

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES  
APPROPRIATIONS FOR 2023

HEARINGS  
BEFORE A  
SUBCOMMITTEE OF THE  
COMMITTEE ON APPROPRIATIONS  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED SEVENTEENTH CONGRESS  
SECOND SESSION

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,  
EDUCATION, AND RELATED AGENCIES

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# **DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RE- LATED AGENCIES APPROPRIATIONS FOR 2023**

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THURSDAY, MARCH 31, 2022.

## **DEPARTMENT OF HEALTH AND HUMAN SERVICES**

### **WITNESS**

**HON. XAVIER BECERRA, SECRETARY, DEPARTMENT OF HEALTH AND  
HUMAN SERVICES**

The CHAIR. Let's move forward and to bang the gavel and call to order the hearing on fiscal year 2023, the President's budget for the Department of Health and Human Services. A hybrid hearing, so we need to address a few housekeeping matters.

For the members who are joining virtually, once you start speaking, there is a slight delay before you are displayed on the main screen. Speaking into the microphone activates the camera, displaying the speaker on the main screen. Do not stop your remarks if you do not immediately see the screen switch. If the screen does not change after several seconds, please make sure that you are not muted.

To minimize background noise and ensure the correct speaker is being displayed, we ask that you remain on mute unless you have sought recognition. The chair, or an individual designated by the chair, may mute participants' microphones when they are not under recognition to eliminate inadvertent background noise. Members who are virtual are responsible for muting and unmuting themselves.

Finally, the House Rules require me to remind you that we have set up an email address to which members can send anything they wish to submit in writing at any of our hearings. That email address has been provided in advance to your staff.

With that, I want to acknowledge the ranking member of the subcommittee, Congressman Tom Cole, and all of the members of the subcommittee who are joining today's hearing, both virtually and in person.

And I would like to welcome my friend and former colleague Secretary Xavier Becerra in his first in-person hearing of this subcommittee as Secretary of the Department of Health and Human Services. So you joined us virtually last year, of course, but there is nothing like being in person and being able to interact with people. So a very, very, very warm welcome this morning.

Today, I am looking forward to discussing HHS's fiscal year 2023 budget, which builds on the historic progress we made in the fiscal year 2022 appropriations package. In the fiscal year 2022 omnibus, we increased funding for biomedical research, public health, behavioral health, child care and early learning, prevention of child abuse and family violence, and the list goes on. And through these investments, we are able to bring transformational change to millions of hard-working American families.

Let me take a second here before I go on to say a thank you to my colleagues on both sides of the dais and those who are virtual today and a really heartfelt thanks for our work together in passing the 2022 omnibus.

And Congressman Cole, I want to say a particular thank you to you for your good offices in all of this. I think we have a bill that we can be enormously proud of. And I would also say that there weren't a lot of folks who thought we were going to get across the finish line, but we showed them.

So, and all done by March 8, on the deadline that they kept changing on us. So, but thank you all very, very, very much for your hard work. And again, a thanks to the staff as well for getting us there.

And we strengthened in the omnibus bill the Centers for Disease Control and Prevention by supporting the public health workforce, continuing to modernize public health data systems, creating a new funding mechanism to support core public health activities at the State and local level. We made strong transformational investments in maternal health, with increased funding for NIH research on maternal mortality through the IMPROVE Initiative, for the Health Resources and Services Administration's Maternal and Child Health Block Grant and Maternal Mental Health Hotline, and for the CDC's Maternal Mortality Review Committees, just to name a few.

We expanded access to behavioral health with investments in the 988 National Suicide Prevention Lifeline, the Mental Health Block Grant, and in Certified Community Behavioral Health Clinics, as well as a new pilot program to support Mental Health Crisis Response Teams to ensure that individuals experiencing a behavioral health crisis received the medical treatment that they need.

In addition, for the first time in 12 years, we included funding for member projects to support hospitals and health clinics, mental and behavioral health projects, K-12 and higher education programs, and job programs in our home districts. And now, with the fiscal year 2023 budget before us, we are strengthening these historic investments and ensuring the seeds of change that we planted in last year's bill grow deep, strong, and sustainable roots.

I want to be clear. My goal is to pass fiscal year 2023 appropriations bills on time, which means sending them to the President by September 30. We have already had conversations, and I plan to work with Ranking Member Granger, Chairman Leahy, and Vice Chairman Shelby to reach an agreement on top-line spending levels so each subcommittee can move forward with a renewed sense of urgency.

In the immediate term, we need to provide additional emergency funding to address the ongoing COVID-19 pandemic, to purchase

lifesaving vaccines, antivirals, monoclonal antibodies, as well as continued support for the uninsured to receive vaccination and testing at no cost.

Surgeon General Admiral Vivek H. Murthy wrote in the New York Times on Tuesday, and I quote, “Now, for the first time, we cannot order enough vaccines to provide boosters for all Americans if a fourth dose is deemed necessary in the fall. If we need variant-specific vaccines, we will not have the funds to secure them, deliver them, or administer them. Last week, we were forced to cut our shipments of lifesaving monoclonal antibodies to States by 35 percent, and we anticipate running out of monoclonal antibodies later this spring. We will not be able to continue making home tests available, and the critical surveillance efforts that help us anticipate new waves and variants will be compromised.”

Let me also add that it is equally critical to support global vaccination efforts, both from a humanitarian perspective and our own self-interest. Viruses do not stop at borders on a map. No amount of domestic preparedness can possibly contend with a continuing onslaught of new variants.

As of today, only 1 in 10 people in low-income countries are fully vaccinated. To achieve the goal of vaccinating 70 percent of each country’s population, including health workers and the elderly, the United States must take a leadership role. It is urgent that we act now to secure more funding to address the ongoing pandemic before the money runs out.

I urge my colleagues on both sides of the aisle to come together to save American lives and to save lives across the globe. And again, it is urgent that we move in this direction.

Mr. Secretary, I am pleased to see your long-term plan for pandemic preparedness. The President’s budget includes \$82,000,000,000 over 5 years to invest in the Office of the Assistant Secretary for Preparedness and Response, ASPR, the CDC, the NIH, and the Food and Drug Administration to be able to identify new potential pandemics and move quickly to develop a vaccine and deploy it within 100 days.

We also need to tap the potential of the Advanced Research Projects Agency for Health, otherwise known as ARPA-H, which we created in fiscal year 2022 in the omnibus, to support transformative research projects to address debilitating diseases like Alzheimer’s, diabetes, cancer, ALS, and many other health conditions afflicting millions of Americans every day.

ARPA-H has tremendous potential to develop breakthrough technologies and advancements while continuing our important work to reduce health disparities. However, Mr. Secretary, you know my view on this. I must say that the decision to place ARPA-H within the NIH I believe is a mistake and will hamper the agency’s ability to achieve these breakthroughs. I believe that ARPA-H would be more successful in its unique mission if it were established as an independent agency within HHS.

And I also believe that the proposed increase of only \$274,000,000 for the rest of the National Institutes of Health is insufficient and threatens the progress this committee has made in the past several years through significant, sustained investments in biomedical research.

Beginning in fiscal year 2023, the President proposes to reclassify the entire Indian Health Service budget, approximately \$9,300,000,000, as mandatory. And I look forward to hearing more about the need and the rationale for the proposal.

Mr. Secretary, I am happy to see the President's budget continues to build on our investments in public health, maternal health, behavioral health, including significant increases for CDC's core public health capacity, as well as increases for SAMHSA's Mental Health Block Grant, Substance Use Prevention Block Grant, State Opioid Response Grants, Certified Community Behavioral Health Clinics.

The budget includes targeted increases to improve mental health services for children and youth, including increases for Project AWARE and the National Child Traumatic Stress Network. It includes increased funding for mental and behavioral health workforce training, which is critically important.

These investments will help make quality care more accessible for those suffering from mental health disorders, as will the July rollout of the new 3-digit number, 988, for the National Suicide Prevention Lifeline. This will be a dedicated number for individuals in crisis to receive help immediately.

It is encouraging that this budget expands access to healthcare services for low-income women by providing \$400,000,000, an increase of nearly 40 percent over the 2021 enacted level, for the Title X Family Planning Program, which will improve overall access to vital reproductive and preventive health services and advance gender and health equity. I will keep fighting for more money for Title X and other reproductive health programs.

Within ACF, HHS is investing once again in refugee resettlement programs. This administration is restoring our reputation in the world as a country that welcomes immigrants of all colors and faiths, as we did for Afghans in Operation Allies Welcome and as I hope this Congress will come together to do for Ukrainians as well.

Let me also tell you, Mr. Secretary that I expect to see substantial progress this year in the Unaccompanied Children Program. You know my position on this. HHS needs to build a sufficient network of State-licensed beds and needs to shutdown the emergency intake sites. It needs to fund the services necessary to support these children and their sponsors as they recover from their traumatic journey and past and as they navigate the asylum process and understand their legal rights.

Mr. Secretary, we thank you for being here today. I look forward to working with you over the next year and look forward to today's discussion.

And with that, let me recognize the ranking member, Congressman Cole, for any opening remarks.

Mr. COLE. Well, thank you, Madam Chairman.

And I am going to start as you did. I am going to be outside my prepared remarks for a minute and do a little lookback before we look forward. And I want to begin, you were nice enough to thank all of us. The reality is all of us should be thanking you and Ranking Member Granger for what you did.

I will point out this committee was ready to go to conference at the appropriate time. All 12 bills have passed out of this committee last year under your leadership, 9 of them across the floor. We were ready before September 30.

And I am particularly proud of how hard you pushed over and over again for demanding the least amount of time. First, December and then February. But you were the leader in pushing the Congress for getting its job done, and there is no more important job than funding the Government across the board at every level.

We know, Mr. Secretary, we hobble you and your colleagues when we don't give you a budget on time. It forces you to wonder what you are going to be operating with. It slows down a lot of things that need to get done in a hurry. But that was not the responsibility of this committee at all. It was, again, ready to go to work, ready to sit down with the administration.

Our friends in the Senate I think could learn a little bit from you, Madam Chair. As I recall, they didn't get any bills across the floor, and they only got three out of committee. I know everything is slower in the United States Senate. But really? Three bills out of committee? Come on, guys. They need to pick up the pace over there.

But I am proud of this committee. Even when I disagreed, and of course, initially, we did. But I am also pleased, as you pointed out, for the seventh year in a row, we got to a bill that we both could vote for.

And again, that wouldn't have been possible without your leadership and Chairwoman Granger's leadership. And I think we certainly have R&D divisions around here, but we have institutional divisions as well. And I think our institution looked better than our counterpart on the other side of the Rotunda, and you bear enormous responsibility for that.

So I want to associate myself with your goal of making sure that we make this done by September 30. My guess is we will do a CR and kick it into the end of the calendar year. But it needs to get done, and sooner is better. On time is best. If not, the calendar year is best. And I think, again, I will pledge to work with you as hard as I possibly can to make sure that that is our goal.

It is a mistake to kick it into a new Congress where we will have new Members on both sides of the aisle, and they will have to vote on something that they have had nothing—very little knowledge, no participation in. And they deserve a clean start, and frankly, the administration deserves a clean start to the third year as well. And so we look forward to working with you on that.

Now let me go to my formal remarks, if I may?

Mr. Secretary, it is a pleasure to have you here. And as the chair said, it is wonderful to be back in the room and have the interaction. Particularly good, frankly, interacting with you, as you know our world better than any Secretary I have dealt with. And I have dealt with some good ones on both sides of the aisle, but it is always nice to have another member here that understands what are the challenges we have from a legislative standpoint, and you do.

I am glad that, again, our chair chose to hold this meeting in our full committee room so that some members could attend in person.

I wish we could all be together in person for this hearing, as I think the dynamic and interaction among members is much better when we are all seated together in the same place, rather than looking at each other through a computer screen.

Nevertheless, Mr. Secretary, I appreciate your personal accessibility to us as members. I have enjoyed the bipartisan breakfasts you have been kind enough to host over the past years. I appreciate your understanding the challenges of legislating and having served this body yourself, and particularly your responsiveness on the phone or things like that, again to both sides of the aisle, have been greatly appreciated.

Today is our annual hearing to discuss the administration's budget proposal for fiscal year 2023. We just completed the final funding bill for fiscal year 2022 only 3 weeks ago. So thanks for getting us right back to work, Madam Chair.

I am hopeful it does not take as long to complete the work on the budget this year for the coming fiscal year, and I was glad to see a return of bipartisanship and compromise in the bill recently completed. Although we had strong differences going in, we were able to forge a compromise that both the chair and I were able to support.

For more than four decades, the Labor, Health and Human Services appropriations bill has carried the so-called Hyde Amendment that restricts Federal taxpayer funding for abortion under most circumstances. The fiscal year 2022 budget just completed was only able to advance because this language was again included.

I thank my chair for seeing the wisdom in continuing this decades-old bipartisan compromise, although I know that she personally disagrees with it. I am confident that the next spending bill we negotiate will continue to include it, as I continue to oppose any appropriations bill that seeks to weaken pro-life protection.

Mr. Secretary, I expect under your leadership, HHS will continue to enforce these provisions of existing law. But let me be very friendly, but firm. No Republican will vote for a budget, in the end, that does not have the Hyde protection, and in the end, we know it takes a bipartisan majority in both chambers to actually move this.

So the choice is squarely with the administration and the majority. We will once again be confronted with a choice, either Hyde comes back into the budget or accept a CR. And I want to be clear on that. I am not trying to be anything else. It is just a political reality.

Coming on the heels of such bipartisan negotiation, I am again disappointed the Biden administration once again is putting forward a partisan proposal that seems little more than a lengthy liberal wish list in some areas. For example, the budget proposes to implement partisan priorities such as climate change, gun research, and even a new center for sexual orientation and gender identity within the NIH.

To pay for these partisan initiatives, longstanding shared bipartisan priorities are shortchanged. Basic biomedical research at the NIH is essentially flat-funded, while the new ARPA-H, which was just created this month—and which, by the way, I supported—has

not even begun to function yet, but is proposed an enormous \$4,000,000,000 increase.

I think it is a mistake to shift funding away from basic biomedical research into a brand-new program in one year. ARPA-H will take time to get up and running and take time to work out the many controversial issues I know this new agency will face. And I will have some questions about your plans on ARPA-H this morning. I appreciate, by the way, your letter that clarified some things about it and also made it clear that you want to work with Congress.

This is a very new entity, and we are going to have a lot of wrestling with tough questions—I mean this in a very bipartisan way—to get to a structure that we all think is producing what I know we all want it to produce. And again, I say that as somebody that supported the creation of the initiative and look forward to continuing to work with you on that, Madam Chair.

Taken as a whole, I disagree strongly with the approach taken in the administration's request. To put it simply, it spends far too much on domestic programs, far too little on defense. Especially now with the current situation in Eastern Europe, America cannot afford to stand or cut back our own defense spending. At a minimum, we need to see at least a 5 percent annual increases beyond the rate of inflation for defense spending for the next several years. But that is a matter for the full committee, not just this subcommittee certainly.

The President's proposal for fiscal year 2023 for this subcommittee amounts to a 15 percent effective increase. Coming in when the fiscal year is already half way over, another huge infusion of spending in these domestic programs in fiscal year 2023 is just not necessary. And I don't think it can be spent prudently and will only serve to increase our already-growing inflation problem, which is now near a 40-year high.

I know we are all hoping that the coronavirus pandemic, which began over 2 years ago, may finally be winding down to a manageable endemic disease. Despite the many challenges of the past 2 years, Congress was able to come together 5 times in 2020 to pass emergency supplemental appropriations to help us through the pandemic. I supported all five of those bills.

I know we are not out of the woods yet. The administration has told us that funding for therapeutics and additional booster shots is running low, and we do not know if new variants are coming in the summer or the fall. Yet the administration has also released documents showing tens of billions of dollars, possibly as much as hundreds of billions, in previously appropriated COVID dollars remain unobligated and available.

And look, let me just be brutally honest here and use my own State as an example. Under the proposed future distribution of money, I think we have something like \$187,000,000 ticketed for Oklahoma. We have a rainy day fund that we added \$1,000,000,000 to last year. We had a tax cut last year. And I can tell you \$187,000,000 is unlikely to be spent for corona-related purposes. We don't need the money.

And I think some of the revolt we saw on my friend's side, again was more governors that wanted to use the money for other pur-

poses. And if I were comfortable they were all going to spend it on the priorities that you have laid out in your budget, Mr. Secretary that would be one thing. I am not.

But I am not for just throwing money away when we have got hundreds of billions of dollars of money that can be repurposed and aligned for this. And I know that is a political discussion as well as a policy debate. I recognize that, and I am happy to work with my friends on that.

But again, most of these States are in better financial shape, quite frankly, than the United States Government is. Most of them have reserve funds. We don't have one. Most of them have balanced budgets. We don't have that.

So the idea of us not taking some of the money that we wanted to lay out for coronavirus and say, no, you guys really don't need it for other purposes, let us redirect it back, I think is a worthy discussion to have.

Mr. Secretary, again, as I said, I urge you to repurpose these existing funds to secure additional doses of monoclonal antibodies and other therapies without delay. I urge you to use the remaining COVID balances, as well as the increases we provided in the bill just passed in the NIH and BARDA accounts, to continue to work on the next generation of vaccines. And hopefully, a universal coronavirus vaccine or a vaccine that targets mucosal membranes can be developed quickly and can not only prevent severe disease, as our current vaccines do, but can also reduce transmissions and need for additional boosters.

Finally, I want to take this opportunity to comment on one part of your budget, which is not under this subcommittee's jurisdiction, but one which I wholeheartedly agree with your proposal. And that is your proposal to move the Indian Health Service to the mandatory side of the budget ledger. That is a move I believe is long overdue, and it will stop the competition for scarce resources that currently exist between the Indian Health Service and other programs important to Indian Country, such as the Department of Interior, the Bureau of Indian Schools, payment in lieu of taxes reprogramming, other programs that are important in preserving our Nation's natural resources.

I hope this can work together to further this idea this year. My colleagues on this subcommittee have had to hear me probably more times than they care to since it is not directly their jurisdiction. But having sat on Interior, the reality is there is just not enough money in the discretionary budget to take care of the needs of Indian health, which is already the largest single item in the Interior Subcommittee appropriation.

I think your approach here is a wise one, and sadly, every time we have had a Government shutdown or a delay in spending, because the Indian Health Service is on the discretionary side of the budget instead of the mandatory, we have disrupted healthcare in reservations and some very poor communities. I think this is a very far-sighted proposal for you. I know you are going to get some stiff resistance on both sides of the aisle for a whole variety of reasons, but I think you are on the right track here.

And I look forward to working with you, and I appreciate very much you advancing this proposal in your budget.

So, with that, Madam Chair, again, I look forward to working with you in the coming year. It has been a delight for 7 years in a row. It has ended successfully 7 years in a row. I hope it ends successfully the eighth time around.

So, with that, again, yield back to my friend, the chair.

The CHAIR. The eighth time is a charm. So there we go.

Thank you very, very much, Congressman Cole. Thank you for your kind words as well. I much appreciate it, and I enjoy so much the opportunity to work with you in these areas. As you pointed out, we may disagree, but we are never disagreeable about it, and we get to a conclusion. And that is really what—that is what this job is about. It is about governing.

So, Mr. Secretary, you know the floor is now yours. Your full written testimony will be entered into the record, and you are recognized for 5 minutes for an opening statement, and then we will move to questions. You know the drill.

Secretary BECERRA. Madam Chair, Ranking Member Cole, and members of the subcommittee, thank you for the opportunity to discuss the President's fiscal year 2023 budget for the Department of Health and Human Services. Pleased to be with you today.

Speaking of today, 255 million Americans have received at least one dose of the COVID-19 vaccine. Two-thirds of adults over age 65 have gotten their booster shots. We have also closed the gap in vaccine rates we usually see fall behind for communities in some of our distressed areas.

It pays dividends to surge resources, including tests and treatment, to our hardest-hit and highest-risk communities. We think the numbers show that.

What are those numbers? Three hundred twenty-five million free COVID-19 tests have been shipped out to Americans. Two hundred seventy million free N95 masks have been made available to Americans.

You all made it possible to have \$186,000,000,000 available to the Provider Relief Fund. So, so far, we have seen some 766,000 claims submitted by doctors, hospitals, community health centers, pharmacies, labs, nursing homes, long-term care facilities. All of them receiving some very critical support at a very necessary time. More than 450,000 providers to date have submitted requests for reimbursement.

Real money. Real relief. Real results.

Beyond COVID-19, today more Americans are insured for their healthcare than ever before. That includes a record-breaking 14.5 million Americans who secure their health insurance coverage through the Affordable Care Act.

In addition, thanks to you, we are now enforcing the new law that protects Americans from being blindsided by surprise medical bills. We launched Operation Allies Welcome, an HHS-led effort that has helped over 68,000 Afghan refugees resettle in America. We are coordinating nearly \$300,000,000 in nationwide support for the launch of the 988 National Suicide Prevention Lifeline in July.

HHS has also made key investments to improve equity in areas like maternal health, where we have extended Medicaid coverage for postpartum care for a new mother and her baby from 2 months to 12 months.

The President's 2023 budget lets us build on that record of investment in America's health. It proposes \$127,000,000,000 in total discretionary budget authority and \$1,700,000,000,000 in mandatory funding, including newly proposed mandatory funding to provide for the Indian Health Service.

It also asks for \$82,000,000,000 for the President's pandemic preparedness proposal to get ready for whatever might come next after COVID-19. Considering that COVID has cost this country more than \$4,500,000,000,000 in direct support from the Federal Government so far, this is a no-brainer to prepare for the next pandemic. The funding we are requesting will be end-to-end, for research, development, approvals, deployment, and effective response.

Madam Chair, budgets represent not just dollars and investments, but our values and our priorities. This budget turns hardship into hope and inclusion into opportunity, and it is a commitment to finish the fight against COVID-19 and to build a healthier America.

On that note, I want to acknowledge our collective national failure to fund the Indian Health Service at the level needed to meet our constitutional treaty and our trust obligations to tribal nations in America. But even more so, to point out how we failed to meet the elemental level of needed support to provide fair and sufficient resources to our families in Indian Country.

I have seen these shortfalls firsthand in my visits to Indian Country, where more than 2.7 million patients are served by Indian Health Services. The President's fiscal year 2023 budget takes a historic first step toward finally delivering on our long-overdue commitments to tribal nations.

In my written testimony, I detail our proposal to convert the IHS budget to mandatory funding, as Congressman Cole mentioned. And we do this not only because it is necessary, because we have to do it long term. We are so far behind, it bolsters significantly the budgets for IHS over the next 10 years. This budget is a strong start, but we must continue to shine a light and hold ourselves accountable on our promises.

Madam Chair, I look forward to working with you and all the members of this subcommittee to make the President's 2023 budget a reality and to continue our efforts to improve the health and well-being of the American people. Working together, I am confident we can give Americans real relief, real results, and real peace of mind.

And with that, I would be happy to answer any questions that you may have.

THE CHAIR. Thank you very, very much, Mr. Secretary. And thank you for your written testimony, which was extensive and in detail. Much appreciate the information.

I have got two or three questions, and this is around the COVID supplemental, pandemic preparation, public health areas. And the administration has told us that more funding is necessary to deal with purchasing the COVID vaccines, therapeutics, tests, including covering vaccination and testing for the uninsured. What is the current status of the COVID-related activities that will be reduced or eliminated without additional funding? What are the potential consequences of failing to maintain these efforts?

