b>	\$55,388,691	\$56,037,969	\$60,009,310	\$3,971,341
<b>Alaska</b>	\$10,838,232	\$10,991,361	\$11,705,702	\$714,340
<b>Arizona</b>	\$80,154,471	\$81,101,230	\$86,832,734	\$5,731,503
<b>Arkansas</b>	\$39,795,202	\$40,264,126	\$43,112,145	\$2,848,019
<b>California</b>	\$508,084,654	\$513,910,346	\$550,621,737	\$36,711,391
<b>Colorado</b>	\$42,653,709	\$43,168,929	\$46,194,204	\$3,025,275
<b>Connecticut</b>	\$33,188,107	\$33,608,334	\$35,920,351	\$2,312,017
<b>Delaware</b>	\$10,418,907	\$10,560,146	\$11,265,792	\$705,646
<b>District of Columbia</b>	\$8,496,504	\$8,618,201	\$9,179,530	\$561,329
<b>Florida</b>	\$189,989,369	\$192,195,855	\$205,862,639	\$13,666,784
<b>Georgia</b>	\$135,952,153	\$137,534,407	\$147,306,813	\$9,772,406
<b>Hawaii</b>	\$14,087,536	\$14,303,901	\$15,203,013	\$899,112
<b>Idaho</b>	\$20,081,513	\$20,323,939	\$21,748,553	\$1,424,614
<b>Illinois</b>	\$92,332,721	\$93,430,593	\$100,017,170	\$6,586,577
<b>Indiana</b>	\$65,696,959	\$66,480,695	\$71,161,629	\$4,680,933
<b>Iowa</b>	\$25,077,633	\$25,389,292	\$27,149,021	\$1,759,730
<b>Kansas</b>	\$24,031,345	\$24,331,778	\$26,014,240	\$1,682,462

<b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b>				
<b>FY 2013 MANDATORY STATE/FORMULA GRANTS</b>				
<b>CFDA Number: 93.268/Vaccines for Children (VFC) Program<sup>1</sup></b>				
State/City/Territory	FY 2011 Appropriation	FY 2012 Appropriation	FY 2013 President's Budget	FY 2013 +/- FY 2012
<b>Kentucky</b>	\$44,492,516	\$45,009,211	\$48,209,819	\$3,200,608
<b>Louisiana</b>	\$67,213,177	\$67,987,806	\$72,835,674	\$4,847,867
<b>Maine</b>	\$10,461,885	\$10,620,053	\$11,293,205	\$673,152
<b>Maryland</b>	\$60,974,411	\$61,685,606	\$66,065,153	\$4,379,547
<b>Massachusetts</b>	\$60,252,712	\$60,978,474	\$65,256,398	\$4,277,924
<b>Michigan</b>	\$90,804,476	\$91,882,493	\$98,363,700	\$6,481,207
<b>Minnesota</b>	\$36,703,085	\$37,150,158	\$39,745,294	\$2,595,137
<b>Mississippi</b>	\$43,353,731	\$43,856,837	\$46,976,316	\$3,119,480
<b>Missouri</b>	\$56,417,831	\$57,084,725	\$61,117,830	\$4,033,105
<b>Montana</b>	\$7,418,976	\$7,519,890	\$8,021,617	\$501,726
<b>Nebraska</b>	\$21,377,061	\$21,632,337	\$23,154,903	\$1,522,566
<b>Nevada</b>	\$33,236,067	\$33,641,371	\$35,990,368	\$2,348,997
<b>New Hampshire</b>	\$8,336,866	\$8,453,488	\$9,010,309	\$556,821
<b>New Jersey</b>	\$75,849,599	\$76,762,846	\$82,148,978	\$5,386,132
<b>New Mexico</b>	\$35,091,101	\$35,520,185	\$37,997,778	\$2,477,592
<b>New York</b>	\$84,715,909	\$85,789,722	\$91,688,898	\$5,899,176
<b>North Carolina</b>	\$97,361,800	\$98,511,513	\$105,474,073	\$6,962,560
<b>North Dakota</b>	\$5,688,437	\$5,765,089	\$6,151,349	\$386,260
<b>Ohio</b>	\$98,675,172	\$99,806,393	\$106,936,523	\$7,130,129
<b>Oklahoma</b>	\$56,917,111	\$57,598,041	\$61,649,219	\$4,051,178
<b>Oregon</b>	\$31,959,508	\$32,362,440	\$34,592,633	\$2,230,193
<b>Pennsylvania</b>	\$79,909,132	\$80,904,227	\$86,507,217	\$5,602,990
<b>Rhode Island</b>	\$13,500,850	\$13,678,455	\$14,604,558	\$926,103
<b>South Carolina</b>	\$48,176,016	\$48,764,745	\$52,166,961	\$3,402,216
<b>South Dakota</b>	\$9,172,505	\$9,290,611	\$9,925,350	\$634,738
<b>Tennessee</b>	\$72,384,462	\$73,231,212	\$78,424,944	\$5,193,732
<b>Texas</b>	\$342,698,254	\$346,691,051	\$371,315,161	\$24,624,110
<b>Utah</b>	\$22,773,277	\$23,062,512	\$24,647,082	\$1,584,570
<b>Vermont</b>	\$6,055,559	\$6,153,125	\$6,529,731	\$376,606
<b>Virginia</b>	\$56,289,087	\$56,938,856	\$60,996,553	\$4,057,698