Secretary BECERRA. I start by first saying thank you very much to what Congress has provided over the last 2 years. As I said, \$4,500,000,000,000 or so in support overall for all aspects of COVID from the Federal Government. That is a major investment.

What we are asking for now is to finish the fight on COVID. We are running out of the money in that Provider Relief Fund to reimburse claims submitted by all those different types of doctors, hospitals, and so forth.

Just to give you an idea, when we told providers that we would have to stop accepting claims about 2 weeks ago, in a period of about 8 days, we received over 2 million claims. And we know that what we are going to see now is just a rush for April 5, when we have announced that we will stop receiving claims as well for vaccination.

The first deadline was for testing and treatment. I think that was March 22. The new deadline for vaccination reimbursement is April 5. We expect another surge of applications to come then.

I am sorry. I think I said number of claims of 2.3. That is what we estimate the number of dollars in claims that we have received. That goes with the \$2,500,000,000—or \$2,000,000,000 to \$2,500,000,000 in existing claims that we are processing as well.

We had to call out these deadlines because we didn't want people to think that they were going to be able to get reimbursed anymore from the money that was in the Provider Relief Fund. The Provider Relief Fund has been a tremendous asset to so many, for the doctors, hospitals, community health centers throughout the country. We don't think this is a time to stop when we are getting real control over COVID.

The therapeutics, the President had us do something very important. He had us buy in advance. And so we not only made the commitment up front, but we were first in line because we made the commitment up front. We can no longer do that because we don't have the monies to make those commitments up front to the therapeutics that we know work, that actually if you do get COVID, you can be saved. You could be possibly spared going to the hospital.

But those therapeutics, whether it is the antivirals or the monoclonal antibody therapies, we need to make sure we are purchasing and we don't have to get in the back of the line to purchase in the future. That money to do that is running out.

We get to boosters. As we heard CDC and FDA announce, we can do some of the boosting right now, but right now, we are talking about those 50 years of age and older. It is going to be tough to continue this without the resources. We hope Congress will work with us to make sure we have them.

The CHAIR. Just a comment on, first of all, with regard to CDC, their ability for surveillance and early detection. The impact on CDC of what we are talking here about, you know, not committing to more resources.

Secretary BECERRA. Yes, well, CDC—by the way, I want to make sure we are clear on something in terms of the President's budget. The President's budget was essentially shaped before we knew if you would pass the omnibus.

The CHAIR. Yes.

Secretary BECERRA. We were having to base our projections for 2023 on what we knew of the CR, which was funding far lower than the omnibus that finally passed. And so when you see the funding for CDC, it was based on where we thought we could go from the CR funding level. Because the omnibus had funding levels vastly better than the CR, we are certainly going to work with you all to make sure the CDC is appropriately treated when it comes to 2023.

But CDC has been the closest partner to our State and local governments when it has come to addressing COVID. And if they don't have the dollars to go out there and do the surveillance, to go out there and communicate to communities what we are seeing, where we see the next wave coming, it makes it very difficult for anyone back home to get ready.

The CHAIR. Let me just—I am glad that the President's budget talks about preparedness for the next pandemic, and he has got new mandatory proposed—that is the \$82,000,000,000 over 5 years. I continue to believe that we underutilize the Defense Production Act, and that we should use the DPA to increase global vaccine supply in the pandemic worldwide.

And I would note that only 11.5 percent of individuals in low-income countries have been fully vaccinated, and that has to—comment on how, in fact, that does hurt us. And under your pandemic preparedness plans, how will the administration invoke the Defense Production Act? How can this be used more aggressively?

Secretary BECERRA. Madam Chair, we have used every tool in that toolbox to secure our supply chains, to ensure domestic manufacturing. The fact that this country was able to produce a vaccine in less than a year is proof of that. The fact that we have been able to disperse it to hundreds of millions of Americans to date, the fact that we have been the leader when it comes to making sure people around the world have access to the vaccine, especially in countries that are further behind the process, is a testament to the work that we have done using the tools we have.

We have engaged in, oh, couple of dozen DPA or DPA-style actions over the course of the past year, whether, as I mentioned, the acceleration of COVID-19 vaccination process, whether it is getting new tests out. Remember when the President took office, there were no at-home tests that were available to Americans. Today, we have several that are out there, and the President made millions of them available for free to Americans to get tested.

We will continue to do that, working with you as best we can.

The CHAIR. Thank you. I am going to ask the indulgence of my colleagues. I want to just finish this up, if I can? I am just going to say instead of asking a question about this, I think that there are serious consequences if we cut off support for low-income countries. I believe that that is going to hurt us at home if we cannot stop COVID across the world.

And one final comment to ask you about, Mr. Secretary, because we have put serious money into modernizing our public health data systems and to support the public health workforce. How does the budget request reflect the lessons that we have been taught about the importance of public health? How does it build on public health investments that we made in the omnibus?

Secretary BECERRA. I will thank all of you here because you made it possible for us to go to Americans rather than wait until Americans came to us to figure out how to attack COVID. We want to continue to do that, working closely with our partners locally and with our State governments.

But we need to be able to have the resources to provide them something, whether it is the data—and by the way, on the data, as much as we need money, we also need authority. There are some States that do a great job of providing this data on where they stand.

The CHAIR. That is interesting.

Secretary BECERRA. Some States don't. And it is tough when you have got these gaps. The more authority we have to collect this vital information, the better off every American will be in every State.

The CHAIR. The authority thing is interesting, and I thank you again, and I apologize to my colleagues for going over.

And with that, Mr. Ranking Member, the floor is yours.

Mr. COLE. Madam Chair, you are the chair. You never have to apologize. You take the time you want.

Just quickly, and I want to make a quick point and then get—I am going to talk mostly about—or ask questions mostly about ARPA-H.

But remember on this COVID thing, honestly, our problem is a lot of stuff in the American Rescue Plan didn't have much to do with COVID. And we see that, at least from our side of the aisle, as the number-one difficulty. There is a lot of money out there that can be redirected here, and that ought to be one of the options in front of Congress.

But I certainly agree with you, Mr. Secretary. You need to have it sooner rather than later, and when we have the progress we have had, we need to keep the pedal on the metal, so to speak, and keep it up. I don't want to get behind the eight ball here. But I also don't want to just say it is okay to send money out willy-nilly to States that is supposed to be for COVID, and it is not being used that way in many areas.

Let me ask you about ARPA, and some of these questions, to be fair to you, you may not be able to ask right now—or answer right now, and that is okay. I just want to lay these out and get some sense of what your initial thinking is and maybe where we are headed.

Give you an example. I am just going to fire off about three or four things here very quickly. Some of the things that would come to my mind would be, literally, where is the agency staff going to be physically located? What is the timeline for coming—who is the Director going to be?

How will the researchers be recruited for ARPA-H? I know we don't want to cannibalize one agency for another. How do you envision the grants being made?

All this is a problem, and I do not blame this on you or anybody else. But the authorizing committees didn't do their work. Now this was the President's top priority. I agree with him on this. But normally, that would be—other committees would have wrestled with

that. But if we are going to continue to fund this, we are going to have to wrestle with this.

And it is particularly going to be a challenge, given the amount of additional resources you have asked for. I just tell you up front from my standpoint, I am not prepared to do that, even though I am for the agency, when I have no earthly idea who the Director is, where it is going to be located, how it is going to give out the grants, what it is going to do.

I know what the NIH does in all those things, and I am certainly not going to do it at the expense of literally lowering the National Cancer Institute's budget, things like that. So just I don't disagree with the kind of spending you are talking about, but I do disagree with the division of labor between NIH and ARPA-H, which seems to me like it is going to have its hands full just getting up and running in the remainder of the fiscal year.

So yield that back to you, Mr. Secretary.

Secretary BECERRA. Congressman, you have essentially asked the questions that we are trying to formulate answers to ourselves. But I will tell you that we have gone pretty far along. In announcing that we will have a Director that is under my supervision versus NIH's Director, what we are hoping to do is show that there will be autonomy.

At the same time, because we want it, as you have just said, to be able to get up and running, we don't want them to worry about who is going to run HR, human resources, instead of who is going to come up with the next innovation, we wanted to be able to pull on those assets, that infrastructure that is already in place.

That is where NIH comes in handy. They don't have to do the administrative work. They don't have to do the human relations, the payroll work, the general counsel work by standing up all those different aspects of a new department or a new agency.

What we are going to do is house it at NIH, but actually, physically, we are looking not to house it within NIH's own structures. We are going to have them separate. It is going to be a very lean and nimble team. It will be far smaller than these agencies or the institutes you are accustomed to.

There will be program managers and including the Director him or herself will likely not be in the job for more than just a number of years, 3 to 5 years, because we want to make sure that everyone knows there is a clock on what you are doing. Unlike NIH, which does that basic research which could take a long, long time and who knows when it will be actually serviceable, what we are hoping out of ARPA is that these are ideas that we could harness right away.

Again, very similar to what the Department of Defense did with DARPA, where the Internet that we know today came out of DARPA, those kinds of things. That is what we want our ARPA to do. But we need to make sure it is not anchored or tethered to doing things an older way.

The program managers that will be hired will know they are on a short timeframe to get their work done, and then they move on. And we are going to really have to lean on the private sector to be partners in this because it is going to be a lean team that really

reaches out to folks who are out there doing it right now, and we are going to do it with some support that you all give us.

Mr. COLE. Well, I don't have much time left, but I would ask that you keep us apprised as you make these decisions. I think we all have a tremendous interest in this and want it to succeed but look at it with a little bit of skepticism until we see the structure and actually experience some success.

So, again, we communicate well back and forth. You have made a priority of that. I appreciate that. I would ask you to keep doing that and, as decisions are made, keep us informed. And hopefully, Madam Chair, we will get to revisit this issue in later hearings.

With that, Madam Chair, I yield back.

The CHAIR. Thank you very much.

Congresswoman Roybal-Allard.

Ms. ROYBAL-ALLARD. Secretary Becerra, thank you so much for being with us today.

For the nearly three decades I have been in Congress, one of my greatest frustrations has been the absence of a Federal commitment to improve childbirth outcomes. As the husband of an OB/GYN physician, I am sure you are aware that the U.S. spends more per capita on childbirth than any industrialized nation, with costs estimated to be over \$50,000,000,000.

Yet in spite of this investment, we have some of the worst maternal and infant outcomes in the developed world, including unacceptably high rates of maternal mortality and morbidity, infant mortality, stillbirths, pre-term births, and cesarean deliveries. To address these critical issues, in 2015 Congresswoman Jamie Herrera Beutler and I formed the Congressional Caucus on Maternity Care. We, together with professional organizations and community activists, have worked hard to highlight the challenges of America's maternity care system and the need to make safe and effective maternity care a national priority for all women and babies.

I extend to you a huge thank you for the \$25,000,000 in your HRSA budget to expand and diversify the midwifery workforce. This Title VIII funding line closely mirrors one of the two provisions in the Midwives for Moms bill that I co-lead with Congresswomen Herrera Beutler, Katherine Clark, and Ashley Hinson.

We all strongly believe midwives are a critical part of the solution to improving maternity outcomes, lowering costs, and addressing the maternity provider shortage. So I look forward to working with you to ensure that the final Labor, HHS bill will include this funding.

Mr. Secretary, as you know, the fiscal year 2022 omnibus agreement includes \$1,000,000 for the Office on Women's Health to convene an Interagency Coordinating Committee on the Promotion of Optimal Birth Outcomes. This coordinating committee is intended to institutionalize the oversight and coordination of Federal efforts to improve maternal and infant health in America.

We believe this is the next logical step to build on recent Federal efforts such as the 2020 Surgeon General's Call to Action to Improve Maternal Health and the 2021 HHS Maternal Health Call to Action Summit.

Mr. Secretary, when do you think the initial meeting of this committee will take place, and will you work with Congresswoman

Herrera Beutler and me to ensure the composition of this committee reflects the wide range of maternity care programs, issues, initiatives across the Federal Government?

Secretary BECERRA. Congresswoman, first, it is great to see you, and thank you for your deep interest in this area. As you mentioned, for me, it is also very important.

I would tell you that probably over the coming few weeks, we probably can get back to you on how quickly we will actually launch, with whom. We are right now trying to make sure that we have put all the correct experts on this committee. It is something that goes across many of the different agencies within HHS. So we want to make sure that we get those who are absolutely interested and committed to this and are the experts to be part of this.

But we are more than committed to work with you and Congresswoman Herrera Beutler in making sure that we address not just the outcomes issue that we face in America for women, but also the fact that we are now trying to take it to the next level.

Ms. ROYBAL-ALLARD. Great. Thank you.

And how will the Office of Women's Health-led coordinating committee engage all of the relevant agencies to stay focused on concrete policies and actions to address the crises and challenges in the maternity care system, and how will you ensure this is an HHS priority?

Secretary BECERRA. By having the interagency committee, we are guaranteeing that we will have reports on a constant basis from all these experts from our different agencies within HHS. So we will make sure—and I will be participating as well.

As you know, the President has made maternal health a major priority within his budget and his activities because we understand that everyone should have a chance to start on the right track, and making sure that both mother and baby have that opportunity is critical. And we are going to make major investments not just in this area, and by the way, midwifery is critical. The doula legislation that we have seen come out of Congress as well, all of us understand in a lot of our communities, the promotoras are extremely important to help a lot of families navigate the healthcare system.

We are going to make that a priority, and I personally will make that a priority.

Ms. ROYBAL-ALLARD. And Mr. Secretary, in order to specifically address our Nation's maternal mortality crisis, the fiscal year 2022 omnibus also provided increased funding for the CDC's perinatal quality collaboratives that would allow for their expansion in all 50 States and territories. How can PQC's be empowered to address the avoidable harms of cesarean rates that have remained appallingly high at about one birthing person in three for more than a decade, despite professional guidance that this is too high?

Secretary BECERRA. Congresswoman, I know the time has expired. So I will be quick and simply say we are going to do our part.

We have, for example, put out a proposal under Medicaid that would allow a woman who is about to deliver have postpartum care after delivery not just for 2 months under Medicaid, but for a full year. Now all we need to do is get the States to buy into that. About five States have, but we want to see every State go there,

and the President would like to see that become a permanent program within Medicaid, where every woman who delivers a baby under Medicaid would have up to 12 months postpartum care.

Ms. ROYBAL-ALLARD. Thank you, Mr. Secretary, and I look forward to continuing to work with you.

Secretary BECERRA. Thank you.

The CHAIR. Congressman Harris.

Mr. HARRIS. Thank you.

And thank you, Mr. Secretary, for being here. And it is great to be back in person.

Secretary BECERRA. Yes.

Mr. HARRIS. I think that is important for these hearings.

First of all, just a few comments. I am glad to see the Strategic National Stockpile funding, asked for \$270,000,000 additional above this year enacted. As I have said for many years, we have plenty of kinetic stockpiles, we better have stockpiles for some of the other threats we face, especially given what we know about the threats of biological and chemical weapons being used.

Second, I want to echo the ranking member's comments about the riders that were left out of the—left out of the President's budget. That is just completely unrealistic. These budgets will not pass—these appropriations bills will not pass through both chambers without those riders in place, and that is just a reality check.

Third, I also want to comment on the ARPA-H. I have some concern because tethering it to the NIH administratively tethers it to the NIH academically and cerebrally. If we wanted to increase the transitional research done at the NIH, we would do that. ARPA-H is supposed to be a different concept, and I think tethering it to an existing agency might muddy that concept.

The last, my remaining time, I want to take up two issues where the Department I think pretty clearly is not following either the law or congressional intent. First one is the surprise billing issue. This is something that I think before the rule came out the beginning of the year, we had some discussions with the Department.

We were assured that all stakeholders were taken into account, and then it appears that really only insurance companies were taken into account. That the rule that came out, found illegal by a Federal court, clearly showed the congressional intent was not the rules that came out of the agency. So I hope that you are committed on the second go-around to actually doing what Congress intended, which is not to have the QPA as the basis of the arbitration, which is to carefully define QPA not to allow insurance companies to define in such ways that will further drive down the number of providers.

And I will tell you in a rural area, it is hard enough to find providers. You drive down reasonable compensation by the surprise billing rules, you will find great difficulty in finding those professionals to practice in those rural areas.

I want to spend the last half of my time talking about an issue that we have spoken about before because the last time you were in front of the subcommittee, I think we talked about the Conscience and Religious Freedom Division of your agency and whether or not you were going to commit the Department to protecting conscience.

Sad to say, despite your assurances to both House and Senate, in House and Senate testimony, it is clear that is just not true. That urging the Department of Justice to dismiss the case against the University of Vermont shows the Department is not serious in protecting conscience. It is not serious in following the law.

The Church Amendment is the law of the land. The purpose of the executive branch is to execute the law of the land. This was an egregious violation of 10 nurses' conscience rights in being forced to perform abortions in clear contradiction of the law established by Congress, and the Department decided to drop the case—to urge the Department of Justice to drop the case.

And with a commitment that I think that—and I will quote directly from your letter in reply, “to continue to evaluate the underlying complaint.” So, in about 20 seconds, can you tell me how the Department is continuing to evaluate the underlying University of Vermont complaint?

Secretary BECERRA. I will do best I can.

Mr. HARRIS. Well, then I will have to do it as a QFR because what I want to say is that in response to that, I filed the conscience and religious—the Conscience Protection Act, obviously supported by the U.S. Catholic Conference of Bishops because we think religious and conscience protection is a very important issue.

I am just going to ask you, is the Conscience and Religious Freedom Division funded in this year's budget request?

Secretary BECERRA. Every aspect of the Civil Rights Enforcement Section will be funded.

Mr. HARRIS. Okay. So it is—so you are asking for funds, and then you are just using those funds to urge the Department of Justice to dismiss a blatant violation of the Church Amendment. Now I want to just reflect that 75 percent of Americans believe that healthcare providers should not be legally required to perform abortions.

And I will tell you, in an age—I am worried not only about abortions, but in an age where a Supreme Court Justice potentially doesn't know the definition of the word “woman” and healthcare providers are going to be asked to perform gender mutilation surgery because some people's religious—according to some people's conscience, that is what it is. And by the way, if you have any question about what a woman is, I know you are not a biologist either, give me a call. I will tell you. It is not that complicated.

I am greatly concerned about conscience protection, and I question why we are funding a Conscience and Religious Freedom Division in a department that is willing to use that against the conscience protection of Americans as the University of Vermont lawsuit, dropping that lawsuit showed.

I yield back.

The CHAIR. Ms. Lee.

Ms. LEE. Good morning, Mr. Secretary. I would like to respond to Dr. Harris, but I won't.

I am glad to see you. Thank you, Congresswoman Frankel.

First of all, thank you for your tremendous leadership, and thank you for ensuring that health equity is an important cornerstone in all of our HHS efforts.

With the support of our chairwoman, Congresswoman Pressley, Senator Warren, in the fiscal year 2022 omnibus, we included language directing HHS to submit a report that involves the detailed plan and proposal for the development of a National Center on Antiracism and Health Equity within the Department. And so following up on that, I would like to know the steps that your agency will be taking to comply with this requirement for its development.

And secondly, just with regard to HIV and AIDS, I am really encouraged to see that the President's budget requested \$377,000,000 increase for Ending the HIV Epidemic Initiative and \$9,800,000,000 over the next 10 years for a PrEP delivery program to End the HIV Epidemic in the United States. So just wanted to know how you envisioned this program being implemented?

Next, the announcement of the new HHS Task Force on Reproductive Health, the announcement, how will that be implemented? What steps are being taken?

And finally, just on poverty. Congresswoman—Chairwoman Lucille Roybal-Allard and myself, we put into the fiscal year 2022 approps bill directing the Secretary, yourself, to convene an interagency coordinating council on both child poverty and comprehensive supports. So I would like to know, in terms of your views, on the development of the implementation of this congressional directive with regard to children and the interagency council.

Secretary BECERRA. Congresswoman, great to see you, and thank you for all the work that you have been doing.

Let me try to give you a bit of an answer, and please probe if you would like to on any of those subjects.

First, the national center, for us that is a priority because we know that bad health outcomes often occur not because of just your health, but because of the social determinants around you. And so we intend to move on that as quickly as we can. We will keep you apprised.

We have a team that is working on that, but that was one that you had us at hello in trying to do that one.

On—if you could tick off so I—

Ms. LEE. HIV and AIDS in terms of the HHS implementing the program to end the AIDS epidemic by 2030.

Secretary BECERRA. I think you would agree we are that close to actually finding a cure, not just keeping people alive, but actually finding a cure on AIDS, HIV. And we should go the rest of the way.

And so you see the President's commitment to try to get us the rest of the way. We intend to try to fully implement that. We have teams at HHS that have been researching this, that have been implementing, that have been guiding America for a long time. They are anxious to be able to get the resources to let that happen.

Ms. LEE. Great, great. I have a few more questions—I may get them to you in writing—under this issue. But on the next two questions, in terms of the announcement of the HHS Task Force on Reproductive Healthcare, which was announced, how that is going and being implemented?

And finally, the children's interagency council, as relates to poverty and comprehensive supports.

Secretary BECERRA. Again, that council, we are in the process of setting that up as well. We know we have a lot of work to do be-

cause we see how throughout the country, reproductive healthcare rights of women are being not only enjoined, but probably undermined. And so we want to make sure that we are out there trying to make sure that we are protecting their rights under the law and making sure that their health is maintained.

And so we will aggressively move on that. We will work with those who are interested, including those in Congress. But we do intend to move on that one as quickly as we can.

Ms. LEE. Okay, thank you.

And the final question I had was the implementation of the children's interagency council that Congresswoman Lucille Roybal-Allard and myself are working on?

Secretary BECERRA. The same there. We were given that charge recently, and so we are moving forward to try to make sure that we put in place the infrastructure to make it happen.

Again, I think this is one of those where we have, whether it is at the Administration for Children and Families or any of our other agencies, HRSA and all those who would have a role in that, we are anxious to get going. We will keep you apprised and see who is interested in working with us on that.

Ms. LEE. Great. One more follow-up, I have a minute and 20 seconds left.

Going back to HIV and AIDS. Okay, the PrEP program, in terms of providing PrEP medication at no cost to people who really need PrEP and don't have the resources, and wanted to find out how does coverage of PrEP and no cost under Medicaid fit into the administration's overall goal for PrEP?

Secretary BECERRA. So I know that—well, what I can tell you right now is that we are doing everything we can to do bulk purchases because we know for a lot of folks it is unaffordable. If we do bulk purchases, we can get those treatments for far less cost. We can then make it more available to more Americans.

We also are trying to make sure we focus on those who are usually left behind when it comes to these types of therapies and treatments, and we are making sure that we reach to them. I would have to get back to you on how we would handle this within Medicaid because you know that is not a simple process of just turning the switch.

Ms. LEE. Okay. Look forward to hearing from you.

Okay. And finally, let me just associate myself with what the chairwoman mentioned and said with regard to our global COVID efforts and, in fact, remind everyone that we have got to have the resources for the global COVID response. There are new variants on the rise, and I just want to remind everyone that this is a very small planet. What affects one affects all. It is in our own interests to fund both domestic and global immediately.

Thank you again.

Secretary BECERRA. We concur.

The CHAIR. Mr. Fleischmann.

Mr. FLEISCHMANN. Thank you, Madam Chair.

Mr. Secretary, good to see you this morning, sir.

Secretary BECERRA. Good to see you.

Mr. FLEISCHMANN. Mr. Secretary, I have a couple of very important questions. So, in all respect, I am going to ask for the most brief response in light of the time.

One of the things that concerns me the most is the administration has announced plans to lift Title 42 within the next 2 months. That greatly concerns me, not only in my role as the ranking member on Homeland Appropriations, but this is going to allow tens of thousands of illegal crossings daily on our Southern border.

Do you support the change in this policy, and are you concerned with the strain it will place on our healthcare system and local hospitals, which are still struggling amid the recovery of the COVID-19 pandemic, sir?

Secretary BECERRA. Congressman, appreciate the question. Let me try to get right to it.

A lot of folks probably don't know what Title 42 is, but it is a law that allows us, based on public health conditions, to impose certain conditions within the country, one of those being at the border. Title 42 is based on healthcare conditions, and we use Title 42 to make sure we are protecting Americans within our country, within our borders.

Title 42 will remain in place so long as the folks at the CDC and others, the scientists give us the facts and the science to show that in order to protect public health, we can and will use Title 42 to protect Americans. And so what I can tell you is that we constantly do an analysis of where we are. We will make a determination at some point as to whether or not Title 42 should remain in place.

Mr. FLEISCHMANN. Okay. So, in addition to the national security concerns that I would have in regard to that and the border crossings, you would understand the implications this would have for the burden on the current healthcare system?

Secretary BECERRA. I recognize everything you have said. You just have to remember Title 42 is based on healthcare.

Mr. FLEISCHMANN. Yes, sir. Okay. Thank you, sir.

Medicare wage index. Over the past decade, well over 100 hospitals have closed, and over the past 2 years, COVID-19 has made healthcare access in this crisis significantly worse. It is no coincidence that most of these hospitals have occurred in areas with the lowest Medicare wage index rates.

Now I know you have inherited this, the administration has, from administrations past. It is a big problem in my State of Tennessee. Do you support, sir, a permanent legislative solution to address the problems in the Medicare area wage system and prevent future hospital closures, sir?

Secretary BECERRA. Big question, Congressman, but I absolutely understand the gist of it. What I will tell you—and I will try to be brief because I know you probably have other questions. We need to tackle this because we have seen so many of our healthcare workforce leave, and we need to make sure that they are in place not just for COVID and any pandemic, but we have to make sure we have a healthcare system that doesn't have gaps.

And so I will tell you that whether it is Medicare, Medicaid, whether it is CHIP, whether it is the Affordable Care Act, we have to make sure that we are promoting Americans going into our public health workforce.

Mr. FLEISCHMANN. So then the answer was—my question is do you support a permanent legislative solution to this?

Secretary BECERRA. Show me the legislative solution, and I will tell you if I support it.

Mr. FLEISCHMANN. Fair enough. Since national minimums for reimbursement formulas seem to be working for the Medicaid program and the Children's Health Insurance Program, do you agree, sir, that a national minimum for the Medicare wage index system is needed?

Secretary BECERRA. Again, you point to a very important program in Medicaid. The devil is in the detail, Congressman. I would love to work with you on this, but the devil is in the detail. We have to make it work not just for us, not just for patients, but for taxpayers.

Mr. FLEISCHMANN. Yes, sir. And for the record, so that you know, particularly in my home State of Tennessee, the insufficient—respectfully, insufficient reimbursements in this are causing undue pressure, particularly on rural hospitals at a time when they are really struggling. We have seen many closures. So in that regard, I would ask that you and the administration work with us to cure this.

Again, this was a patchwork system from the inception, created years and years ago. It was politicized. And if you will, it awards or rewards inefficiencies many times to raise these indexes in other areas of the country, where fiscal restraints and good policies tend to get punished for their fiscal responsibility. And that is what we see in our State, sir.

Secretary BECERRA. Congressman, what you have said I have heard before.

Mr. FLEISCHMANN. Yes, sir. Thank you.

Madam Chair, I yield back.

Secretary BECERRA. Thank you.

The CHAIR. Mr. Pocan.

Mr. POCAN. Thank you very much, Madam Chair and Ranking Member Cole. Appreciate it.

And Secretary, thank you so much for being here.

Just this month, we celebrated the 12th anniversary of the Affordable Care Act, and I just wanted to quickly congratulate you on that anniversary because I know you were an instrumental part of those bills, making sure that got signed into law, and even as the California attorney general in defending those laws.

A key piece of the Affordable Care Act was its protections from discrimination for the LGBTQ+ community seeking healthcare. Can you talk a little bit about how your team at HHS is continuing to build on these protections and further expanding care for this community?

And a related question, if I can? As you know, across the country, many States are passing laws that harm youth, especially transgender youth. I want to thank you for your commitment to these kids and ensuring that they receive the healthcare they need. What kind of outreach and support is HHS providing to stakeholders in States where these attacks on LGBTQ+ youth are taking place?

Secretary BECERRA. Congressman, appreciate the question, and it sort of goes to the question that Congressman Harris asked earlier. I believe you are referencing Section 1557 of the Affordable Care Act law, where it provides for protections for Americans against any type of discrimination in the healthcare setting.

We are going to do everything we can to make sure we are protecting people's rights that they have under law, under the Constitution. Whether it is the right of an LGBTQ person or whether it is someone who is claiming that there has been a violation of their religious freedom, we will do everything we can within our Office of Civil Rights to protect those rights of Americans.

We know that there are a number of individuals and families that are under attack these days on an LGBTQ basis. We are out there trying to inform people of their rights. We are trying to make sure providers know of their legal obligations, and we are ready to step in. If someone comes forward with a legitimate complaint demonstrating facts of violation of the law, we will jump on it.

Mr. POCAN. Great. No, I appreciate that. Thank you.

Also one thing I think that has really been highlighted through COVID is our Nation's mental health. In one area specifically, there was a congressional initiative around the National Suicide Designation Act, which is going to designate a 988 number, emergency number, to be rolled out this summer.

Can you talk a little bit how your agency is looking at educating the public on that and how this budget will provide funding to have a broad campaign so the public can understand this? And again, a related question. In my State of Wisconsin, I think 89 percent of the calls are going from local crisis centers, about 11 percent get routed to the national, just how that support and the importance of those local crisis centers fits into this?

Secretary BECERRA. So, Congressman, as you are probably aware, suicide is the leading cause of death of young Americans and young adults in this country. We are in a crisis. COVID exposed just how much mental stress so many of our families are going through.

I believe half of American parents report that their children are thinking of suicide. It is a crisis, and fortunately, the President has not only decided that it is a priority, but he is putting money behind it as well in his budget. We have invested over \$300,000,000 in trying to help States help us patch together what is the existing set of suicide prevention centers that are available throughout the country.

We finally—through your good work in Congress, we now have the ability to talk about suicide prevention by something akin to what we think of in terms of an emergency response. Everyone knows 911. If you are in an emergency, you call 911. Well, if you are facing a mental health emergency, now you will get to call 988.

And if you call 988, we want to make sure you have got not just a supportive hand, but a professional hand ready to assist you. And so what we are doing is we are working with States throughout the country to make sure everyone is ready. This will not be a national, Federal Government-run hotline. It will be brought together by the Federal Government with the President's support for this.

And what we are hoping to do is make sure that if you call 988, you don't find a busy signal or you don't get put on hold. That you will actually get assistance. Because if you are reaching out at a time when you could have gone the other direction and just said I am just going to end this thing, we want to make sure that when you reach out, we are there.

Mr. POCAN. A very important initiative. I don't think in 16 seconds I can ask another question fairly. So I will submit those.

Madam Chair, I yield back.

Thank you, Mr. Secretary.

Secretary BECERRA. Thank you.

The CHAIR. Thank you. Ms. Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Mr. Secretary, for being here.

And I wanted to bring up just a quick follow-up on my colleague's question about Title 42 and rescinding that authority. And you made the point that it is a health-related decision. And I agree with you, which is one of the reasons I would ask you to help us get the administration to reconsider.

You could do a quick Google search of just drugs flowing in from Mexico. And fentanyl, which is a huge problem in Washington State and across this country, certainly on the west coast. Every major newspaper has stories on how this drug, which, as you know, is killing people, and methamphetamine are flowing over that border.

And we can almost tell. I have met with my local law enforcement in the middle—I am I-5, Canada to Mexico. You know I-5. They can tell within a week of a surge, drug prices for fentanyl drop to \$3 a pill, and we see increases in overdose deaths and hospitalizations.

So I would argue that it is, in fact, a health crisis as well, which would give you the reason to use that Title 42 authority to gain some more control over the border. So I just wanted to put that in your wheelhouse.

And let me start by saying Congresswoman Lucille Roybal-Allard made several really good points about our efforts on infant care and maternity care. And you know that the numbers for the developed world, the U.S. is not where we should be on both of these fronts. So I do want to say I am very grateful that you are working to implement an extension of Medicaid for women during that first year of life.

We know that most of the mortality incidents that happen happen within that first—happen within that first year, not within the first couple of weeks or 6 weeks of giving birth, but it is most of them happen after that. So making sure that that Medicaid coverage extends to that first year of life for the baby and the mother to treat that is incredibly important. We have legislation to that effect, but I am glad to see that the administration is moving forward with that.

On the fiscal year 2022 omnibus package, Lucille and I were able to secure \$750,000 for the first-ever Stillbirth Task Force at HHS. More than 22,000 babies are stillborn every year in the United States, one of the worst stillbirth rates in the developed world.

Where is HHS in the process of setting up that task force, and how can we utilize existing programs like the Safe Motherhood Initiative to optimize the work of this task force?

Secretary BECERRA. Congresswoman, first, thank you for all the work that you and Congresswoman Roybal-Allard have been doing on these subjects. Small investment, big change. And I would—we are going to work with you on that. Thank you for making it possible. We are going to get to work as quickly as we can on some of these things.

I can't tell you how many stories my wife has told me about stillbirths, as an OB/GYN. That is as devastating as it gets. And so we will do everything we can. We will include you. We are going to try to make sure everyone understands that we have an opportunity now to really shine a light on this and focus a bit more.

Ms. HERRERA BEUTLER. Great. Thank you.

Switching a little bit to telehealth. One of the silver linings, I think, if there is that, of the pandemic was that we recognized that we can do telehealth and do it well.

The biggest challenge—and for those of us in more rural areas, it has been a godsend. The biggest challenge I have heard is it has been great that CMS, there were waivers in place to pay for it. Will those be extended?

And I know that there is a little bit not totally within your purview, but I would like to hear you for a moment just share what your intentions are with regard to trying to help us make that more permanent?

Secretary BECERRA. Well, first, I have to thank you all for giving us the extension of another 5 months of the authorities on telehealth under this public health emergency. We need more help because we only have certain authorities to continue some of the telehealth activities that we have engaged with.

And we are hearing from all sorts of providers and families about what happens if they can't use telehealth. So we are going to do what we can. We are going to stretch our authorities as much as we can under law, but we do need Congress to help because the statutes constrain how much we can use telehealth. So please help us with that. Thank you for the 5-month extension.

Ms. HERRERA BEUTLER. In my area, switching to workforce shortages, and very quickly, obviously, we don't have enough of anything, right? We don't have enough RNs. We don't have what we need. Again, this is another piece where telehealth can help.

But your budget proposes a \$2,100,000,000 increase in the HRSA workforce program. How can we ensure that we are focusing on the entire workforce pipeline? And how can we do this in the most expeditious manner possible?

Secretary BECERRA. We have explicitly, specifically targeted rural health as well as some of the underserved areas. A quick example is on telehealth, you could have someone who wants to do telehealth as a provider, as a doctor, but if you don't have good broadband, there is a really strong chance you are still not going to be able to take advantage of that.

So the investments in broadband that now have been made available, the fact that we are trying to figure out how we allow that service to cross State lines as well because there are different

standards in different States for those medical professionals. Not to let the old way of doing business get in the way. We are going to try to do all of that, but that is where we will need your help to give us the authorities to go beyond what we have done before.

Ms. HERRERA BEUTLER. Thank you. I yield back, Madam Chair.

The CHAIR. Congresswoman Clark.

Ms. CLARK. Thank you, Chairwoman.

And it is so wonderful to be with you, Secretary Becerra. And I want to thank you for this budget that puts the American family first and is concerned about their health and their security, and it is a great piece of work.

Specifically, I want to ask you about child care. We know we are not going to have an economic recovery. We are certainly not going to have one that includes women unless we make investments in child care, and I am grateful for this administration's help with the American Rescue Plan, the \$40,000,000,000 we were able to secure to stabilize child care. And we know we have to go further, and this budget does that.

But I specifically want to ask you about the workforce issues. Child care providers are overwhelmingly women and women of color. They make an average of \$12 an hour caring for our children, leaving too many of them in a position they can't care for their own. And they have lost one out of nine jobs in this sector.

So, specifically, how is this budget investing in that workforce? Are there other things Congress can do to help prioritize?

And in addition, just yesterday, I was with a healthcare leader from my district who was telling me about how linked in his hospital the nursing shortage and the shortage of child care is. And I specifically want to know if the \$324,000,000 for the Health Workforce Programs address the caregiving needs of our healthcare professionals?

Secretary BECERRA. Well, Congresswoman, first here I have to thank those of you who supported the American Rescue Plan because it made available to us billions of dollars to help a lot of those child care workforce participants, but also the families. We know that if we are able to get the child care proposals in the Build Back Better agenda, that we would have the ability to actually meaningfully tackle this, not just try to put a band-aid over it.

It is tremendously important for the tens of millions of families who need child care. We saw women lose jobs in numbers never seen before because of COVID and the need to be home to care for kids, not being able to have a child go to school.

And so I don't think there is any question that we have to make major investments in child care, Head Start. The proposals that have been put forward would help us go there. The President's budget makes additional investments into child care, but to really take this where we have got to go to the next plateau, we hope that Congress is able to get across the finish line in the child care proposal that is in the President's Build Back Better agenda.

Ms. CLARK. Thank you.

Next, I am also grateful for your leadership in releasing through the ARP and the fiscal year 2021 omnibus LIHEAP increases, a lifeline for families in Massachusetts and across this country. But we know that due to Putin's war, the pandemic, corporate greed,

prices are still going to continue to soar and be out of reach for way too many families.

There is an increase of \$175,000,000, and I just want to know how you are preparing for increased volatility in this line-item, and are you working with Department of Energy to anticipate to the best you can?

Secretary BECERRA. We are hoping to work not just with the Department of Energy, but with the Department of Education, with the Housing and Urban Development Department so that we can coordinate our activities. So that if there is a family in need, it might be energy—help with energy bills. It might be help with staying housed and not lose your home. Whatever it is, we are going to try to make sure that we are working together to make sure that we are tackling this.

No doubt that the dollars that you provided previously and the dollars the President is requesting for LIHEAP will take us a ways. And the more we are able to see success in this effort to keep the leadership in Russia from this crazy war in Ukraine will help us. But we are going to meet every need we can with the dollars that you have given us because we know it could be the difference between life and death for someone who needs that heat or someone who has to stay away from the horrid temperatures in the summer.

Ms. CLARK. And briefly at the end of my time here, we know that overdose deaths have increased by 30 percent, and that not the area we want equality. Now black deaths of opioid overdose—due to opioid overdose are exceeding those of white people. And so I just am urging there is a program that we helped create and I led on that helps link student loan repayment to encourage and retain people in substance use providers.

You have increased that account by \$4,000,000. We are very grateful to your attention to this program, but we also know that only 8 percent of those 3,000 applicants to this STAR LRP program last year were able to be funded. So we hope we can continue to work with you to meet this need so we can get people the treatment they need and deserve and reduce these terrible rates of deaths and overdose.

Secretary BECERRA. We want to give you wind underneath those wings to make that happen because getting those professionals out there is absolutely important.

Ms. CLARK. Thank you so much.

Thank you, Madam Chairwoman.

The CHAIR. Mr. Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair.

Good morning, Mr. Secretary, and thank you for your service to our country.

One of your—within your statutory authority as Secretary is not only to declare a public health emergency, but also to terminate that decision. One of the questions I have is when do you plan to declare an end to this public health emergency? What scientific metrics will you use? Is there a specific rate of transmission? How will you make that decision?

Secretary BECERRA. And Congressman, I think there are a whole bunch of folks waiting to hear this answer. So, great question.

It will be based on the science and the facts that we are collecting. And by the way, that goes back to the question about data, why it is so important to collect accurately so we make the right decisions. It will be based on the science, on the conditions we have in the health sector.

There are a number of issues that we could—that are obviously floating around there, but in terms of the health of the Nation, where are we, and are we at a point of still an emergency? We are in the process over the next couple of weeks of getting ready to review again if we should continue the public health emergency forward.

We have also made a commitment because we know providers are counting on us, whether it is on the telehealth issues, to continue to have authorities to use telehealth or not. A lot of providers are relying on our extended authorities to do things. And so we have committed to try to give people at least 60 days' notice if we think we are going to take down that emergency declaration.

Mr. MOOLENAAR. Okay.

Secretary BECERRA. What I can tell you is in the next couple of weeks when we review it, we will assess the facts, science, and make a determination. But we do hope to be able to give people at least 60-day notice.

Mr. MOOLENAAR. Okay, thank you.

And then, with respect to the mandate, CMS has a mandate on vaccines. You had mentioned the workforce issues. Are you aware that people are leaving as healthcare workers because of this mandate, and shouldn't we be allowing the medical professionals to make that decision of how best to protect themselves and their patients?

Secretary BECERRA. I think we always want to work with and respect what the experts in the medical field are telling us we should try to do. We do follow the experts that we have at CDC, NIH, FDA, and what they have told us is that keeping people safe and especially in a medical setting like a hospital, a nursing home, requires us to do—use every precaution we can, whether it is a vaccine, whether it is a mask, whether it is the social distancing or the sanitary conditions.

And so when it comes to the provisions that we put out there in some cases requiring folks to use masks, requiring them to get vaccinated, it is for the protection of the American people.

Mr. MOOLENAAR. But are you aware that is actually creating workforce issues where we are losing healthcare workers, the people who have been on the frontlines, heroes, who are deciding to leave rather than submit to this mandate?

Secretary BECERRA. Congressman, I have heard some of those stories. I would simply say if you are one of those heroes, one of the ways you become a hero is by making sure the people you are treating are as safe as they can be. And if you are not vaccinated and by chance you contract it, even if you show no sign of the illness, you might pass it on to somebody.

Mr. MOOLENAAR. But that is true even if you are vaccinated. Correct?

Secretary BECERRA. Less likely to happen if you are vaccinated. Far more likely to happen if you are not.

Mr. MOOLENAAR. I recognize your commitment to vaccines, vaccination. One of the concerns that has been raised is about the level of commitment to therapeutics and making those available, approving as many safe possible therapeutics. Are you committed to that?

Secretary BECERRA. Absolutely. Can I give you a bit of an extended answer? Right now, a vaccine likely costs us about \$25 to \$30 to make available to Americans. Those antivirals, those alone, those therapeutics probably cost us somewhere between \$500 to \$750 to \$1,000 a treatment.

Those monoclonal antibodies are costing us in the several thousand dollars a piece. Thirty dollars versus several hundred dollars versus several thousand dollars. One might keep an American from contracting COVID. The others are trying to keep them from dying from COVID.

We would rather do the—as we say in Spanish, “mejor prevenir que remediar.” Better to prevent than to remediate. If we spend the \$30 to prevent it, rather than pay later, pay now \$30 than pay later hundreds or thousands of dollars per American, we think it is a smart investment.

But we are going to have the therapeutics available, and that is why we need some funding from Congress.

Mr. MOOLENAAR. Just so I know, the President recently received a booster on television. How often is he going to need a booster? How often are you going to recommend that to the American people?

Secretary BECERRA. That is up to the scientists and the medical professionals. But just as we get vaccinated for flu on a constant basis, what we are finding is that COVID is a—it is a treacherous animal, and it is hard to control. We will do what we can to keep Americans safe, and we will make sure that if we give them a medicine, a vaccine or therapy, it will also be safe.

Mr. MOOLENAAR. Thank you.

Secretary BECERRA. Thank you.

Mr. MOOLENAAR. I yield back, Madam Chair.

The CHAIR. Ms. Frankel.

Ms. FRANKEL. Thank you, Madam Chair.

First, I want to just thank all my colleagues for the bipartisan approach in getting this budget done. With that said, I want to just say this, that compromise does not only always mean agreement. In my opinion, without any personal disrespect to any member, the Hyde Amendment is not wise. I think it is unjust and cruel, and I believe it takes away the freedom from people to make the most personal decisions that they can have, and it hurts the people who have the least amount of resources.

Let me just also just add that no patient should be denied the care they need, and I appreciate the administration’s position on that.

So let me just add my thanks to your proposed budget. The funding for—increased funding for Title X, child care—that is reproductive care—to child care, maternal health, mental health. And I think it is very important that not only are we helping people take care of themselves, but we are reducing the costs for people so they can take care of themselves. And I would like to just say that I

think the best defense for this country is to have a strong economy and have people live well.

I have a couple of questions. Thanks to the—and thank you for being here. Thanks to the Affordable Care Act, there is a contraceptive coverage requirement really allowed millions of people across the country to really to afford contraception, but we have been hearing lots of stories that health insurance companies are not complying with the law.

So, for example, they pick a couple of products that a consumer can use, a patient can use, and not others. Or they are actually requiring payment and cost-sharing. I wanted to know what the Department is doing to ensure that every plan subject to the ACA's birth control coverage requirement is complying with the law.

Secretary BECERRA. Congresswoman, thank you for the question.

I have experience with this not only as the Secretary, but as the former attorney general in California, where we moved to make sure that women's rights to contraception coverage were protected. As the Secretary, we have been working jointly with the Department of Treasury as well as the Department of Labor to make sure that there is clear guidance to providers on what they are obligated to do when it comes to providing healthcare services to Americans.

We will continue to make the case that under the ACA, individuals, including women, are entitled to certain protections and services, including contraception coverage. And if someone points out to us a case where there is a provider that is violating the law, we are prepared to take action as well.

Ms. FRANKEL. Thank you for that.

And this is an issue that I hope Mr. Cole is going to join me in in vigorously tackling. He is smiling. He knows what I am going to talk about.

Each year, there are about 36 million falls reported among older adults, and it is amazing what it costs our health system. Not only cost to the individuals themselves, just in terms of their physical, mental health, and their pocketbook, but it costs us over \$38,000,000,000 for Medicaid and Medicare, and then another \$12,000,000 just in private insurance costs or out-of-pocket costs.

I was astonished in researching this that the Federal Government only invests a few million—CDC \$2,000,000, I think it is—in fall prevention programs. I want to thank our chairlady because I know we are going to have a hearing on this. I was just wondering whether you all are doing any work to look at this?

Secretary BECERRA. So we right now have our National Institute on Aging, the CDC, which you mentioned, as well as our Administration for Community Living, those three agencies within HHS have been working on these issues. We work with the States and the local health authorities there to figure out how we can invest in some of these activities.

But Congresswoman, as you know, at the Federal level, we don't usually try to figure out which program is best and give the money to that program. We work with the States to let them decide locally which are their best programs. We try to support, make investments in those programs, and we have done some of the research. We try to provide that to the States, and then, working together, we hope that with the resources that you made available to us that

we make available to them, that they will make investments in those types of activities.

Ms. FRANKEL. All right. Well, I look forward to further discussion on that.

And Madam Chair, I yield back.

The CHAIR. Mr. Cline.

Mr. CLINE. Thank you, Madam Chair.

Thank you, Mr. Secretary, for joining us. It is good to have you with us. It is good to be in this room in person, and I am pleased to be a new member of the committee in this room.

But you talked about facts and science guiding your decisions when it comes to Title 42, for example, which I would advise we should not repeal. I think it is a policy that is necessary to protect the public health, and I would urge you to continue to enforce it.