<b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b>				
<b>FY 2013 MANDATORY STATE/FORMULA GRANTS</b>				
<b>CFDA Number: 93.268/Vaccines for Children (VFC) Program<sup>1</sup></b>				
State/City/Territory	FY 2011 Appropriation	FY 2012 Appropriation	FY 2013 President's Budget	FY 2013 +/- FY 2012
<b>Washington</b>	\$101,108,135	\$102,343,898	\$109,483,807	\$7,139,910
<b>West Virginia</b>	\$17,786,674	\$18,005,112	\$19,258,882	\$1,253,770
<b>Wisconsin</b>	\$45,571,882	\$46,112,188	\$49,366,451	\$3,254,263
<b>Wyoming</b>	\$5,728,464	\$5,807,878	\$6,192,043	\$384,165
<b>Chicago</b>	\$47,180,950	\$47,769,251	\$51,075,782	\$3,306,532
<b>Houston<sup>2</sup></b>	\$739,395	\$780,730	\$762,988	(\$17,742)
<b>New York City</b>	\$137,278,447	\$138,880,858	\$148,738,375	\$9,857,517
<b>Philadelphia</b>	\$27,268,035	\$27,621,898	\$29,502,881	\$1,880,983
<b>San Antonio</b>	\$25,033,172	\$25,336,064	\$27,110,467	\$1,774,403
<b>American Samoa</b>	\$844,197	\$856,769	\$911,237	\$54,467
<b>Guam</b>	\$2,179,805	\$2,218,795	\$2,345,017	\$126,221
<b>Northern Mariana Islands</b>	\$890,499	\$906,603	\$957,776	\$51,173
<b>Puerto Rico</b>	\$64,305,315	\$65,069,630	\$69,657,516	\$4,587,886
<b>Virgin Islands</b>	\$2,344,349	\$2,405,882	\$2,500,215	\$94,333
<b>Total States/Cities/Territories</b>	<b>\$3,512,787,595</b>	<b>\$3,554,700,132</b>	<b>\$3,804,965,615</b>	<b>\$250,265,483</b>
<b>Other Adjustments<sup>3</sup></b>	\$439,889,106	\$454,359,868	\$466,049,385	\$11,689,517
<b>Total Resources<sup>4</sup></b>	<b>\$3,952,676,701</b>	<b>\$4,009,060,000</b>	<b>\$4,271,015,000</b>	<b>\$261,955,000</b>

<sup>1</sup>This 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://www.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

<sup>2</sup>Funding for Houston only includes funding for operations, not the cost of vaccines. Funding for Texas includes the cost of vaccines for Houston.

<sup>3</sup>Other 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.

<sup>4</sup>Total resources for FY 2011 reflect actual obligations. Total resources for FY 2012 and FY 2013 are based on the FY 2013 VFC President's Budget ten year table. The FY 2012 level represents estimated total obligations, including \$3.119 billion in prior year recoveries and refunds brought forward and \$4.006 billion in transfer from CMS. The FY 2013 net increase of estimated total obligations, inclusive of prior year recoveries and refunds brought into FY 2012 totals \$261,955,000; the FY 2013 net increase of the non-expenditure transfer from CMS, exclusive of prior year recoveries and refunds brought into FY 2012 totals \$265,074,280.