But I want to talk about a different subagency that you have, the CDC, and allowing politics to override policy and science. A report of the Select Subcommittee on the Coronavirus Crisis revealed that the CDC allowed the American Federation of Teachers to rewrite critical portions of the Biden administration's school reopening guidance. The CDC initially planned to issue guidance that would have been more favorable toward opening schools but reversed course after consulting with teachers union bosses, giving favorable treatment and access to teachers unions instead of parents and ignoring science and the necessity of opening our schools.

And we see what that resulted in. Not just lower test scores for our children, but also increases in depression rates, increases in suicide rates, increases in drug and alcohol addiction rates, increases in domestic violence in the home.

So let me ask you first, Mr. Secretary, were you in contact with the American Federation of Teachers about these guidelines?

Secretary BECERRA. Congressman, I would love to probe what you said but—

Mr. CLINE. "Yes" or "no" would be perfect.

Secretary BECERRA. I have not been in direct touch with any particular stakeholder just on those guidelines itself. We have done numerous stakeholder meetings with all sorts of organizations, individuals, governments on the issues because that is what we always do is whether it is CDC or us, we always consult with everyone that might be impacted.

So along the way in formulating any proposal, we speak to anyone who might be impacted.

Mr. CLINE. So the answer is "yes" to that.

Secretary BECERRA. I didn't say that that was the answer. I said we speak to every—if you want to characterize it properly, Congressman—and having been in your seat before, I would make sure no one gets misquoted.

Mr. CLINE. I would love a "yes" or "no" answer to that.

Secretary BECERRA. I have—we have sat down with every stakeholder who has asked us on those particular issues.

Mr. CLINE. Okay. And that includes the AFT?

Secretary BECERRA. I am pretty sure it has.

Mr. CLINE. Okay. Is it Department policy to keep draft guidance confidential?

Secretary BECERRA. Draft guidance is within the internal operations of the Department.

Mr. CLINE. Right. And historically in the CDC, draft guidance has been kept confidential. Correct?

Secretary BECERRA. Well, it is an internal document. It is not something for public consumption because it is not yet ready for prime time.

Mr. CLINE. Right. So sharing it, as testified to by the Director of the CDC for the Select Coronavirus Crisis Task Force, they testified that it was unusual to release that guidance to an outside group?

Secretary BECERRA. I am not sure I would characterize what happened as you have, but what I will tell you is in consulting and meeting with stakeholders, we certainly give them some sense of what we are looking at and ask for their guidance. How much actually translated into what you have described? That is where I think the facts have to answer that question.

Mr. CLINE. Are you aware of other cases in which the CDC or any other agencies under HHS have incorporated language from outside stakeholders?

Secretary BECERRA. We certainly—as I said, we offer every stakeholder an opportunity to comment, whether it is a formal rule that we are getting ready to promulgate or whether we are looking to have a guidance. We always reach out. Every administration has, at least I hope they have, to have those who might be impacted to get their input.

Might their input help us shape the final version of that guidance or rule? I would hope so because we are supposed to listen to the American people.

Mr. CLINE. Okay. Moving forward, would you commit to citing those outside partners who are—who may have been consulted in the development of these guidelines?

Secretary BECERRA. Congressman that is all public record.

Mr. CLINE. When you are developing these guidelines, you just told me that it is policy to keep draft guidance confidential.

Secretary BECERRA. Oh, the draft guidelines, anything that is still internal is internal. But when we reach out to stakeholders that is publicly available.

Mr. CLINE. Are you committed to listing those stakeholders?

Secretary BECERRA. Again, as I said, it is already publicly available. Those meetings are in the public domain.

Mr. CLINE. And citing them in the development of these types of official guideline?

Secretary BECERRA. If you take a look at regulations when they are issued, they will note the comments that have been received, and we usually have—try to be responsive to most of the comments that we receive as we are getting ready, for example, to promulgate a rule. So, again, that information that comes in from the public, when we react to it, you will see it in writing.

Mr. CLINE. Well, you didn't cite AFT when you put out those guidelines for school reopening. So I would encourage you to be more forthcoming.

Secretary BECERRA. You have reached a lot farther along than what I am saying we have done.

Mr. CLINE. You are talking about regulations. I am talking about guidelines where you neglected to disclose that the AFT edited the guidelines, on the orders of the White House, and put them forward as CDC guidelines and neglected to release the fact that the AFT altered those guidelines.

And I am asking you if you would commit to publicizing the fact that you allow politics to override science when it comes to your guidelines?

Secretary BECERRA. Congressman, it would be tough for me to respond to that because I don't agree with the premise that you have just laid out.

Mr. CLINE. Well, I don't agree with what your CDC did in promulgating those guidelines. Children died because of that.

I yield back.

The CHAIR. Mrs. Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Chairman.

Secretary Becerra, it is so good to see you. It is so good to hear the good things that are happening, and let me also echo that I think our budget is moving—your budget requests are moving in the right direction, even though I would like to see some more things in some places.

From a general perspective, I am very interested in all of those issues from mental health to suicide to maternal health. I am particularly concerned how all of those issues impact black women and the black community and black children. Because as we all know, unfortunately, in this country, we represent the bottom of the heap when it comes to the direness of all of these issues.

So I am going to ask you some questions about that, but before I do, I want to ask you about something that is very disturbing to me. Recently, the CMS drafted—made a decision impacting the access to Alzheimer's disease medication. And this decision is delaying the availability of that medicine, even though the FDA had already taken it through its procedures and had deemed it ready to be more available.

And so I am wondering is there some miscommunication, is there some new authority that CMS has? Does this represent a redundancy? Are you at all aware of it, and do you have a thought about addressing this issue? Because Alzheimer's disease is something that is just so devastating to our various communities, and the sooner we can get a handle on it, the better.

Secretary BECERRA. Congresswoman, first, I couldn't agree with you more. I think all of us believe that in the near future, we will probably see medicines and therapies that will help us tackle some of these just devastating conditions and diseases like Alzheimer's. And we want to be there. I think all of us would like to make sure we are there as quickly as we can.

And for that, we have to make sure we have got the science coming along with us because we want to make sure that we are telling people we are giving them the treatment, the medicine that will help either cure them or stabilize them and not harm them.

And so remember that FDA has to operate and does operate under a different set of rules than does CMS. FDA has to tell us if they think there is a treatment out there that might be safe and effective and under what conditions, and FDA gives a conditional

approval to Aduhelm to provide some treatment for some individuals who might be on the stages of—into the early stages of Alzheimer's.

CMS has to make a very different determination. Whether or not, now that FDA has moved on a conditional basis, that all the 65 or so million Americans who receive Medicare services would qualify to receive Aduhelm and have it reimbursed or have their doctors and providers get reimbursed for having provided it. Two very different things. Two very different analyses.

One had—FDA had——

Mrs. WATSON COLEMAN. However——

Secretary BECERRA. I am sorry.

Mrs. WATSON COLEMAN. Can I interrupt you? Because I have so many other questions.

Secretary BECERRA. Yes.

Mrs. WATSON COLEMAN. It seems to me that the FDA is relying on—that we rely upon the FDA on the science, on the efficacy of the therapy or the medication, and CMS makes a determination as to whether or not it should be covered. The latter is important, but the former is the determination in my mind as to whether or not that medication should be available.

My understanding is this is an unusual step for CMS to get into after FDA, and I would like to have more information on that. I did send you a letter on that. I am looking forward to a response on that. Maybe we can't answer it at all today, but I get it that there is two lanes. But it looks like there is an unnecessary cross-over through CMS into a lane that isn't theirs to be in in the first place.

But moving on, I am concerned about an issue that you all have been touching upon. We know what is happening with mental health issues in all of our communities. I am particularly concerned about mental health and suicide and those things that affect black youth, black women, black men. Other sort of underserved communities.

I am interested in 988 being made publicly available and diverse in who answers that phone, who has the capacity to answer those questions, and making sure that everyone—and I want to know what you all are doing to make sure that there is wide knowledge of it and diversity in it.

And I also want to know one last thing, and that is that we really have experienced an amazing impact on children and adults through this pandemic. One thing that I see that I think we need to give greater attention to is the children who have lost their protector, the person who has taken charge of them, who has cared for them, who has paved the way for them up as a result of this COVID.

And I think that we need to be looking at what are the long-term needs and how do we pay for those long-term needs so that those children have adequate mental health support, as well as any other support that they need?

I see that all the red lights are zero, zero, zero, which means that I am out of time. But I have given you kind of a flavor of where I am and where my concerns are, and I certainly will follow up with some additional questions to you in writing.

Thank you so much.

I yield back.

Secretary BECERRA. Congresswoman, you have never stopped letting me know where you are. So that is good.

The CHAIR. Congresswoman Lawrence.

Mrs. LAWRENCE. Hello. Thank you so much for being here. So good to see you. I have called you a lot of things—colleague, and now I call you my Secretary.

I want to commend the Department for more than \$250,000,000, including \$8,000,000 to Michigan's Department of Health and Human Services, to expand and restore access to affordable Title X family planning. I just want to thank you for that.

As previously noted, the COVID-19 pandemic has undoubtedly had an impact on the mental health of our children across this country. I have a unique passion for protecting foster youth, which they are no different.

Earlier this year, I led a bipartisan, bicameral group of my colleagues, urging your Department to determine what resources States and territories need to ensure that every child can have access to timely mental health services in foster care. And we know that the CFSRs provide an opportunity to review State child welfare systems. This includes assisting the States by ensuring children and families achieve positive outcomes.

However, in order to fully understand the work, we need updated data to reflect the number of mental health screenings and the frequency in which they are conducted. So, Secretary, today I am asking if you will commit to reviewing the letter from me and my colleagues and the critical information in forthcoming CFSRs?

Secretary BECERRA. Congresswoman, first, thank you for your devotion to this issue. We are going to make a special emphasis within the Department on foster care. Because of the resources you all have made available, we can actually try to take States to the next level because we know that they are behind on their assessments.

Mrs. LAWRENCE. Yes.

Secretary BECERRA. They haven't been providing the right data. We have talked about how valuable data can be. Bad inputs produces bad outputs, and so we are going to try to do as much as we can. If you get to the point of getting this Build Back Better, I will tell you that we will have an opportunity to do far more.

But we are going to do what we can because we know in the foster care system, we are seeing too many of our young people age out and then really be in trouble. And so we would love to work with you further on this, and thank you for that letter.

Mrs. LAWRENCE. Thank you so much.

Also, the pandemic has worsened America's maternal mortality crisis. I am encouraged that the President's budget is reflective of putting resources into it. Last year, I introduced the Doula for VA Act to create a pilot program at the Department of Veterans Affairs providing veterans the access to doulas, which they have been denied.

So, Secretary, can you explain to me how the President's budget will grow and diversify the doula workforce as well as other proposed maternal health pilot programs?

Secretary BECERRA. And Congresswoman, thank you for the question.

As you have heard in some of the previous responses I have given, we are making maternal health a major focus. There is no reason why a woman in this country today should die as a result of birth of a child. Even worse, of course, for the child as well now going without his or her mother.

And so we are going to do everything we can. We are encouraging States to join us. I mentioned the program where we are going to expand access to postpartum care to one full year instead of just 60 days. But we need States to buy in. So I would encourage you to go back home and chat with your folks in your State of Michigan.

Mrs. LAWRENCE. But I wanted to specifically encourage you to incorporate doulas. We know, especially in low-income areas, sometime the doula that are in the community are the only support system that can help nurture a woman through her pregnancy and post pregnancy.

So my ask specifically is for please—and continue what you are doing—and I am going to continue fighting, but I know how important a doula component is to ensuring maternal health.

Secretary BECERRA. You all are moving us in that direction through some of the legislation that has been proposed. We understand the importance of some of the paraprofessionals. You don't need to have an OB/GYN like my wife in order to provide good care.

Mrs. LAWRENCE. Right.

Secretary BECERRA. In fact, she is one of the first ones who will tell you that if you get a person who can give guidance to that woman during the 9 months of pregnancy, we are all going to be better off.

Mrs. LAWRENCE. And I want to just remind while I have these 2 seconds is that foster children are wards of the court. It is on our dime and our responsibility to take care of them. They have been through more trauma than most adults, and our commitment to them through their mental health is extremely important.

I thank you, and I yield back.

The CHAIR. Thank you.

We have been through with the first round. What I would like to do is proceed to a very shortened second round of questions. Secretary Becerra has a hard stop at 12:30 p.m.

So I am just going to say it is your question and allowing time for the Secretary to answer, we are talking about within the time-frame of about 2 minutes. So if we can. So we want to—and thank you. Thank you, Secretary.

Let me begin by just saying that we have a shift in how we respond to behavioral health these days. I think the 988 will be able to direct calls to behavioral health and would deal with mobile crisis teams and be able to respond to these crises. And these teams are being set up around the country.

We funded these teams in two ways last year. We created a new pilot program at SAMHSA. We funded several community project requests for members who wanted to support these teams in their

own communities, and they are composed of people who are trained with medical care.

An individual experiencing behavioral healthcare crisis needs that versus law enforcement. We did a hearing here on that several months ago, and the result has been they are spread all over the country. Now we are going to implement this program.

How does the request—I am concerned about States that do not have a robust crisis care and want to be able to follow up on how we are going to make sure that this new system in place is really working and so forth. And how are we going to ensure that the individuals are going to be linked with that care?

Secretary BECERRA. Madam Chair, we just did another stakeholder meeting on this. We have done several on this. We are doing everything we can to shepherd this within the States. I just finished having a conversation when I was in Colorado with one of the leaders, executive leaders at the Western Governors Association, reminding them that we are ready to work with any State and any governor who wants to work with us to make sure that they are ready to go.

We don't want anyone to be at the back of the bus when it comes to how you handle this. And so we are doing everything we can. We are providing resources.

I will say to you, and I say this to each and every member. Help us make sure that your States are ready. Because we can't dictate to them everything. We are trying to use the carrot, but the stick comes when some kid calls and ends up with a busy signal.

The CHAIR. Right, right. Thank you.

And we need to deal with resources, but we need to deal with the oversight to make sure it is happening.

Secretary BECERRA. Absolutely.

The CHAIR. With that, I recognize Congressman Cole.

Mr. COLE. Thanks very much, Madam Chair.

Mr. Secretary, I want to go back very quickly to this issue of additional money for COVID relief because I have very little quibble with what the Department is asking for in terms of what the purpose is going to be. Do you have a clear understanding—because we get all kinds of figures that are hard to nail down—about how much unpurposed money there is in specific accounts and what have you that could, if we could come to an agreement, be diverted to give you the resources that you need to tackle the problem as quickly as possible?

Secretary BECERRA. Unpurposed, the numbers are fairly small in most cases. The Provider Relief Fund, for example, we have reached almost the \$186,000,000,000 that was made available. There is some still available that is kept to make sure that we didn't miss any particular claims, didn't do them right.

There was some money that was going to be used, for example, for testing. We are going to probably have to figure out if we can reprogram, but most of that money, as far as I can tell, has been purposed.

Mr. COLE. Is there money—and look, these are never popular decisions to be made. I get that. But it is going out the door, particularly to State governments. It is not being used for COVID. It could

be repurposed, quite frankly. And that is a political problem for us, but just my understanding is there is quite a bit of that there.

I had very little problem, honestly, with the administration proposal or the legislative compromise on the COVID package that was stripped out. Fine. Let us take that money from these States where I know it is not being used for this. This is more important. Let us do this. And I am sorry that that honestly wasn't part of our package.

Moving forward, I think we ought to revisit that, find another way legislatively, you know, not to bore everybody with this stuff because everybody here knows it. But that came down on what is called a rule vote. It wasn't a vote of the substance of the policy. We didn't disagree with you on the policy.

So if you could help us at least get a clearer vision of what is available, it is our decision, not necessarily yours. But I do think this funding issue is going to get in the way of letting you do the things that I think you know need to get done as a department and that we don't disagree with you. We just got to use some of this other money that was not directly COVID related that went out the door.

Secretary BECERRA. I appreciate the way you framed it.

Mr. COLE. Okay, thank you very much.

Yield back, Madam Chair.

The CHAIR. Congresswoman Roybal-Allard.

Ms. ROYBAL-ALLARD. Mr. Secretary, as you know, every year, 4 million babies are born in the United States, and nearly every one of those infants is screened by newborn screening programs for certain serious or life-threatening hereditary disorders and medical conditions that can be treated. And on average, newborn screening saves or improves the lives of more than 12,000 babies each year.

My Newborn Screening Saves Lives Act passed in 2008. It was reauthorized in 2014, and we are currently working to get the House-passed 2021 reauthorization bill also passed in the Senate. The Newborn Screening Saves Lives law established national newborn screening guidelines. It ensured the quality of laboratory newborn screening tests and established grants to help States expand and improve their screening programs. Also to enable them to educate parents and healthcare providers and improve follow-up care for infants with a condition detected through newborn screening.

The subcommittee has recognized the critical role that both the CDC and HRSA programs play in protecting our children and has been providing generous increases to them each year, including \$25,800,000 for the HRSA program and \$23,000,000 for the CDC quality assurance program in last year's House bill.

Unfortunately, in the final fiscal year 2022 bill, both of these programs received \$19,000,000 appropriations for fiscal year 2022. While this funding is, in fact, significant, it unfortunately falls short of what is needed to meet the needs of the CDC and HRSA screening programs.

I applaud the President's commitment to advancing maternal and child health, but I was disappointed to see that he requested \$19,000,000 for both the HRSA and \$19,000,000 for CDC newborn screening programs for fiscal year 2023. I hope that I can get your commitment to work with me to ensure the viability of these crit-

ical screening programs through robust funding in the final fiscal year 2023 appropriations bill.

And my hope is that until this law is authorized, that you will ensure that the lifesaving programs continue, and the Secretary's Advisory Committee is able to make its critical—

The CHAIR. The gentlelady's time has expired.

Ms. ROYBAL-ALLARD. I just need a "yes" answer. [Laughter.]

The CHAIR. I understand that. So got to get to "yes."

Secretary BECERRA. Madam Chair, I want to give a straight "yes," but what I have to say is that the funding levels that we put in, again, as I mentioned before, were based on what we thought we were going to have based on the continuing resolution.

So we are absolutely committed to this. The President has it in his budget, and CDC is committed to this program.

Ms. ROYBAL-ALLARD. Thank you.

The CHAIR. Thank you. Congressman Harris.

Mr. HARRIS. Thank you. Thank you very much.

Briefly, I just want to ask about the expansion of fetal tissue research at HHS because this is—I am curious about this. Because the Trump administration did not ban fetal tissue research from extramural researchers. What they just said is you have to come before an ethics advisory board.

Now, interestingly enough, 13 of the 14 research proposals that came before that board actually were found not to pass muster at the ethics advisory board. What is the thinking behind not requiring—and again, I served on the special Investigative Panel on Infant Lives. Some atrocities were being committed at clinics with regards to making profit from selling baby body parts.

That is what the panel found. You can read it. Google it, read it. What is the thinking behind not requiring an ethics advisory board just to review these research projects that would use fetal tissue from aborted fetuses?

Secretary BECERRA. Congressman, I am going to be real honest with you. That was not one issue I am prepared to respond to because I don't know the details of it, but we can get back to you.

Mr. HARRIS. I would greatly appreciate that. Again, now for intramural research, the Trump administration did ban it, and one might argue that, well, maybe you should just have an ethics advisory board for that, too. But my particular question—and I appreciate you getting back to me—is about the extramural research.

Because some of the things that came out of University of Pittsburgh, you can read about some of those experiments. I just think these should go to ethics advisory boards and let the chips fall where they may.

Thank you very much.

Secretary BECERRA. I appreciate that, and I will get back to you. But I know that there are standards and protections in place, but let me give you a thorough answer.

Mr. HARRIS. Thank you very much. I yield back.

The CHAIR. Ms. Lee.

Ms. LEE. Thank you very much.

Mr. Secretary, following up on our discussion, and you were there with our beloved, the late supervisor Wilma Chan during your visit to my district, my colleagues and I sent a letter—and

this was something we discussed—to HHS to lead the National Food as Medicine pilot program using food as medicine in a clinical setting to help our healthcare system improve health outcomes for the underserved. And our colleague, Congresswoman Chellie Pingree, who serves on the Ag Committee, along with myself and our chairwoman, has championed the Food as Medicine for many, many years.

So this pilot would be modeled after the work being done in my home county, Alameda County, as part of the county's ALL IN Recipe4Health initiative. But our intent, though, is that we establish a national pilot program that could expand the efforts of this program to integrate healthcare, regenerative agriculture, economics, and the environment to improve health and racial equity and food security.

And so I would like an update from you on your plans to look at this as a national pilot, to develop a national pilot for this.

Secretary BECERRA. Congresswoman, first, thank you for pushing that. Secretary Vilsack and I have had some conversations about how the Department of Ag and HHS can work together on this issue because we agree completely that food should be considered medicine. And so we will follow up with you on some of the details on what we are doing.

By the way, we hope you will join us in the work we are trying to do to reduce sodium in our food products. You can buy a bag of potato chips in the U.S., and it is probably twice as much sodium in it as it does the same product in Europe. And we have to make sure that we are not the place where some of these manufacturers try to entice us into getting some of these things that aren't good for us.

So I look forward to working with you because we agree.

Ms. LEE. And I would like to work with you on that. Thank you. Secretary BECERRA. Yes.

The CHAIR. Mr. Fleischmann.

Mr. FLEISCHMANN. Thank you, Madam Chair.

Mr. Secretary, just one topic. Last year, Mr. Secretary, we discussed at length the issue of safely resettling unaccompanied minors who cross our border into ORR facilities.

Secretary BECERRA. Yes.

Mr. FLEISCHMANN. The safety and well-being of children should be of the utmost concern to the administration and to members of the subcommittee. In my own district, a contracted ORR facility was shut down last year after instances of sexual battery were reported to authorities.

My question, Mr. Secretary, what since the last time we spoke has the administration done to better oversight and ensure safety net procedures throughout the contracting and hiring process of these ORR facilities? And sir, how will the President's budget request of \$6,300,000,000 be used to remedy this issue, sir?

Thank you.

Secretary BECERRA. Congressman, thank you for that question.

Because, again, we have custody of these children who have come unaccompanied during that temporary period that they are in the U.S. And I will tell you that we are bending over backwards. Any time we receive a report, whether or not—we don't try to determine

if it is true or not, we report it to local law enforcement. We report it to our inspector general's office, and we get on it.

And as quickly as we can because, as you mentioned, most of these are contractors that we are working with. We make sure that they move to make sure if there is an instance where a worker has violated rights and committed some activities that is inappropriate, that they move on.

And so we are doing that as much as we can, and we are doing everything we can to make sure we keep the oversight going in these places.

Mr. FLEISCHMANN. Thank you, sir.

My final request is that perhaps somebody on your staff would get with me—your office has been working on a constituent issue, and I would just like a little bit of an update on that when it is convenient.

I thank you, sir.

Secretary BECERRA. We will follow up.

Mr. FLEISCHMANN. And I appreciate your being here today.

Secretary BECERRA. Your staffer's name is—can you give me your staffer's name so I know how to tell—

Mr. FLEISCHMANN. Oh, sure. I would call Daniel Tidwell. I will make him famous.

Secretary BECERRA. Daniel. I will make sure my team is listening. [Laughter.]

Mr. FLEISCHMANN. I like him. Good to see you.

Secretary BECERRA. Thank you.

The CHAIR. Ms. Frankel.

Ms. FRANKEL. Thank you. Thank you again for being here.

And I will follow up on this, but just for the record, I wanted to say that your answer to me on enforcing the Affordable Care Act's contraceptive coverage, it really wasn't the best answer. So, but I will follow up on that.

I will ask you another question. Ninety percent of pregnant women report taking a medication during their pregnancy, but only 1 percent of clinical trials mention the word "pregnancy" or "pregnant." The Congress did create a task force to take a look at that.

There was a report with recommendations, and then another report with implementation recommendations. And I am just—do you know where we are with that?

Secretary BECERRA. Congresswoman, I will have to get back to you on that.

Ms. FRANKEL. Okay. Okay, then you got two things to get back to me on now.

Secretary BECERRA. Look forward to it.

Ms. FRANKEL. Maybe I will give you an easier question here. I know that your budget does have some increases on the home care and so forth. Can you tell us what that does and what that means?

Secretary BECERRA. We are going all in on home and community-based care. We believe that every American, whether they are going through an infirmity or whether they are in their last days, should be able to be with loved ones through that difficult time. And so we are making major investments in home and community-based care. We are going to try to increase the workforce and rec-

ognize that the workforce in those settings has to be paid decently so that they will remain in there.

We want to recognize in some cases family members are the people who are caring, and just because they are family members doesn't mean they don't deserve to be compensated where possible. And so we are going to do everything we can to make sure if you can be at home, we will let you stay at home.

You can't be at home, we want it to be in a setting that is as close to your home as possible. And we applaud those who are providing services in nursing home and other long-term care facilities. But to the degree that we can move care to where you live and where your loved ones are, that is what we will try to do.

Ms. FRANKEL. Okay. Thank you very much.

Yield back, Madam Chair.

The CHAIR. Ms. Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Madam Chair.

I wanted to follow up on the fentanyl conversation a little bit. In December, the DEA issued a warning about the alarming increase of fake prescription medications obviously being laced with fentanyl. And in Lewis County, Washington, the Joint Narcotics Enforcement Team seized 106,000 pills suspected to be laced with fentanyl as of September of 2021.

Mr. Secretary, what will you do to ensure that HHS continues to work not only on the treatment, but the prevention piece?

And I wanted to make sure you were aware many of the traffickers in Mexico are targeting children via social media, right? So they can access these fentanyl-laced drugs. I mean, that is the whole new—new horrible game. What can HHS do to increase awareness to protect our communities?

Secretary BECERRA. Congresswoman, as you are probably aware, we have changed direction in terms of our strategy. We are not just trying to treat. We are now trying to help prevent. And one of the ways we do that, for example, we are letting go some of those taboos where forgetting about how things were done in the 20th century.

A fentanyl strip, it used to be thought, well, you don't want to give people something that helps them test to see if the drug they are about to ingest also has fentanyl because you are just helping them take the drug. The problem, of course, is that too many Americans think they are taking an illicit drug nonetheless, but not going to kill them, and lo and behold, it is laced with fentanyl.

So we are now making—we are now supporting those local efforts that have shown that fentanyl strips help save lives. And so we are going to try to do what we can to prevent that and then follow people through the process as well.

Ms. HERRERA BEUTLER. I appreciate that. I am just going to go out on a limb here because I know everybody in this space is saying we need to do things like test the drugs so that someone can ingest it safely. But I am not sold on the science behind that yet.

I still—you know, I grew up in the “don't do drugs.” And man, I can remember the commercials. I remember the message. I remember those were the things we talked about, and I believed it. Silly me.

And I feel like now recreational use of—in Washington State, by 2023, you can use meth and heroin, not just marijuana, in front of cops and not go to jail for it. And my concern is the message we are sending to the next generation.

So I know that this is where a lot of the new talk is about going. But that concerns me, and I want to see science on it before we move in that direction.

Secretary BECERRA. And so, Congresswoman, I don't want to give you the impression that that is only type of prevention work we do. We actually devote the majority of our resources to actually prevent people from ever using drugs. We are working closely to try to keep children, especially in the middle schools, from getting to them. That is about the time they start using recreationally.

And so we are doing a lot in that space, but we also don't want to forget those who are beginning to use, keep them alive, because hopefully we can move them in a different direction.

The CHAIR. Mrs. Lawrence.

Mrs. LAWRENCE. Thank you.

I have a question. Because we are experiencing child care deserts. I just had a conversation with my lieutenant governor where, when we tour the child care facilities in low-income areas, there are waiting lists. And so, as we look at addressing and complimenting you and the President on the Child Care and Development Block Grant and Head Start, we need to do something different in those areas where we know we have challenges. And so can you talk to me about that?

In addition to that, what are we doing to ensure that we have a workforce that can address the deserts and the shortages that are happening in low-income areas?

Secretary BECERRA. Congresswoman, this is where I hope I can convince you that my own personal beliefs and upbringing mean that we will have equity infused in everything we do. We proved that when it came to the Affordable Care Act. A lot of black and brown communities were not participating. We raised the bar when it came to the participants, and we got the numbers of black families and Latino families that signed up for health insurance under ACA to levels they have never been before.

When I came into office, the number of black and Latino families that were getting vaccinated was well below what we saw for white America. Today, they are almost all at the same level, and that is because what we are doing is we are going to where they are instead of waiting for them to come to us.

When it comes to child care, it is the same thing. Most of the caregivers we know are people, women of color, and so we are going to do everything we can to make sure we elevate those caregivers and that workforce at the same time we make those services available. So if we get the dollars to expand access to child care, we are going to work with States to make sure that they are also making sure they are providing that extra care.

Mrs. LAWRENCE. I am going to be reaching out to you. We do accelerators for other type of businesses and shortages that we see. We need an accelerator to train professionals in child care, and I will want your partnership.

Secretary BECERRA. Look forward to it.

Mrs. LAWRENCE. Thank you.

Secretary BECERRA. Look forward to talking.

The CHAIR. Mr. Cline.

Mr. CLINE. Thank you, Madam Chair.

And Mr. Secretary, you are committed to upholding them and enforcing the laws that are on the books in this country. Correct?

Secretary BECERRA. Correct.

Mr. CLINE. Can I get a "yes"?

Secretary BECERRA. Yes.

Mr. CLINE. Okay. The Title X statute itself says that abortion is not a method of family planning, and taxpayer dollars should not be used to fund abortion providers. Can you tell me how it has come to pass that HHS is awarding \$6,600,000 in Title X funds from the American Rescue Plan to abortion providers?

Secretary BECERRA. So, Congressman, as you probably are aware, the services that are provided by a number of the family planning programs go well beyond just providing contraceptive care or abortion services. They provide the full panoply of services that you think of in terms of family planning.

Mr. CLINE. You don't view it as a disqualifier, the fact that they provide abortions?

Secretary BECERRA. If you are following the rules of the law and you qualify, you should be able to receive the funding. If you are providing family planning services, you should be able to get family planning money.

Mr. CLINE. Okay. I am going to move on to Title 18 of the U.S. Code, Section 1531. Last year, you claimed there is no law dealing specifically with the term "partial-birth abortion." This drew a lot of attention and was roundly debunked.

You voted yourself against this law when it was considered by Congress. You repeatedly committed to enforcing these laws, as you just said. That extends particularly to laws with which you disagree, like the laws that protect the unborn. Will you commit to enforcing this law against partial-birth abortion?

Secretary BECERRA. Without question, Congressman, I will not only comply with the law, but enforce the law.

Mr. CLINE. Thank you. I yield back.

The CHAIR. Thank you. I would now like to yield to Congressman Cole for any closing remarks he may have.

Mr. COLE. Thank you.

First of all, Madam Chair, thanks for holding the hearing. It is good to get back in person, and again, thanks for your hard work in getting our last year's bill done and across the line.

Mr. Secretary, thank you. As always, you are forthcoming. We don't agree on everything. We are going to disagree very strongly on Hyde, and I just want to underline that triple fold. I respect the President to submit what budget, but at the end of the day, if he wants bipartisan support that is going to be an issue we are going to have to confront. And we are just not movable on this.

I am very interested in the ARPA process, and I appreciate your commitment to keep in touch with this as these decisions are made. Count me as very skeptical that we could hit the administration's proposed number because I just think it is going to take longer to set this up and organize it than perhaps you envision.

And I think that money would be better redirected toward NIH and traditional biomedical research.

Finally, I want to reiterate again thank you, thank you, thank you for the bold stance that you took with respect to how we fund the Indian Health Service. That is a big deal. I know that that will actually not be a partisan fight. There will be people on both sides against it. I think I respect fiscal discipline. I just don't think it needs to come at the expense of the healthcare of this population when we have made commitments over and over again.

And your willingness to step out front and offer some bold, new thinking. I don't think any other administration that I am aware of on either side of the aisle has ever proposed doing what you are proposing here. So, to my colleagues, this is a really big deal in Indian Country, and the Secretary and the administration are to be commended for it.

So I am hopeful that at the end of the day, because it is sort of like the wonderful working relationship I have had over the years with the chairwoman, we don't agree on everything, but we get to a deal. And we have been able to do it seven times in a row, and you are very much part of this deal-making process obviously in this particular subcommittee. And the administration has to sign anything we produce. So you have as a big a seat at the table as anybody else.

But I appreciate the manner in which negotiations were done last time, and I have had several discussions with our good mutual friend Shalanda Young, our new OMB Director. We are very proud of her, great Appropriations staffer. And frankly, she helped me on a number of occasions clarify, okay, this is really important to the President.

And even if I don't agree with the President, what is important to him matters. And certainly when we have to come to a cooperative deal, and again, we were able to do that.

But I just end by saying we won't always agree on everything, but I appreciate you being here. You have been accessible. You have been good to work with. You have been fair. You always keep your word.

And it is a pleasure having the opportunity to work with you again. I look forward to it in the coming year.

Yield back.

The CHAIR. Thank you very much.

And thank you, Mr. Secretary. It is wonderful to be with you in person. It was virtual last year, but this is just really in person. So I offer congratulations. So delighted you are where you are.

I can recall so many meetings over and over again with the two of us, and we are so like-minded on so many issues. And oftentimes in our Democratic leadership meetings, we stood together. So I really appreciate your remarkable professional history and your service here in the Congress and the values that you hold, which is what drives you in terms of the public policy initiatives that you care about and you put forward.

And I, too, will say to my colleagues that we did work cooperatively. In the end, we got the bill across for 2022, and I think we made some very, very important investments in biomedical research, public health, behavior health, child care, early learning

and so many others. And that was after years of austerity with regard to some of these efforts.

And what you have done with this budget is that you have now provided the opportunity to build on that success. And whether it is through public health and maternal health, behavioral health, all these things we talked about today, the NIH, ARPA-H, early childhood, et cetera, the range of issues that fall within the mission—and it is a mission—at Health and Human Services and what you do.

We need to provide additional emergency funding. I think there is a morality about the COVID pandemic and that it is about life-saving vaccines. It is about therapeutics. It is about covering the uninsured.

And I worry about the uninsured and what will happen to them if there isn't a funding there. And therefore, we will see less people getting the tests and vaccinated, et cetera, which is harmful. And I think also I would emphasize our global efforts as well. I think we have, again, real moral leadership to lead there.

What is really—this investment with people, and if I might just say for a moment that for years Federal resources have gone often-times to the richest 1/10 of 1 percent of the people in this Nation, or a number of the corporations who are the biggest corporations who don't pay their fair share of taxes or pay taxes at all.

And for me, looking at the shift in where Federal resources have been going and looking at the Rescue Plan, looking at the bipartisan infrastructure plan, I know we will get to where we are going on some package with regard to Build Back Better that will continue this effort of looking at our Federal resources, that they are going to children, they are going to families. They are going to State and local governments. They are going to small businesses, and they are going to where they need with allowing people to have the economic opportunity for security in their future.

And the budget you have presented reinforces all of those efforts. So look forward to working with you and with my colleagues both sides of the aisle as we move forward on what we look forward to is a strong spending bill for 2023.

So thank you for your time. Thank you for your work. And thank you for your commitment and devotion to public service.

Thanks so much. Great to be with you.

[Answers to questions submitted for the record follow:]

**Committee on Appropriations**  
**Labor, Health & Human Services, and Education Subcommittee**  
*FY 2023 Budget Request for the Department of Health and Human Services, March 31, 2022<sup>1</sup>*

Questions for the Record for Secretary Xavier Becerra

**Submitted by Chair DeLauro**

***Coverage of COVID-10 Diagnostic Testing and Vaccinations***

**1. Question:**

Mr. Secretary, on February 26, 2021, CMS issued guidance designed to remove barriers to COVID-19 diagnostic testing and vaccinations. The guidance makes it clear that private group health plans and issuers cannot use medical screening criteria to deny coverage for COVID-19 diagnostic tests for individuals with health coverage. This includes individuals who are asymptomatic and who have no known or suspected exposure to COVID-19. In spite of that guidance, the Committee is hearing from laboratories that are experiencing denial of payments for thousands of tests at community and state-run testing sites. In some cases, private insurers are now requiring submission of extensive medical records to justify payment, medical records that laboratories do not have and cannot provide. It also appears that private insurers are not covering testing that they deem to be “workplace testing” even at facilities such as nursing homes. While I applaud the continued efficacy of vaccines, testing remains an important surveillance and public health tool. What is HHS doing to enforce the CMS guidance and ensure that private insurers are carrying their fair share of the cost of fighting the pandemic, particularly for vulnerable populations?

**Response:**

Diagnostic testing is critically important to help reduce the spread of COVID-19, as well as to quickly diagnose COVID-19 so that it can be effectively treated. The Department of Health and Human Services (HHS), including the Centers for Medicare & Medicaid Services (CMS), has worked closely with partners across the federal government to ensure that Americans can access free COVID-19 diagnostic testing and vaccinations. The Biden-Harris Administration has implemented several policies designed to increase the number of providers that can administer the COVID-19 vaccines and ensure adequate payment for administering the vaccines in Medicare, while making clear to private issuers and Medicaid programs that it is their responsibility to cover the COVID-19 vaccines and their administration at no charge to enrollees and beneficiaries.

A critical part of our efforts has included implementing provisions passed by Congress in the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127) and the Coronavirus Aid,

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<sup>1</sup> All responses are current as of the date of hearing, March 31, 2022.

Relief, and Economic Security (CARES) Act (P.L. 116-136) that generally require plans and issuers to cover a range of COVID-19 diagnostic testing items and services without any cost-sharing requirements, prior authorization, or other medical management requirements throughout the public health emergency. CMS, together with the Department of Labor (DOL) and the Department of the Treasury (collectively, the Departments), has issued guidance on several occasions that answers questions from stakeholders and clarifies requirements for plans and issuers.

In addition, as part of its ongoing efforts to expand Americans' access to free testing, the Biden-Harris Administration requires insurance companies and group health plans to cover the cost of eight over-the-counter, at-home COVID-19 tests per covered individual per month. This coverage requirement, effective January 15, 2022, means that most consumers with private health coverage can go online or to a pharmacy or store and purchase a test, and either get it paid for up front by their health plan, or get reimbursed for the cost by submitting a claim to their plan. This requirement incentivizes insurers to cover these costs up front and ensures individuals do not need an order from their health care provider to access these tests for free.

The Departments will enforce the applicable provisions of the FFCRA (and the related provisions of the CARES Act), in conjunction with states, where applicable. If you are covered by a private-sector, employer-sponsored group health plan and have concerns about your plan's compliance with these requirements, you may contact DOL at [askebsa.dol.gov](mailto:askebsa.dol.gov) or by calling toll free at 1-866-444-3272. If you are covered by a non-federal public-sector employer-sponsored plan (such as a state or local government employee plan) and have concerns about your plan's compliance with these requirements, you may contact HHS at 1-877-267-2323 extension 6-1565 or at [phig@cms.hhs.gov](mailto:phig@cms.hhs.gov). If you have insured coverage, you may contact your State Department of Insurance (For contact information, visit [https://content.naic.org/state\\_web\\_map.htm](https://content.naic.org/state_web_map.htm)).

### *Accelerating Access to Critical Therapies for ALS (ACT for ALS) Implementation*

#### **2. Question:**

On December 23, 2021, President Biden signed the *Accelerating Access to Critical Therapies for ALS (ACT for ALS)* (P.L. 117-79) into law. *ACT for ALS* directs entities across HHS to take steps to streamline the scientific community's efforts to better understand ALS and to facilitate patient access to promising treatments outside of clinical trials. Please provide a description of the activities that HHS and its agencies have undertaken to implement *ACT for ALS*?

#### **Response:**

**Section 2:** Section 2 of ACT for ALS, as amended, authorizes the Secretary to establish a grant program for scientific research utilizing data from studies of subjects treated under expanded access to investigational drugs for individuals who are not otherwise eligible for clinical trials for the prevention, diagnosis, mitigation, treatment, or cure of ALS. The National Institutes of Health (NIH) has requested that the Secretary delegate to NIH the authority to administer the provisions under Section 2.

On April 13, 2022, after several meetings to coordinate with the Food and Drug Administration (FDA) and a joint FDA and NIH listening session to get input from advocacy groups, NIH released a Notice of Intent to Publish a Funding Opportunity Announcement for Amyotrophic Lateral Sclerosis (ALS) Intermediate Patient Population Expanded Access (NOT-NS-22-096<sup>1</sup>) and is currently drafting a Request for Applications to be published in May of 2022 with an application due date in June of 2022. NIH plans to organize a clinical research review panel with a wide variety of clinical research expertise, including ALS experts as well as people living with ALS, to review applications in July or August of 2022. Applications will then undergo a second level of review by the National Advisory Neurological Disorders and Stroke Council on September 7-8, 2022, as mandated by the NIH two-stage review process. Meritorious grant applications will be awarded in mid-September of 2022, with a funding start date before October 1, 2022 to utilize FY 2022 funds.

**Section 3:** Section 3 directs the Secretary to establish and implement a Public-Private Partnership for Neurodegenerative Diseases between the NIH, the FDA, and one or more eligible entities through cooperative agreements, contracts, or other appropriate mechanisms with such eligible entities, for the purpose of advancing the understanding of neurodegenerative diseases and fostering the development of treatments for ALS and other rare neurodegenerative diseases. FDA and NIH have established regular meetings to collaborate on implementing the Public-Private Partnership and will have established the Public-Private Partnership by December 23, 2022, as mandated by ACT for ALS.

FDA has heard Congress' call to action with the landmark ACT for ALS legislation and is swiftly acting to implement this new law. The entire Biden-Harris Administration is committed to developing effective interventions that improve the diagnosis of, and prevent, mitigate, treat, or cure ALS and other rare and fatal neurodegenerative diseases. For people living with these diseases, and their families, we understand access to effective treatments cannot come soon enough.

The NIH and the FDA are implementing the ACT for ALS Act. As you know, efforts to research and develop promising therapies for patients is a collaborative endeavor. Work has already begun on the FDA action plan for ALS and other rare neurodegenerative diseases due in June of this year. We are working quickly to operationalize the remaining parts of the legislation.

FDA intends to use \$2.5 million in appropriated funds received for FY 2022 for the purposes of ALS clinical trials and investments in regulatory science, specifically to award grants and contracts through the Orphan Products Grant Program that will also meet the goals of the Rare Neurodegenerative Disease Grant Program that was created under the ACT for ALS Act. We anticipate that these solicitations will be released in the next few months to enable distributing of awards in FY 2022. Additionally, we are also reviewing FY 2022 grant applications for clinical trials and natural history studies within the Orphan Products Grants Program that may have potential to also meet some of the goals of the ACT for ALS Act.

**3. Question:**

Section 2 of *ACT for ALS* establishes a grant program for expanded access to eligible ALS therapeutics. In the *Consolidated Appropriations Act, 2022* (P.L. 107-103), Congress provided \$25 million for this program in fiscal year 2022. Section 3 of *ACT for ALS* requires the establishment of a public-private partnership for rare neurodegenerative diseases no later than December 23, 2022. The law requires that the public-private partnership involve one or more eligible external entities. When will HHS be prepared to accept and consider applications under Section 2 of *ACT for ALS*? What additional steps do HHS and its agencies need to take to enable the acceptance and consideration of applications under Section 2 of *ACT for ALS*? Please describe the process through which HHS will select one or more eligible entities to participate in the public-private partnership. Does HHS believe that rulemaking is required as part of the process to begin the public-private partnership? Is the establishment of such partnership possible without rulemaking? Please describe the steps that HHS is planning to take to set up the public-private partnership and the anticipated timeline of that process.

**Response:**

**Section 2:** Section 2 of ACT for ALS, as amended, authorizes the Secretary to establish a grant program for scientific research utilizing data from expanded access to investigational drugs for individuals who are not otherwise eligible for clinical trials for the prevention, diagnosis, mitigation, treatment, or cure of ALS. NIH has requested that the Secretary delegate to NIH the authority to administer the provisions under Section 2.

On April 13, 2022, after several meetings to coordinate with the FDA and a joint FDA and NIH listening session to get input from advocacy groups, NIH released a Notice of Intent to Publish a Funding Opportunity Announcement for Amyotrophic Lateral Sclerosis (ALS) Intermediate Patient Population Expanded Access (NOT-NS-22-096) and is currently drafting a Request for Applications to be published in May of 2022 with an application due date in June of 2022. Grant applications will be reviewed by a clinical research review panel with a wide variety of clinical research expertise, including ALS experts as well as people living with ALS, in July or August of 2022 and will then be reviewed by the National Advisory Neurological Disorders and Stroke Council on September 7-8, 2022, as mandated by the NIH two-stage review process. Meritorious grant applications will be awarded in mid-September of 2022, with a funding start date before October 1, 2022, to utilize FY 2022 funds.

**Section 3:**

FDA and NIH have considerable experience establishing and participating in Public-Private Partnerships (PPPs). Indeed, for over 10 years, FDA has supported the Critical Path Institute, which has worked with FDA, NIH, and other stakeholders on numerous regulatory science initiatives. FDA staff also engage with over 50 other PPPs. NIH and FDA are currently identifying priorities that a PPP could address to advance drug and biological product development for ALS and other rare neurodegenerative diseases. The agencies are also discussing possible conveners. We are confident that we can meet the December deadline for establishing the PPP. There is no need for rulemaking to establish this PPP.

## ***Gun Violence Prevention Research***

### **4. Question:**

Federal firearms data are housed in many federal agencies. For example, the Department of Health and Human Services collects health data describing the victims of firearms injuries and mortality, and the Department of Justice collects criminal justice data describing the circumstances of shootings and characteristics of gun violence perpetrators. Significant efforts to share data across different government agencies have substantially contributed to remediating and preventing many major public health crises, but we have not seen meaningful federal efforts to better integrate firearms-related data. Has the Department integrated firearms data with data from other agencies, and what steps are you taking to ensure that linked data is accessible to bona fide researchers for further analysis?

### **Response:**

CDC continues to identify opportunities for sharing firearm data across federal agencies. For example, CDC has ongoing collaborations with the Departments of Defense (DoD) and Veterans Affairs (VA) to strengthen suicide-related data. Because an overwhelming number of suicides in the military and veteran populations are by firearm, CDC is collaborating with the Department of Defense to link and analyze data from the DoD's Suicide Event Report and CDC's National Violent Death Reporting System (NVDRS). This project leverages these two unique data systems to collect information on Veteran, active-duty, and civilian suicides for a unique opportunity to better understand the contributors to suicide in these populations. Combining different data elements from each system creates a more holistic picture to inform upstream prevention.

NVDRS data (which includes death by firearms) are stored in an incident-based database. Descriptive data can be accessed free of charge from the [Web-based Injury Statistics and Query System \(WISQARS\)](#). CDC's WISQARS™ is an interactive, online database that provides fatal and nonfatal injury, violent death, and cost of injury data from a variety of trusted sources. Researchers, the media, public health professionals, and the public can use WISQARS™ data to learn more about the public health and economic burden associated with unintentional and violence-related injury in the United States, including firearm-related violence.

More detailed data from NVDRS is available through the [NVDRS Restricted Access Database \(RAD\)](#), including information from medical examiner and coroner reports as well as law enforcement reports. The data set is available to researchers who meet specific criteria. The RAD database also includes short narratives to describe violent deaths, including descriptions abstracted from law enforcement and coroner/medical examiner reports. There is no cost for accessing the NVDRS RAD.

### **5. Question:**

As many Americans witnessed during the coronavirus pandemic, the Centers for Disease Control and Prevention (CDC) plays a critical role tracking and monitoring public health crises, particularly through their work overseeing local data collection efforts. There are significant gaps in CDC's current tracking of the burden of gun violence in the US, particularly when it comes to

nonfatal gun injuries. At present, CDC estimates counts of nonfatal gun injuries across the country from a sample of just 60 hospitals. This data is released with a significant lag and cannot be broken down by geography, limiting our ability to compare across states. Perhaps most alarmingly, since 2016, CDC has chosen not to publish nonfatal gun injury data, citing an unstable sample size and wide confidence interval on the data. Given that there are nearly twice as many nonfatal gun injuries as there are gun deaths, what steps are being taken to improve our collection of this data and ensure that it is publicly available to researchers, policymakers, and the general public? Fatal injury data is also released with a significant lag, with final data for 2021 not expected to be released until December of 2022. What efforts are being made to improve the timeliness of these releases?

**Response:**

While CDC's WISQARS™ (Web-based Injury Statistics Query and Reporting System) provides fatal and nonfatal injury, violent death, and cost of injury data from a variety of trusted sources, CDC is also investing in efforts to improve timeliness. The Firearm Injury Surveillance Through Emergency Rooms (FASTER) program funds 10 state health departments to collect syndromic data on nonfatal firearm injuries to provide near real-time, local data that is unavailable from other data systems. Efforts under this initiative will also result in the development and dissemination of tools and methods that can be used by state and local health departments to rapidly track and respond to firearm injuries. In addition, CDC is now providing provisional mortality data in its Wide-Ranging Online Data for Epidemiologic Research (WONDER) system. With the addition of these provisional data, estimates of firearm-related deaths in the United States are now available with an approximate six-month lag from the date of death.

**Submitted by Rep. Lucille Roybal-Allard**

***Advisory Committee on Immunization Practices (ACIP)***

The COVID-19 pandemic has highlighted the critical role played by the CDC's Advisory Committee on Immunization Practices in issuing vaccine recommendations. It continues to be a concern that ACIP lacks sufficient representation of providers who care for older adults. As a result, for adult vaccinations such as those for pneumonia, ACIP's recommendations appear complex and confusing.

**6. Question:**

How will you direct the CDC to streamline and simplify vaccine recommendations for older adults in our country?

**Response:** The Advisory Committee on Immunization Practices (ACIP) develops recommendations on how to use vaccines to control disease in the United States. The Committee's recommendations are forwarded to CDC's Director for approval. Once recommendations have been reviewed and approved by the CDC Director and the Department of Health and Human Services, they are published in CDC's Morbidity and Mortality Weekly Report (MMWR). The MMWR publication represents the final and official CDC recommendations for immunization of the U.S. population.

CDC works to communicate these recommendations to clinicians, healthcare providers, and the public to educate which vaccines are needed across the lifespan. CDC and its partners continue to work to increase vaccine uptake through education. The current adult vaccine recommendations can be found here: [Recommended Vaccines for Adults | CDC](#)

**7. Question:**

Will you ensure that health care providers who specialize in gerontology and care for older adults are included on the Advisory Committee on Immunization Practices panel?

**Response:**

HHS and CDC view the specialty of gerontology as important to the work of ACIP. Members and representatives serve on the Committee voluntarily and are selected by the Secretary following an application and nomination process. Currently the ACIP includes 15 voting members responsible for making vaccine recommendations. Fourteen have expertise in vaccinology, immunology, pediatrics, internal medicine, nursing, family medicine, virology, public health, infectious diseases, and/or preventive medicine; one member is a consumer representative who provides perspectives on the social and community aspects of vaccination. Gerontologists have been members of ACIP previously; however one is not presently serving. The American Geriatrics Society is an important liaison to the committee.

### ***Vaccine Hesitancy and Confidence***

The COVID-19 pandemic and subsequent vaccination campaigns exposed the significant inequities that exist across populations (e.g., women of color, those living in low-income and rural settings and/or enrolled in Medicaid).

#### **8. Question:**

How will the President's budget proposal ensure that we continue to address the longstanding disparities and misinformation that have plagued communities and depressed immunization rates among these populations?

#### **Response:**

The proposed increase to the immunization program in the FY 2023 President's Budget would continue to support implementing and evaluating new strategies for hard-to-reach populations, such as those who may be vaccine hesitant, those who are members of racial and ethnic or other minority groups, and those who are underserved due to socioeconomic or other reasons. In addition, the budget includes a proposal for mandatory funding to establish the Vaccines for Adults (VFA) program which would provide uninsured adults with access to recommended routine and outbreak vaccines at no cost. CDC is also proposing enhancements to the Vaccines for Children (VFC) program to expand eligibility to all children under age 19 enrolled in the Children's Health Insurance Program (CHIP) and make program improvements, such as updating the provider administration fee structure to increase provider capacity and eliminating cost-sharing for eligible children.

The spread of misinformation on social media and through other channels can affect vaccine confidence, which in turn affects immunization rates. To stop misinformation from eroding public trust in vaccines, CDC will continue its work with local partners and trusted messengers to improve confidence in vaccines<sup>2</sup> among groups placed at higher risk, including racial and ethnic minorities and with parents of very young infants and expectant parents. CDC will also work with social media companies and establish partnerships to contain the spread of misinformation and engage with groups to provide clear information about vaccination and the critical role it plays in protecting the public. CDC publishes numerous resources online to increase vaccine confidence, including information on how to address misinformation and tailor messaging for specific audiences.

The federal activities as supported by the President's budget proposal will be reflected in progress in the Vaccines National Strategic Plan 2021-2025, the roadmap for the U.S. vaccination program. Goal 3 in the plan describes promoting vaccine confidence and covers vaccination disparities. The National Vaccine Program, under OASH and informed by the National Vaccine Advisory Committee, coordinates the activities of HHS offices, including CDC, that will programmatically administer initiatives described in the President's budget proposal. These initiatives that address vaccination disparities and mis- and disinformation are described by HHS offices and operational divisions.

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<sup>2</sup> <https://www.cdc.gov/vaccines/partners/vaccinate-with-confidence.html>.

**9. Question:**

The COVID-19 pandemic has brought an unprecedented level of coordination and cooperation. Health care providers, community-based organizations, civil rights and religious leaders have come together around the COVID-19 vaccination campaign. How does the President's budget propose to leverage these relationships to instill confidence in all routinely recommended vaccines vaccination moving forward?

**Response:**

OCR's proposed FY 2023 budget of \$60,250,000 includes funding for our continued COVID-19 work to reach underserved communities who frequently are subject to discrimination and to take appropriate enforcement actions. In particular, OCR's work will build upon outreach to health care providers, community-based organizations, civil rights, and religious leaders to enhance vaccinations and ensure federal civil rights protections through guidance to providers about their legal responsibilities and stakeholders about their legal rights. This work will build upon recent OCR guidance specifically on vaccines: Guidance on Federal Legal Standards Prohibiting Race, Color and National Origin Discrimination in COVID-19 Vaccination Programs, Guidance on Federal Legal Standards Prohibiting Disability Discrimination in COVID-19 Vaccination Programs, and Comprehensive FAQ's on Protections for Persons with Disabilities and Healthcare Provider Nondiscrimination Obligations During COVID -19. The proposed FY 23 budget increase of \$21,452,000 also supports OCR's enforcement activities to address the more than 9,700 COVID-19 complaints filed since the beginning of the pandemic to remove discriminatory barriers to vaccinations, other treatments, and preventative measures.

As described in the response to question 8 above, the National Vaccine Program coordinates the activities of HHS offices and operational divisions that will programmatically administer initiatives described in the President's budget proposal. These initiatives also apply to HHS offices, including CDC, working with their external stakeholders to broaden and deepen community partnerships to promote the use and increase the uptake of all routinely recommended vaccines. The Office of the Assistant Secretary for Health (OASH) enhances communication among and coordinates the activities of HHS offices and operational divisions that are synergistic and support the President's budget proposal. The specific programs that leverage community partnerships to increase routine vaccination rates are described by HHS offices and operational divisions.

CDC has launched several partnerships with a diverse set of organizations from large national partners to small community-based organizations, with the goal of improving equity and uptake across all adult vaccinations (specifically those groups that experience disparities in immunization – including racial and ethnic minority groups, individuals living with disabilities, rural communities, older adults, individuals with chronic conditions, and more.). A critical part of our approach is to engage and support a network of partners across multiple levels on vaccine confidence and access activities to reach people wherever they are. CDC has made significant investments in vaccine confidence strategy implementation, providing funding and technical assistance to traditional and non-traditional partners including partnerships with approximately 20 national organizations to improve both COVID-19 and flu vaccination coverage.

For example, in 2020, CDC launched the Partnering for Vaccine Equity (P4VE) program to support national, state, local, and community-level partners who are prioritizing equity in vaccination access and uptake for adult groups that experience disparities in immunization. The P4VE program provides opportunities for group learning, peer-sharing, and expert coaching, as well as an online engagement platform and online resource hub to share and access resources, materials, and promising practices among partners and across the nation. Resources requested in the President's budget will help to fund partnership activities such as this that will continue to address health equity and vaccine confidence.

### ***ACA and Medicaid Redeterminations***

Enrollment numbers in the ACA Marketplace have expanded dramatically since the passage of the American Rescue Plan Act (ARPA) enhanced tax credits. In my district/state of California, we have nearly 1.8 million total Marketplace enrollment in 2022, a 9% increase since passage of ARPA.

A recent HHS ASPE report predicts that over 3 million people would lose coverage if the Marketplace enhanced American Rescue Plan Act (ARPA) tax credits are not extended past 2022. When you add the issue of Medicaid redeterminations at the end of the PHE, that number will likely be even higher. For example, some lower income enrollees may either move from a silver to bronze plan with dramatically higher deductibles if they can no longer afford premiums without the enhanced tax credits – or they may decide to become uninsured.

On the other hand, some current Medicaid enrollees may have seen their income go up, becoming eligible for a Marketplace product, but without the enhanced tax credits, they may decide they can't afford it and forego insurance altogether. In this case, extending the enhanced tax credits solves a worrying kitchen table concern. The jump in income allowed them to move off Medicaid, however, without the enhanced tax credits, it is not enough to afford a private coverage plan on the ACA marketplace.

#### **10. Question:**

Related to both the ARPA enhanced tax credits and Medicaid redeterminations, what do you recommend that Congress do to address this potential significant loss in health insurance coverage?

#### **11. Question:**

Is HHS planning to take additional steps beyond the recent CMS guidance on Medicaid redeterminations?

#### **Response to 10 & 11:**

The Biden-Harris Administration has made it a priority to build on the success of the Affordable Care Act (ACA) by continuing to invest in and strengthen the law, most notably through the passage of the American Rescue Plan Act of 2021 (ARP). The ARP's subsidies enabled record enrollment and eased financial burdens on Americans during the worst public health crisis in a generation. President Biden is committed to extending financial assistance that reduces health

coverage premiums for millions of Americans who enroll in Marketplace coverage and closing the Medicaid coverage gap, which would allow 4 million uninsured people to gain coverage.

The Biden-Harris Administration is also encouraging states to take advantage of opportunities to expand access to life-saving coverage. For example, because of the ARP, as many as 720,000 pregnant and postpartum people could be guaranteed Medicaid and Children's Health Insurance Program coverage for a full 12 months after pregnancy, regardless of the types of changes in circumstances you described. CMS is actively working with states to adopt the postpartum extension option.

Finally, it has been a top priority for the Centers for Medicare & Medicaid Services (CMS) to ensure, when the PHE eventually ends and states resume routine operations, including terminations of Medicaid eligibility, that renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage. CMS has launched a landing page—[Medicaid.gov/unwinding](https://www.medicicaid.gov/unwinding)—dedicated to supporting states in this process. CMS has issued guidance on state requirements and best practices, communications tools to support beneficiary outreach, and state reporting requirements and templates to oversee the return to normal operations, among other resources. CMS has held calls with Medicaid agency leadership with each state, the District of Columbia, and four U.S. territories to discuss their plans to return to routine operations after the end of the PHE, and identify their technical assistance needs and best practices to share with other states.

### ***Alzheimer's Public Health Funding***

Now more than ever it is apparent how crucial it is to have an established infrastructure in place to respond to public health threats. In 2018, Congress passed the bipartisan BOLD Infrastructure for Alzheimer's Act to create a nationwide Alzheimer's public health response to achieve population-level improvements, a higher quality of life for those living with the disease and their caregivers, and reduce associated costs. I am glad to see progress on this law's implementation with the three Public Health Centers of Excellence and the funding to now 23 public health departments across the country.

#### **12. Question:**

How important is it to broaden implementation of this law nationwide to ensure our public health system is prepared for the growing population of those living with Alzheimer's?

**Response:** Alzheimer's plans are available in 49 states, the District of Columbia, and Puerto Rico. However, Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act funding only supports implementation of these plans in 20 states. The development of a uniform and prepared public health infrastructure in all 50 states and territories is key to advancing public health actions that promote the health, well-being, and independence of people with Alzheimer's disease, such as living in their homes longer and delaying costly institutionalized care.

Today, another person develops the disease every 66 seconds; by 2050, someone in the United States will develop the disease every 33 seconds. More than 6 million Americans are currently

living with Alzheimer's and, without significant action, as many as 16 million Americans will have Alzheimer's by 2050. This growth will cause Alzheimer's costs to increase from an estimated \$259 billion in 2017 to \$1.1 trillion in 2050 (in 2017 dollars). CDC aims to support implementation of BOLD Act plans in order to increase early detection and diagnosis, reduce risk, prevent avoidable hospitalizations, reduce health disparities, support the needs of caregivers, and support care planning for people living with the disease consistent with CDC's Healthy Brain Initiative Road Map Series.

### ***Increasing Access to Colorectal Cancer Screening and Treatment in Medicaid***

March is Colorectal Cancer Awareness Month. Despite being preventable if caught early, colorectal cancer remains the second leading cause of cancer death. 1 in 3 people are not up to date with colorectal cancer screening - a statistic that has only been made worse by the COVID-19 pandemic. The CDC's Colorectal Cancer Control Program has made meaningful strides in working to increase screening rates - particularly in communities impacted by health disparities as a result of social determinants of health, as seen in communities where screening rates are lower and mortality rates tend to be higher.

Because of the CDC Breast and Cervical Control Program, positive diagnoses immediately qualify an individual for Medicaid for treatment, something vitally important to ensure that those who need care the most can get it. There is not a similar such option for those identified by the CDC's Colorectal Cancer Program.

#### **13. Question:**

What is HHS doing to increase access to colorectal cancer screening as well as access to care should a patient be diagnosed with colorectal cancer?

#### **Response:**

CDC's Colorectal Cancer Control Program (CRCCP) is working to increase colorectal cancer screening rates among people between 45 and 75 years of age. The program does this by working with clinics, hospitals, and other health care organizations to implement and strengthen strategies that have been shown to increase colorectal cancer screening (called *evidence-based interventions*), as described in the *Guide to Community Preventive Services (the Community Guide)*. Patient navigation services are also available through CRCCP clinics to help patients access treatment if they are diagnosed with colorectal cancer.

- Through March 2022, CRCCP funding recipients have partnered with over 1,074 health system clinics that serve over 1,605,893 patients who are age-eligible for colorectal cancer screening.
- Among the clinics recruited in the first year of the program (2015), screening rates have increased an average of 13 percentage points from a mean rate of 38.1% in 2015 to 51.4% in 2019 but declined to 48.3% in 2020 during the COVID pandemic.

CDC's *Screen for Life: National Colorectal Cancer Action Campaign* is a multimedia effort promoting colorectal cancer screening. Launched in 1999, this campaign informs people about colorectal cancer and the importance of screening.

CDC is also working with the health care provider community to improve awareness and uptake of home-based colorectal cancer screening options. Non-invasive home-based colorectal cancer tests are an important tool in fighting colorectal cancer, particularly in light of the challenges many patients face in getting preventive care during the COVID-19 pandemic.

In addition, on May 18, 2021, the USPSTF updated its recommendation for colorectal cancer screening. The USPSTF continues to recommend with an “A” rating screening for colorectal cancer in all adults aged 50 to 75 years and extended its recommendation with a “B” rating to adults aged 45 to 49 years. Furthermore, a plan or issuer must cover and may not impose cost sharing with respect to a colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer for individuals described in the USPSTF recommendation.

In February 2022, President Biden announced that he is reigniting the Cancer Moonshot initiative he launched as Vice President in 2016. The Cancer Moonshot sets ambitious goals: to reduce the age-adjusted death rate from cancer by at least 50 percent over the next 25 years, and to improve the experience of people and their families living with and surviving cancer. The President and First Lady Jill Biden also announced a call to action on cancer screening to jumpstart progress on screenings that were missed as a result of the COVID-19 pandemic, and to help ensure that everyone in the United States equitably benefits from the tools we have to prevent, detect, and diagnose cancer.

Today, we know cancer as a disease for which there are stark inequities in access to cancer screening, diagnostics and treatment across race, gender, region, and resources. This Administration is committed to ensuring that every community in America – including those living in rural, urban, and Tribal communities – has access to cutting-edge cancer diagnostics, therapeutics, and clinical trials.

Specifically with regard to Medicare, CMS prioritizes expanding access to these essential preventative health care services, including cancer screenings. Medicare covers a broad range of colorectal cancer screening tests, including Cologuard® Multitarget stool DNA, screening fecal occult blood test, screening flexible sigmoidoscopy, screening barium enema, screening colonoscopy and most recently, blood-based biomarker tests if they meet certain criteria, including specified test performance characteristics. The final rule entitled “Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements” codified the requirements of section 122 of the Consolidated Appropriations Act (CAA) of 2021, Waiving Medicare Coinsurance for Certain Colorectal Cancer Screening Tests (86 FR 65177). This provision amended section 1833(a) of the Act to offer a special coinsurance rule for screening flexible sigmoidoscopies and screening colonoscopies, regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure, that is furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test. The reduced coinsurance

began phasing in on January 1, 2023. Ultimately, for services furnished on or after January 1, 2030, the coinsurance will be zero.

CMS also helps state Medicaid programs expand access to preventative care by providing technical assistance and facilitating the exchange of information about promising practices of high quality, high impact, and effective preventative care delivery. In December 2021, CMS updated the Medicaid Adult Core Health Care Quality Measurement Set to include a new measure of colorectal cancer screening for 2022. The new colorectal screening measure assesses the percentage of patients ages 50 to 75 who had appropriate screening for colorectal cancer. This measure supports CMS's efforts to assess health care disparities and address health equity as colorectal cancer is the second leading cause of cancer deaths in the United States and research has found disparities in screening rates for those with Medicaid versus commercially insured.

I look forward to working with partners across the federal government, along with Congress and other stakeholders, to examine ways we can increase access to services for the prevention, diagnosis, treatment, and survival of cancer. All Americans are invited to share perspectives and ideas, and organizations, companies, and institutions to share actions they plan to take as part of this mission at [whitehouse.gov/cancermoonshot](https://www.whitehouse.gov/cancermoonshot).

#### **14. Question:**

What is HHS doing to make sure that low-income people and racial/ethnic groups with limited access to screening & care are getting screened and placed into treatment if they are diagnosed with colorectal cancer?

#### **Response:**

The Affordable Care Act ensures that Medicare covers screening colonoscopies without cost-sharing for average-risk individuals. Specifically, with regard to Medicare, CMS prioritizes expanding access to these essential preventative health care services, including cancer screenings. Medicare covers a broad range of colorectal cancer screening tests, including Cologuard® Multitarget stool DNA, screening fecal occult blood test, screening flexible sigmoidoscopy, screening barium enema, screening colonoscopy and most recently, blood-based biomarker tests if they meet certain criteria, including specified test performance characteristics. The final rule entitled "Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements" codified the requirements of section 122 of the Consolidated Appropriations Act (CAA) of 2021, Waiving Medicare Coinsurance for Certain Colorectal Cancer Screening Tests (86 FR 65177). This provision amended section 1833(a) of the Act to offer a special coinsurance rule for screening flexible sigmoidoscopies and screening colonoscopies, regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure, that is furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test. The reduced coinsurance began phasing in on January 1, 2023. Ultimately, for services furnished on or after January 1, 2030, the coinsurance will be zero.

CDC's Colorectal Cancer Control Program (CRCCP) has been very effective in implementing evidence-based approaches at the practice level with a focus on clinics servicing communities disproportionately burdened by colorectal cancer and helping improve colorectal cancer screening rates and supporting patients seeking treatment through patient navigation. This includes developing partnerships between public health and healthcare systems to implement evidence-based interventions such as provider reminders, patient reminders, provider assessment and feedback, and reduction of structural barriers can increase colorectal cancer screening rates even among groups experiencing disadvantage. CRCCP funding recipients implementing four or more new evidence-based approaches improved screening rates by nearly 33 percent between 2015 and 2020.

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***CMS Support of Full Non-Invasive Screenings for Colorectal Cancer for Medicare Beneficiaries***

To help increase colorectal cancer screening rates, it is important that we are able to use all the tools in our toolbox. There are several non-invasive colorectal cancer screening tests that can help get people screened who are unable or unwilling to undergo a colonoscopy. However, if a patient receives an abnormal result on a non-invasive screening test, they must undergo a colonoscopy to confirm diagnosis.

HHS, Treasury, and Labor recently put out guidance to private insurers saying that the follow-up colonoscopy should be covered in accordance with US Preventive Services Task Force recommendations. This was also a recommendation in the President's Cancer Panel's Colorectal Cancer Companion Brief that accompanied its report focused on Closing Gaps in Cancer Screening as part of the reignited Moonshot. However, Medicare patients currently face out-of-pocket costs for this follow-up colonoscopy, creating a significant barrier to completing screening.

**15. Question:**

How will CMS take steps to help increase access to colorectal cancer screening and ensure that colonoscopy following an abnormal non-invasive screening test is covered without cost-sharing for Medicare beneficiaries in alignment with HHS, Treasury, & Labor Guidance, USPSTF screening guidelines, and recommendations of the President's Cancer Panel?

**Response:**

In February 2022, President Biden announced that he is reigniting the Cancer Moonshot initiative he launched as Vice President in 2016. The Cancer Moonshot sets ambitious goals: to reduce the age-adjusted death rate from cancer by at least 50 percent over the next 25 years, and to improve the experience of people and their families living with and surviving cancer. The President and First Lady Jill Biden also announced a call to action on cancer screening to jumpstart progress on screenings that were missed as a result of the COVID-19 pandemic, and to help ensure that everyone in the United States equitably benefits from the tools we have to prevent, detect, and diagnose cancer.

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Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements” codified the requirements of section 122 of the Consolidated Appropriations Act (CAA) of 2021, Waiving Medicare Coinsurance for Certain Colorectal Cancer Screening Tests (86 FR 65177). This provision amended section 1833(a) of the Act to offer a special coinsurance rule for screening flexible sigmoidoscopies and screening colonoscopies, regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure, that is furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test. The reduced coinsurance began phasing in on January 1, 2023. Ultimately, for services furnished on or after January 1, 2030, the coinsurance will be zero.

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### ***AHRQ Participation in the HHS Improving Maternal Health Initiative***

The AHRQ FY 2023 budget request includes \$7 million to fund AHRQ’s contribution to the HHS-wide *Improving Maternal Health Initiative*. According to the Budget Justification, this initiative would focus on expanding state capacity to link local and federal healthcare, vital statistics, and social service data; using predictive analytics to improve maternal health and outcomes; expanding the Medical Expenditure Panel Survey to provide better data on maternity care; and expanding the capacity to measure pregnant individuals’ experience with care in settings, care processes and/or the care continuum where disparities persist.

It is my understanding that this request is for the first year of support for a five-year AHRQ initiative to ensure that Federal, State, and local policymakers have timely and accurate data and useful analytic resources about maternal morbidity and mortality and the healthcare system with which to make informed policy decisions.

**16. Question:**

What activities is AHRQ currently involved in to address Maternal Health, and how would this budget request build on these activities?

**Response:**

The President's FY 2023 Budget Request for AHRQ will allow us to continue the Agency's efforts to improve maternal health. AHRQ is currently engaged in efforts to improve maternal health that span our core areas, which include data and analytics, research and evidence generation and synthesis, and practice improvement and implementation.

AHRQ has two flagship data programs – the Healthcare Cost and Utilization Project (HCUP) and Medical Expenditure Panel Survey (MEPS) -- that are routinely used to examine utilization, quality, and costs related to maternal health services. HCUP is a family of healthcare databases and related software tools and products that create a national information resource of encounter-level healthcare data. HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. MEPS is a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States. MEPS is the most complete source of data on the cost and use of health care and health insurance coverage. The data are used for both quick turnaround analytics to support agencies across the Department as well as conduct intramural and extramural research. For example, AHRQ annually provides HRSA's Maternal and Child Health Bureau with rates of severe maternal morbidity nationally and by state, and sub-state estimates by expected payer, urban/rural location of the mother, and race/ethnicity of the mother. These data and measures are also included in AHRQ's annual National Healthcare Quality and Disparities Report (QDR). The QDR tracks health care quality and health care disparities, including adverse maternal events, and identifies strengths and opportunities for improvements in health care. Researchers, including those at AHRQ for example, have used HCUP data to examine the impacts of insurance coverage expansions on the use and costs of pre and post-natal care, disparities in postpartum hospital and emergency department care, deliveries in safety net hospitals, and state variation in maternal opioid use disorders.

AHRQ also invests in health systems research and evidence generation to address maternal health. For example, in the last twelve months, the AHRQ Evidence-based Practice Center (EPC) Program has commissioned several evidence reports to inform next steps by clinicians, patients, health systems, policymakers, and Federal agencies on improving maternal health. These reports examine risk factors for maternal morbidity and mortality, best practices for antenatal care, postpartum coordination of care, and management of hypertensive disorders of pregnancy. AHRQ also provides scientific, administrative, and dissemination support to the US Preventive Services Task Force (USPSTF), which is an independent panel of clinical experts that makes evidence-based recommendations about the effectiveness of specific preventive care services for patients. Many of these recommendation statements apply to pregnant women. Lastly, AHRQ supports investigator-initiated research and has supported a number of research grants to produce evidence relevant to maternal health and healthcare.

An example of AHRQ's maternal health work in the area of practice and quality improvement is AHRQ's Safety Program in Perinatal Care (SPPC). This program was developed in order to

improve the patient safety culture of labor and delivery (L&D) units and decrease maternal and neonatal adverse events. The program will be expanded to train providers on how to deliver care that both allows individuals to feel empowered to assert their rights and advocate for themselves, and providers to listen and trust their patients. AHRQ has initiated a systematic review on respectful maternity care that will support integration of best practices into the existing SPPC teamwork and communication tools. Delivering care in this way is central to patient-centered care and is recognized as an evidence-based implementation strategy for improving maternal and neonatal health outcomes and addressing disparities on the basis of race and ethnicity, age and socioeconomic status, across all aspects of care delivery. This program will be distributed by AHRQ in concert with the HRSA AIM programmatic framework.

**17. Question:**

What could the Agency do if additional funds were provided beyond this investment?

**Response:**

With additional funding, AHRQ could develop new initiatives across its core areas, which include data and analytics, research and evidence generation and synthesis, and practice improvement and implementation, including a focus on minority populations.

***Nondiscrimination in Child Welfare***

Over the last year, LGBTQI+ and religious minority children and families have continued to suffer terrible discrimination in federally funded child welfare programs, resulting in specific harms to children. In Tennessee, a heterosexual Jewish couple, were turned away from fostering a child in need due to their faith. In Texas, transgender children and their parents are terrified of being separated due to Governor Abbott's policy that providing needed medical care to transgender children constitutes child abuse.

HHS issued a memorandum on March 2 of this year clarifying that such medical care is not child abuse, and barring federally funded programs from discriminating against LGBTQI+ children in care. However, the memorandum does not have a clear enforcement mechanism and does not bar discrimination against families of origin, kin, and foster and adoptive parents based on sex, sexual orientation, gender identity, or religion.

**18. Question:**

What kind of outreach and support is HHS providing to stakeholders in states where these attacks on LGBTQ youth are taking place?

**Response:**

HHS has been clear that we support LGBTQ youth, their caregivers, their medical providers, and individuals that support such youth. Through our Office for Civil Rights (OCR), on March 2, 2022 we have released a [Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy](#), detailing the civil rights and privacy laws that we enforce, and how they apply to

discrimination on the basis of gender identity and improper disclosure of protected health information.

OCR has participated in listening sessions with individuals and advocacy organizations in impacted communities; coordinates frequently with the Departments of Justice and Education on areas of overlapping civil rights jurisdiction; and has recently re-launched the OCR call center so that individuals seeking information are able to connect with an OCR staff member directly. Additionally, OCR anticipates issuing a [Notice of Proposed Rulemaking for Section 1557 implementing regulations](#), which will address issues of discrimination on the basis of sex (including gender identity).

HHS has also issued:

Guidance to state child welfare agencies through an [Information Memorandum](#) that makes clear that states should use their child welfare systems to advance safety and support for LGBTQI+ youth, which importantly can include access to gender affirming care; and

Fact sheet on [Gender-Affirming Care and Young People](#)

We also remain in communication with child welfare agencies, advocates, foster parents, and LGBTQ young adults who have experienced foster care.

HHS has also released information and guidance to support to the LGBTQI+ community, for example the [Office of Adolescent Health issued a document on gender affirming care and young people](#). HHS also issued guidance to state child welfare agencies through an [Information Memorandum](#) that makes clear that states should use their child welfare systems to advance safety and support for LGBTQI+ youth. Last, HHS recently updated its [LGBTQI+ resource page](#).

[CDC's most recent data show that LGBTQ students are experiencing a mental health crisis and are less likely to feel connected to others at their schools](#). CDC's *What Works in Schools* approach, focuses specifically on improving school connectedness<sup>3</sup> as well as supporting schools in implementing policies and practices that support LGBTQ youth.

The *What Works* approach provides flexible, scalable infrastructure from which administrators and staff can build programs that best work for their school and students, and that can be tailored to respond to different communities' needs. CDC is currently funding and providing technical assistance to 28 local education agencies across the country to implement this approach;

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<sup>3</sup> **School connectedness** – a student's sense of belonging and that others at school care about them – is a well-known and important protective factor with lifelong impact on health and well-being. Protective factors are strengths and supports that allow children to succeed despite risk factors such as lower socio-economic status or having parents with a substance use disorder.

however, we make our program guidance to any district that would like to adopt the approach available on our website.

### ***Gun Violence Prevention Strategies***

Communities across the U.S. are experiencing heightened rates of gun violence, with communities of color impacted more acutely, particularly from community violence. This particular kind of gun violence has been described by researchers as a contagion. Being the victim of violence significantly increases the chances of a person becoming a perpetrator of violence, which means that gun violence can spread from person to person through the contact of the violence itself. Similarly, research indicates that up to 45 percent of patients in urban hospitals who are treated for injuries like gunshot wounds were violently re-injured within five years.

Shootings and gun homicides spread like a transmissible disease through neighborhoods. There are definite patterns in gun violence networks, which can be used to determine when and where intervention can occur in the cycle of violence to stem the contagion, with one study finding that gun violence in an area can spread in cascades through networks of people arrested together for the same offense.

There are evidence-based public health focused strategies that effectively address, reduce, and prevent community violence, commonly referred to as "community violence intervention (CVI) programs." There are multiple models of CVI programs, including programs based in the hospitals where gunshot victims are treated, known as hospital-based violence intervention programs (HVIPs). HVIPs connect violently injured patients with intervention specialists and peer counselors to provide desperately needed services to reduce the patient's risk of retaliation or re-injury and are remarkably effective. Patients who received HVIP services were four times less likely to be convicted of a violent crime and roughly four times less likely to be subsequently re-injured by violence than patients who did not receive HVIP services. Despite the effectiveness of HVIPs, they are vastly underfunded, with the federal government allocating a very small amount to support these programs in select cities while the majority of states provide zero funding for violence prevention programs.

#### **19. Question:**

What is being done within HHS to support hospital-based violence intervention programs?

#### **Response:**

To help communities implement prevention strategies based on the best available evidence, CDC developed the [Youth Violence Technical Package](#). This resource includes hospital-based violence prevention programs and other proven strategies that communities can use to prioritize prevention activities that have the greatest potential for achieving population-level reductions in violence and its consequences. CDC also developed a [toolkit](#) on the Cardiff Violence Prevention Model, which helps communities to understand where violence is occurring by combining and mapping both hospital and police data on violence and to inform prevention strategies.

CDC is also funding a study to determine the effectiveness of a hospital-based violence prevention program for reducing risk of firearm-related violence and injury in adult victims of violence at Virginia Commonwealth University. With dedicated funding for community violence prevention, as requested in the FY 2023 President's Budget, CDC would support hospital-based violence programs along with other evidence-based prevention strategies for a comprehensive approach that addresses the multitude of factors contributing to violence in communities across the country.

**20. Question:**

Would a dedicated program to provide grants for community-based violence intervention programs, including HVIPs, help the Department support this critical work in communities most impacted by community violence?

**Response:**

Yes, a dedicated program would assist communities most impacted by violence. The FY 2023 President's Budget proposes a \$250 million investment in the new community violence intervention (CVI) initiative to stem the rise of violence in cities across the country through prioritizing evidence based-prevention strategies, research, and data.

With dedicated funds, CDC would fund up to 75 cities and communities with high numbers of homicides and communities with high numbers of homicides per capita to establish a collaborative, community driven approach to reduce community violence. Funds will support scaling up existing community violence prevention efforts and implementing and evaluating evidence-based and evidence-informed community violence prevention strategies. Communities will select strategies based on their needs and priorities. Strategies will include hospital-based interventions and street outreach. They may also include place-based approaches, and provision of trauma-informed screening and treatments, among others.

***CDC Antimicrobial Resistance Efforts***

Drug-resistant infections sicken at least 2.8 million people and kill at least 35,000 people in the United States each year. Addressing antimicrobial resistance (AMR) is central to preparedness, as resistant secondary infections complicate public health emergencies. The President's Budget Proposal prioritizes antimicrobial resistance by requesting \$1 billion dollars to exponentially expand CDC efforts to prevent, detect, respond to, and contain antibiotic resistant infections.

**21. Question:**

Please provide a detailed breakdown of the Administration's \$1 billion request for AMR efforts at the CDC. Specifically, does it include the \$15 million increase that was requested for the Antibiotic Resistance Solutions Initiative?

**Response:** The \$15 million increase in discretionary resources for the Antibiotic Resistance Solutions Initiative is not part of the Administration's \$1 billion 5-year request for AMR efforts included in proposed investments in pandemic preparedness efforts. The \$1 billion in proposed funding will complement discretionary resources and will support domestic and global capacity

to control antibiotic resistance. CDC would increase funding to jurisdictional health departments; increase national healthcare safety network reporting for antibiotic resistance and increase the number of facilities and providers that implement CDC's antibiotic use best practices.

**22. Question:**

How does the FY23 budget align with the Department's discretionary AMR requests?

**Response:**

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Several agencies support research and prevention activities aimed at achieving the goals outlined in the Combating Antibiotic-Resistant Bacteria (CARB) National Action Plan 2020-2025.

Each of these agencies fills a unique role in achieving AMR priorities –

- The FY 2023 budget includes \$10.0 million for **AHRQ** to support of the national CARB enterprise. AHRQ's efforts in antibiotic stewardship are primarily focused in ambulatory and long-term care settings as well as hospitals. In addition, AHRQ will continue funding a project to address diagnostic accuracy and antibiotic stewardship in telehealth.
- The FY 2023 budget includes \$185 million for **ASPR**, aimed at CARB activities within **BARDA**.
- The FY 2023 budget includes \$51.7 million to support **FDA's** antimicrobial resistance efforts.
- The FY 2023 budget includes \$1 billion dollars to exponentially expand **CDC's** already-intense efforts to prevent, detect, respond to, and contain antibiotic resistant infections.
- The FY 2023 budget includes \$818.7 million for **NIH** to support intramural research for critical long-range priorities with funds carefully aligned to key research on infectious diseases, such as HIV/AIDS, malaria, influenza, antimicrobial resistance/combating antibiotic-resistant bacteria (CARB), and tick-borne diseases.

The FY 2023 budget also includes a legislative proposal designed to combat antibiotic-resistant bacteria by encouraging the development of innovative antimicrobial drugs. This proposal would provide annual payments from a contract valued between \$750 million and \$3 billion to the developers of newly approved antimicrobial drugs.

***National Institute of Allergy and Infectious Diseases Antimicrobial Resistance Efforts***

Challenges in securing research funding are discouraging people from pursuing research careers at a time when infectious diseases (ID) scientists who may hold the key to defeating COVID-19, antimicrobial resistance, and ending the HIV epidemic are needed now more than ever. Without sufficient investment, I'm concerned we will not have the next generation of scientists we need to develop new vaccines, diagnostics and therapeutics.

**23. Question:**

Can you describe NIAID's efforts to foster a more diversified infectious diseases (ID) research workforce and provide increased resources to bolster early career ID researchers—and how they would be impacted by the administration's proposed \$54 million funding cut at NIAID?

**Response:**

The National Institute of Allergy and Infectious Diseases (NIAID) conducts and supports basic and applied research to better understand, treat, and ultimately prevent infectious, immunologic, and allergic diseases. NIAID recognizes that growing and supporting a diverse biomedical workforce is critical to achieving these goals and therefore strives to promote diversity at every stage of biomedical research training. The primary goal of NIAID efforts in Diversity, Equity, Inclusion, and Accessibility (DEIA) is to engage and recruit trainees from diverse backgrounds, including those from populations underrepresented in biomedical research such as individuals from underrepresented racial and ethnic groups, those with disabilities, and those from disadvantaged backgrounds. NIAID has established a DEIA Council, part of whose charge is to develop specific plans to enhance DEIA in the NIAID intramural and extramural research communities. These plans will be integrated into existing NIAID efforts in this space, some of which are described below.

The NIAID Office of Research Training and Development (ORTD) works to develop new opportunities that will enhance recruiting and retention and to generate diversity awareness in the intramural divisions across the institute. For example, the NIAID ORTD, through the Intramural NIAID Research Opportunities (INRO) program, sponsors postbaccalaureate research trainees from U.S. populations underrepresented in the biomedical sciences and those dedicated to promoting diversity and inclusion for a year-long fellowship at NIAID. Trainees are included in the laboratory and training community at NIAID, with access to mentoring and skill development events. The INRO program encourages individuals from diverse backgrounds, including those from underrepresented populations, to join the scientific community at the earliest stages of specialized training and provides opportunities to develop transferrable skills that can be used throughout a career in the biomedical sciences.

NIAID intramural programs participate in the National Institutes of Health (NIH) Stadtman Tenure-Track Investigator search designed to attract a diverse group of highly talented early-career scientists who might not apply to a more narrowly defined position description at the NIH. Scientists selected through this process are appointed to a tenure-track position at NIH and are offered competitive salaries, research space, resources, and an operating budget. NIAID also participates in the NIH Distinguished Scholars Program, which aims to build a more inclusive community within the NIH Intramural Research Program by reducing the barriers to the recruitment and success of scientists from groups underrepresented in biomedical research. Through these programs, NIAID intramural divisions engage scientists from diverse backgrounds and provide them with mentoring and other professional development activities that foster research and career success.

NIAID also is engaged in multiple programs to develop and support extramural biomedical researchers, including those who are early in their career. These include training grants to provide funds for training predoctoral and postdoctoral candidates; National Research Service Award fellowship grants to provide research and research training experiences to students,

postdocs, and scientists at various career stages; and career development awards to enable scientists with diverse backgrounds to enhance their careers in biomedical research. NIAID recently launched the NIAID New Innovators program to provide support for early-stage investigators who propose creative, novel, and high-impact research concepts that may be risky or at a stage too early to fare well in traditional peer review. The program is designed to facilitate the movement of talented postdoctoral fellows into independent positions and to support talented newly independent investigators.

NIAID and other NIH Institutes, Centers, and Offices support the Maximizing Opportunities for Scientific and Academic Independent Careers (MOSAIC) program. The MOSAIC Postdoctoral Career Transition Award to Promote Diversity (K99/R00) program aims to support a timely transition of promising postdoctoral researchers from diverse backgrounds from their mentored, postdoctoral research positions to independent, tenure-track or equivalent faculty positions at research-intensive institutions. The MOSAIC K99/R00 program will provide independent NIH research support before and after this transition to help the researchers launch successful, independent research careers. In addition, MOSAIC researchers are assigned to a participating independent organization (e.g., scientific society) that provides professional development and networking opportunities throughout the K99/R00 grant award.

NIAID also provides additional funding opportunities designed to enhance diversity within the biomedical research workforce. NIAID awards supplemental funding to existing NIAID-funded grants, including Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) grants, to promote diversity in the research workforce through recruiting and supporting students, postdocs, and faculty scientists from diverse backgrounds, including those who are members of an underrepresented group. Recently, NIAID initiated the Research Education Program Advancing the Careers of a Diverse Research Workforce (R25). This program provides support for research education activities that encourage individuals from diverse backgrounds to pursue further studies or careers in research. Participants in these programs can range from undergraduate level through early career faculty. NIAID encourages applications that propose innovative courses for skills development, research experiences, and mentoring activities and that focus on factors that have been shown to affect retention of groups nationally underrepresented in biomedical research.

In addition, NIAID participates in two other programs led by the National Institute of General Medical Sciences: the Native American Research Centers for Health (NARCH) program and the Support for Research Excellence (SuRE) program. Through the NARCH program, NIH partners with the Indian Health Service to support opportunities for research and career enrichment to meet health needs prioritized by American Indian/Alaska Native (AI/AN) tribes or tribally based organizations. The NARCH program also supports research capacity building and the development of research infrastructure to enhance the biomedical research capabilities of AI/AN communities, which may help to increase engagement of these communities in biomedical research over time as capacity builds. The SuRE program supports research grants for faculty investigators and provides funding to build research capacity at institutions that receive limited NIH research support and serve students from disadvantaged backgrounds or have a mission statement to educate students from groups underrepresented in biomedical research. This

program aims to provide students with research opportunities and enrich the research environment at the applicant institutions.

The NIAID-supported Infectious Diseases Clinical Research Consortium supports a Mentorship Program designed to offer mentoring and development of early career investigators and fellows in clinical and translational infectious diseases research. In addition to professional development opportunities, the program includes the New Investigator Pilot Grants Program, providing funding to generate research results in support of future NIH grant applications. In 2022, there will be specific outreach to Minority-Serving Institutions in an effort to support diverse investigators.

NIAID prioritizes a diverse biomedical workforce and will continue explore all possible avenues to facilitate opportunities for individuals from diverse backgrounds, including those from underrepresented populations, to participate in the biomedical research community and to strengthen support for early career scientists.

The President's Budget for FY 2023 used the FY 2022 Continuing Resolution as the base for all discretionary budget decisions and proposes an increase over the Continuing Resolution for NIAID and each of NIH's other Institutes and Centers. The administration developed the FY2023 budget in this way because appropriations were significantly delayed this year. It typically takes the administration months to prepare and submit the President's Budget, so pivoting to update the President's Budget for FY 2022 enacted appropriations would have significantly delayed its release.

In this situation, in which the proposed spending level for NIAID in the President's Budget for FY 2023 is less than the appropriations enacted for FY 2022, the difference can be explained by the size of the Congressional increase in the Consolidated Appropriations Act, 2022, and not the administration's intent to reduce funding for NIAID.

### ***ASPR and the Development of Innovative Antimicrobial Drugs***

The President's Budget Request includes significant increased funding to support antimicrobial research and development, as well as antimicrobial stewardship to ensure these drugs are used appropriately. Specifically, the inclusion of a proposal to delink antimicrobial drug revenue from volume of sales through annual contract payments for innovative antimicrobials—a proposal that aligns with the bipartisan PASTEUR Act—represents major progress that would revitalize sustainable antimicrobial R&D.

#### **24. Question:**

The FY23 budget includes a proposal to encourage the development of innovative antimicrobial drugs. How is this proposal similar to the PASTEUR Act, and how does it differ from that legislation?

**Response:**

To mitigate the threat of antimicrobial resistance, the U.S. Government is taking a multi-pronged approach that includes surveillance, prevention, stewardship and innovation of new products to treat and prevent infections. However, the value of reduced morbidity, mortality, and disease duration is not currently captured by many antimicrobial products' current market value, and many large pharmaceutical companies have stopped investing in new antimicrobial products. The majority of products currently in clinical trials are being developed by small companies without the infrastructure and economies of larger firms-- these small companies face difficulty self-funding commercialization and Phase 4 studies and the development pipeline is at significant risk of falling short of current and future needs.

The FY23 budget proposal is intended to create an incentive for a more robust pipeline of novel antimicrobial products while enhancing stewardship. While there are similarities between this proposal and the PASTEUR Act, the Administration has not vetted the PASTEUR Act and there is no official position on this bill.

***Nursing Home Quality Measures***

Ensuring high quality care in nursing homes is a key priority, as is ensuring that regulatory guidance follows the latest scientific and clinical evidence. However, I am concerned that residents with neuropsychiatric symptoms often do not receive appropriate care and treatment due to a range of factors, including measures that impact the five-star quality rating system, stigma, and lack of understanding and awareness of appropriate treatment.

In 2021 the Office of the Inspector General found that the current CMS measures related to the use of antipsychotics are insufficient and do not focus on inappropriate use. Despite these findings, no action has yet been taken or announced by CMS to address these shortcomings.

**25. Question:**

How will HHS and CMS address the need to improve the meaningfulness of nursing home quality measures?

**Response:**

The CMS Care Compare website and Nursing Home Five Star Quality Rating System serve as valuable resources for consumers to view information about nursing homes to support health care decisions for themselves or a loved one. CMS will implement a range of initiatives to improve Nursing Home Care Compare, the website designed to help families pick a facility for their loved ones. Under the Biden-Harris Administration's leadership, CMS has already published new measures on Care Compare, which allow users to consider nursing home staff turnover, weekend staffing levels, and other important factors in their decision-making process. CMS will further improve Care Compare by improving the readability and usability of the information displayed—giving you and your family insight into how to interpret key metrics. Finally, CMS will ensure that ratings more closely reflect data that is verifiable, rather than self-reported, and will hold nursing homes accountable for providing inaccurate information.

CMS is committed to reducing the unnecessary use of antipsychotics in nursing homes and holding facilities accountable for compliance with federal requirements. CMS uses quality measures as tools to quantify health care processes, outcomes, and organizational systems that are associated with effective, safe, and efficient health care. In addition, through the National Partnership to Improve Dementia Care in Nursing Homes (National Partnership), CMS has partnered with federal and state agencies, nursing homes, other providers, advocacy groups, and caregivers to improve comprehensive dementia care. There have been notable reductions in the prevalence of antipsychotic medications use since the launch of the National Partnership.

The Administration is also launching new initiatives to improve nursing home quality, including efforts to continue to bring down the inappropriate use of antipsychotic medications, and the provision of technical assistance to nursing homes to help them improve. Inappropriate diagnoses and prescribing still occur at too many nursing homes. On February 28, a set of reforms were announced to further improve the safety and quality of nursing home care and hold nursing homes accountable for the care they provide. As part of these reforms, CMS will launch a new effort to identify problematic diagnoses and refocus efforts to continue to bring down the inappropriate use of antipsychotic medications.

### ***Coverage for Comprehensive Obesity Treatment***

Since the COVID-19 pandemic began early in 2020, hundreds of peer-reviewed publications have found that patients with obesity are at high risk for complications of COVID-19 and are more likely to experience worse health outcomes—including increased rates of hospitalizations, critical illness, and death—than those with normal body weight. A report from the CDC reveals that a shocking 78 percent of COVID-19 patients requiring admission to a hospital, needing a ventilator, or dying from COVID-19 were individuals living with obesity or overweight. Similarly, a meta-analysis of peer-reviewed papers covering 399,000 patients found that people with obesity who contracted COVID-19 were 113% more likely than healthy people to be admitted to the hospital, 74% more likely to end up in the ICU, and 48% more likely to die. And just a few months ago, the New York Times published an article showing that medical researchers have now discovered why they think that is – “the coronavirus infects both fat cells and certain immune cells within body fat, prompting a damaging defensive response in the body.”

These effects have been felt particularly among diverse populations, including Black Americans and Hispanic/Latino Americans. For example, nearly half of the reduction in hospitalizations, ICU admissions, and deaths were among Black Americans and nearly one-quarter among Hispanic Americans.

Obesity and COVID-19 are twin epidemics that are disproportionately affecting communities of color, yet Medicare still does not cover the spectrum of interventions to combat obesity specifically prohibiting coverage of drugs to treat obesity. In fact, it is the only place within the government where these medicines are not covered – DOD, VA, Medicaid, and just recently the FEHBP all cover anti-obesity medications.

**26. Question:**

What will you do to remove this current barrier in Medicare to provide comprehensive obesity care including access to FDA approved anti-obesity medications?

**Response:**

CMS recognizes the important link between obesity and COVID-19 complications. People with excess weight are at a greater risk during the pandemic, and obesity may triple the risk of hospitalization due to a COVID-19 infection. With respect to coverage of anti-obesity medications under Medicare Part D, however, the Social Security Act excludes “agents when used for . . . weight loss” from the definition of a Part D drug. Despite this statutory exclusion, Part D plans may provide coverage of prescription weight loss agents as a supplemental benefit to enhanced alternative Part D plans.

For Medicare beneficiaries with a body mass index over 30, Medicare Part B (Medical Insurance) covers obesity screenings and behavioral counseling to help beneficiaries lose weight by focusing on diet and exercise. Medicare covers this counseling if the primary care doctor or other qualified practitioner gives the counseling in a primary care setting (like a doctor's office), where they can coordinate the beneficiary's personalized prevention plan with their other care.

CMS is also committed to leveraging existing community partnerships and centering cultural competence to expand access to resources and reduce obesity.

***Child Care and Early Learning Opportunities***

Given the known benefits of high-quality child care and early learning opportunities, Congress has provided bipartisan support to help extend the reach of state and federal programs to serve more families and improve the overall quality of care.

**27. Question:**

Can you please speak to how additional funding will help low- and middle-income families be able to continue to access and afford high-quality childcare and what additional investments will be needed to address the early learning needs of families?

**Response:**

The FY 2023 President's Budget requests \$7.5 billion in discretionary funds for the Child Care and Development Fund (CCDF), which is a \$1.4 billion increase over FY 2022 enacted levels. This increase is needed in order to maintain and increase the support provided to children and families. Over the past decade, child care prices have risen faster than family incomes, making quality child care out of reach for many families—particularly low-income families. The pandemic exposed the fragility of the child care sector, while at the same time highlighting the essential nature of child care to a healthy economy and for shaping and nurturing the next generation. In FY 2019, the CCDF program served 1.4 million children and almost 900,000 families. Yet, the program is inadequately funded. The number of children served has steadily declined over the last decade from a high of 1.7 million children in FY 2010. Only about 15 percent of federally eligible children receive child care subsidies. Moreover, states are forced to

limit eligibility, enforce waitlists, charge unaffordable family co-payments, and establish payment rates that fail to reimburse providers for the full cost of quality child care because of current funding levels. Increased resources are needed to ensure additional families have access to child care, improve the quality of care, increase wages, and strengthen the child care sector.

**Submitted by Rep. Barbara Lee**

***National Center on Antiracism and Health Equity***

Thank you for working to ensure that health equity is an important cornerstone of all of HHS' efforts. With the support of Chair DeLauro, Rep. Pressley, and Senator Warren, the FY22 Omnibus includes language directing HHS to submit a report that provides detailed proposals to establish a National Center on Antiracism and Health Equity within the Department.

**28. Question:**

Following the submission of your proposal for the Center, what steps can we take to through the FY23 appropriations process to ensure its development?

**Response:**

The House Appropriations Committee, in a report on H.R. 4502, the "Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2022", recommended that HHS establish a National Center on Antiracism and Health Equity. See H. Rep. 117-96 at 237. Congress can, through the appropriations process, provide additional funding to enable the Department to establish this Center and to develop its programs.

***HIV/AIDS – PrEP Program***

I am extremely encouraged to see that the President's budget request includes a \$377 million increase for the Ending the HIV Epidemic Initiative and \$9.8 billion over the next ten years for a "PrEP Delivery Program to End the HIV Epidemic in the United States". The 10 year anniversary of FDA's approval of PrEP will be this year. While much progress has been made in expanding PrEP, there is still a lot more that needs to be done. Only 9% of black people and 16% of latinx people who could benefit from PrEP have received a prescription. These populations are already disproportionately impacted by HIV, yet racial and social health barriers prevent these populations from accessing a medication that can prevent HIV acquisition.

There must be a "no wrong door" approach to PrEP. Regardless of where a person lives, what type of insurance they do or don't have, where they seek medical care, or who provides that care, people should be able to get PrEP with no cost to them both for the medication and the lab services required to maintain a prescription. Leadership on all levels of government should quickly work to erase access barriers, which will help achieve the goal of ending the HIV epidemic by 2030.

**29. Question:**

How does HHS envision this program being implemented? Can you explain how the program will both provide medication at no cost to people who want PrEP, as well as ensure that the myriad of wrap-around and ancillary services associated with PrEP use are provided at no cost? How does coverage of PrEP at no cost under Medicaid fit into the administration's overall goals for PrEP?

**Response:**

The PrEP Delivery Program is designed to advance equitable access to HIV prevention by addressing many of the systemic barriers. The program will guarantee access to PrEP at no cost; eliminate costs for essential associated services; and establish a network of providers in underserved communities that provide culturally and linguistically appropriate services. The PrEP Delivery Program will create an efficient, systematic approach to drug acquisition and distribution and also provide the critical wrap-around services that make it possible for individuals to successfully participate in the ongoing intervention. Most health insurance plans must cover both PrEP and the full range of laboratory and counseling services that are part of PrEP care without any copay or cost-sharing. The PrEP Delivery Program will expand PrEP access at clinical settings through on-site dispensing and lab services for those without health care coverage. Additionally, the PrEP Delivery Program will establish and support PrEP programs within current federal infrastructure to implement PrEP education campaigns, medication support services, and provide outreach and education to increase utilization of PrEP and PEP among individuals at risk of HIV infection. This national PrEP Delivery Program requires coordination across operating divisions and the Office of the Secretary will be responsible for administering and coordinating the implementation.

This initiative will fund efforts to increase knowledge, generate demand, increase access, and help people stay on PrEP across the United States. HHS looks forward to working with Congress on the development of this program. This program at the national level will need to leverage the strengths of all HHS agencies to accomplish the goals. The PrEP Delivery Program will support those seeking PrEP by funding PrEP Assistance Programs that provide, at a minimum, all drugs and ancillary medical services needed for people to successfully start and maintain on PrEP.

CMS looks forward to working with you, along with partners across HHS and other federal agencies, on ways to meet the President's goal of ending the HIV/AIDS epidemic by 2030, including by increasing access to PrEP and other important preventative measures. The President's Budget continues to support the fourth year of the Ending the HIV Epidemic initiative with \$850 million in funding across CDC, HRSA, IHS, and NIH for FY 2023, \$377 million above FY 2022 enacted. The initiative is a bold plan announced in 2019 and further solidified in the National HIV/AIDS Strategy (2022-2025) that aims to reduce the number of new HIV infections in the United States by 75 percent by 2025, and by at least 90 percent by 2030. HHS works closely with communities to support the four key strategies – Diagnose, Treat, Prevent, and Respond – to end the HIV epidemic. The budget also creates a national program that invests \$9.8 billion in mandatory funding over 10 years to guarantee pre-exposure prophylaxis (also known as PrEP) at no cost for all uninsured and underinsured individuals; provide essential wraparound services through States, IHS and tribal entities, and localities; and establish a network of community providers to reach underserved areas and populations. The budget also expands access to PrEP under Medicaid by covering the drug and associated services without cost sharing, while removing utilization management practices that may limit access.

The Biden-Harris Administration is committed to fighting HIV/AIDS, including by strengthening prevention efforts and increasing access to treatment.

***HIV/AIDS - EHE*****30. Question:**

The HHS Budget includes an increase of \$377 million for the Ending the HIV Epidemic Initiative. What are HHS's plans for expanding and improving the EHE Initiative? What progress has been made in the first three years of EHE that you hope to continue?

The FY23 budget will be the fourth year of EHE. The first year of EHE was focused on planning, with the second year of implementation coinciding with the beginning of the COVID pandemic. Even with the challenges of COVID, jurisdictions were able to implement their EHE plans and there was progress made in bringing people living with HIV into care, as well as expanding PrEP use within community health centers. Biden's FY22 budget proposed to increase EHE funding by \$266 million, but the final FY omnibus only increased funding by \$70 million. Increased funding is needed for EHE to ensure that prevention, treatment, response and research can be expanded in the jurisdictions that are a part of EHE.

**Response:**

The PrEP Delivery Program is designed to advance equitable access to HIV prevention by addressing many of the systemic barriers. The program will guarantee access to PrEP at no cost; eliminate costs for essential associated services; and establish a network of providers in underserved communities that provide culturally and linguistically appropriate services. The PrEP Delivery Program will create an efficient, systematic approach to drug acquisition and distribution and also provide the critical wrap-around services that make it possible for individuals to successfully participate in the ongoing intervention. Most health insurance plans must cover both PrEP and the full range of laboratory and counseling services that are part of PrEP care without any copay or cost-sharing. The PrEP Delivery Program will expand PrEP access at clinical settings through on-site dispensing and lab services for those without health care coverage. Additionally, the PrEP Delivery Program will establish and support PrEP programs within current federal infrastructure to implement PrEP education campaigns, medication support services, and provide outreach and education to increase utilization of PrEP and PEP among individuals at risk of HIV infection. This national PrEP Delivery Program requires coordination across operating divisions and the Office of the Secretary will be responsible for administering and coordinating the implementation.

The vision for the National Institutes of Health (NIH) role in EHE is to provide evidence for the most effective approaches and interventions, and to build sustainable capacity among most impacted populations and communities to end the HIV epidemic domestically. The NIH-wide EHE goals are to: 1) Expand culturally competent implementation research to integrate evidence-based interventions and approaches into practice; EHE uses community-engaged approaches to tailor activities to local contexts, specific populations and localities; and 2) Build multi-faceted, multi-disciplinary, inclusive local research capacity and partnerships.

NIH has received sustained yearly increases to the NIH Centers Programs for AIDS Research (Centers for AIDS Research and AIDS Research Centers, CFARs) to foster community-based research designed to address the barriers to implementing the EHE pillars. In consultation with CDC, HRSA, local health departments and community groups, NIH, from FY 2019 –2021 has supported 127 projects through CFARs and AIDS Research Centers (ARCs) in the following

areas of special focus: strategic partnerships working with racial/ethnic populations, addressing HIV risk in cisgender heterosexual women, data driven communication strategies and social/structural determinants of HIV using an intersectional framework. Through the NIH-funded EHE coordinating center and implementation science hubs, the results of these projects have been widely distributed to any group seeking a best practice for implementation of a strategy address the EHE pillars.

As part of the EHE Initiative, the HRSA Health Center Program provides HIV testing and prevention services, delivers HIV care and treatment where appropriate, and also assists with responding quickly to HIV cluster detection efforts. The Health Center Program's primary focus in the EHE Initiative is on expanding HIV prevention services, including outreach, care coordination, and access to PrEP-related services, to people at high risk for HIV transmission through selected health centers in the identified jurisdictions. In FY 2020, the first year of the EHE Initiative, HRSA provided \$54 million to 195 health centers that received Health Center/Ryan White Program funding and/or were located in close proximity to a Ryan White Program where no jointly funded health center currently existed in the target jurisdiction. Despite the impact of COVID-19, health centers have made progress towards the goals of expanding access to PrEP-related services, HIV testing, and treatment services nationwide. For CY 2020, health centers with EHE funding reported that over 151,000 patients received PrEP services. Since FY 2020, health centers provided PrEP related services to nearly 400,000 patients, provided nearly 2.5 million tests, and linked 81% of patients with a first-ever HIV diagnosis to care within 30 days. Additionally, in comparing the two years prior to EHE Initiative funding (CY 2017) to the first year after (CY 2020), all of HRSA's health centers reported significant growth in HIV tests (+19%), patients (+15%), and visits (+8%), as health centers continue to provide vital HIV outreach and health care to underserved populations within their communities.

In FY 2021, HRSA awarded approximately \$48 million to support the participation of 108 additional health centers in the targeted jurisdictions and in FY 2022, HRSA will increase its investment in the EHE Initiative by \$20 million to include an additional 60 health centers.

For FY 2023, the budget request includes \$172 million to support the EHE Initiative, an increase of \$50 million above the FY 2022 enacted level, which will support participation of an additional 40 health centers, resulting in the participation of approximately 400 health centers.

HRSA's Ryan White HIV/AIDS Program (RWHAP) has funded 47 jurisdictions, 2 cooperative agreements to provide technical assistance, and 12 RWHAP AIDS Education and Training (AETC) recipients through the EHE initiative. During the first two years of the initiative, recipients have been successful in providing HIV care, treatment, and support services to an increasing number of newly diagnosed and re-engaged clients. HRSA's goal for the first year of EHE was for the EHE jurisdictions to provide HIV services to 18,000 newly diagnosed or re-engaged people with HIV; the jurisdictions exceeded that goal by providing services to over 19,400 people with HIV despite the challenges of the COVID-19 pandemic. The EHE initiative has increased the recipients' ability to reach those most affected by the epidemic and increased community engagement resulting in the identification of specific service needs from the community. It has also allowed recipients to innovate services models and interventions that are

directly responsive to the populations being served. Lastly, the EHE initiative has highlighted the need for more collaboration with new partners at the jurisdiction level. The Technical Assistance Provider (TAP) and System Coordination Provider (SCP) have provided TA to jurisdictions and the RWHAP AETC Programs have trained and supported service providers in the EHE jurisdictions. Types of TA provided to the jurisdictions include but are not limited to: improving Rapid ART programs; developing or enhancing community engagement efforts; creating evaluation plans; improving linkage to care after incarceration; enhancing data collection and sharing activities; partnering with Medicaid; and increasing access to temporary and emergency housing.

Understanding the activities and challenges of the jurisdictions has allowed HRSA to provide targeted TA as well. The EHE jurisdictions have been focused on implementing the EHE initiative during the COVID-19 pandemic which has resulted in many innovations in service delivery that are now being continued and expanded as the COVID-19 pandemic evolves. Finally, HRSA RWHAP will encourage the TAP and SCP to support jurisdictions in developing innovative practices and engaging with the key leaders in their community.

Additional resources will be used to fund the current jurisdictions, the TAP and SCP, as well as the RWHAP AETC Programs. HRSA estimates that approximately 76,000 clients will be served by this initiative through FY 2023.

CDC's FY 2023 request for EHE is \$310 million, an increase of \$115.0 million above the Consolidated Appropriations Act, 2022. The multi-year program will provide additional expertise, technology, and resources needed to end the HIV epidemic in the United States. CDC expects that proven and innovative activities will be employed across all four strategies of the initiative: diagnose, treat, prevent, and respond. The majority of funding will support state and local health departments for the 57 EHE jurisdictions to implement their Integrated HIV Prevention and Care plans. Critical investments in key HIV prevention activities through health departments, national, regional, and local and community organizations, and school health provide the foundation needed to fully implement new activities in EHE. Sufficient funding is critical for EHE to ensure scaling up of testing, prevention, treatment, response, and research strategies to provide affected communities with the expertise and resources they need to continue addressing the HIV epidemic locally.

Even while the COVID-19 pandemic disrupted HIV-prevention services and care, the 57 EHE jurisdictions began to implement their plans; CDC and EHE jurisdictions capitalized on innovations to continue providing essential services and advance health equity. For example, HIV testing options were expanded to include the delivery of over 100,000 self-tests kits. Pre-Exposure Prophylaxis (PrEP) was also expanded, specifically in community health centers, making PrEP accessible to more people. CDC also encouraged the use of telemedicine for HIV treatment and prevention services, which included expanding Pharmacy Data to Care to increase re-engagement in care and viral suppression. Finally, prevention efforts included strengthening the infrastructure of sexually transmitted disease (STD) clinics to offer HIV prevention services, including increased testing and the provision of PrEP, and expanding support for syringe services programs.

The Biden-Harris Administration is committed to fighting HIV/AIDS, including by strengthening prevention efforts and increasing access to treatment. I look forward to working with you, along with partners across HHS and other federal agencies, on ways to meet the President's goal of ending the HIV/AIDS epidemic by 2030, including by increasing access to PrEP and other important preventative measures.

### ***HIV/AIDS – Racial and Ethnic Inequities***

I am very pleased to see that the Biden administration has released an updated HIV National Strategic Plan, which focuses more on racial and ethnic inequities, the social determinants of health, calls out racism as a public health threat, and addresses HIV stigma and criminalization.

#### **31. Question:**

In what ways will HHS encourage the review and repeal of Federal, State, and Local criminalization laws and policies that discriminate against people living with HIV?

#### **Response:**

HHS staff currently participate in a HIV Criminalization Workgroup led by ONAP Director, Harold Phillips and are actively looking to identify strategic approaches to address the issues of HIV criminalization elimination and modernization of HIV laws. In January 2022, HHS participated in an ONAP-led Community Listening Session to hear directly from those affected by HIV criminalization as well as subject matter experts from the field. HHS anticipates that the National HIV/AIDS Strategy Implementation Plan which will be released in the summer of 2022 will include activities proposed by several agencies to address HIV criminalization. HHS is also currently working with ONAP to organize a HIV criminalization roundtable, to be led by ONAP with participants from the public health law community to discuss necessary next steps in ending HIV criminalization.

#### **32. Question:**

Can you explain how you would use the additional resources as we work to end HIV in all populations and all geographic areas, and address the syndemics of HIV, including hepatitis and drug use?

#### **Response:**

CDC will continue HIV prevention efforts around the country, focusing on the populations who are most affected by HIV - especially Black/African American, Hispanic/Latino, and LGBTQ communities. CDC is embracing strategies to increase access to HIV prevention services, enhance community engagement, and combat stigma to achieve health equity. In FY 2023, CDC will continue to amplify core efforts of Diagnose, Treat, Prevent and Respond resulting in, approximately:

- 16,000 people diagnosed with HIV who did not know they had HIV

- 13,000 people with previously diagnosed HIV infection who had fallen out of care tested and re-linked to care
- 15,000 people at risk of HIV enrolled in PrEP services and treatment
- 100 HIV clusters or outbreaks investigated and responded to in communities experiencing rapid transmission
- investments in at least 30 STD clinics to expand access to HIV prevention and care services, including PrEP and nPEP support

CDC is committed to using HIV Prevention funding, guidelines, and technical assistance to support syndemic approaches (approaches targeting an aggregation of two or more concurrent or sequential epidemics or disease clusters in a population) that provide more holistic care to people who are disproportionately affected by HIV, STDs, and viral hepatitis. Specifically, CDC is focusing efforts on providing a range of services in settings where people affected by syndemics might seek care, including syringe services programs, STD clinics, community-based organizations (CBOs), health department clinics, and community health centers. Ideally, an individual who seeks care in these settings would be able to get tested for all of these conditions, and obtain the prevention, care, and support services they need for all of these conditions to stay healthy. CDC strives to provide flexible funding to health departments and CBOs to address syndemics through our core HIV infrastructure. For example, health department grantees can use up to 10% of their total funding amount to enhance these efforts. Health department and CBO grantees are also encouraged to support activities that address social determinants of health and linkage to other critical services such as housing, transportation, mental health, and substance use disorder treatment.

With additional resources HHS will expand its efforts to integrate Administration priorities as detailed in the recently released National HIV/AIDS Strategy, including extensive piloting of strategies and interventions that address social and structural barriers to prevention, treatment and care; piloting of innovative syndemic approaches involving HIV, viral hepatitis, STIs, and substance use and mental health disorders; integrating “status neutral” programming to better meet persons at risk for or living with HIV where they are; increasing the uptake of PrEP among those who could benefit; and accelerating public/private partnerships to help reach communities most impacted. The additional funding to end HIV in all populations and all geographic areas will further HHS efforts to reduce persistent HIV-related health disparities and meet the challenge of promoting health equity.

Some examples of innovative efforts include, CDC’s HIV prevention efforts around the country, focusing on the populations who are most affected by HIV - especially Black/African American, Hispanic/Latino, and LGBTQ communities. CDC is committed to using HIV Prevention funding, guidelines, and technical assistance to support syndemic approaches that provide more holistic care to people who are disproportionately affected by HIV, STDs, and viral hepatitis. Specifically, CDC is focusing efforts on providing a range of services in settings where people affected by syndemics might seek care, including syringe services programs, STD clinics, community-based organizations (CBOs), health department clinics, and community health centers.

Currently, over 200 NIH activities are planned or underway to support NHAS goals and priority populations (MSM, youth, Black women, transgender women, and persons who use drugs). For example, NIH has completed clinical trials that resulted in the FDA approval of a long-acting injectable PrEP medication, cabotegravir, as a long-acting formulation (Apretude®). NIH is seeking to expand the study of the implementation of long-acting agents for special populations at HIV risk including people who use drugs, and adolescents, and young black men who have sex with men in the parts of the U.S. where these special populations are particularly vulnerable. The FY 2023 budget will support more substantial investments in Early Stage Investigators, including investigators of color and those serving minority institutions, and expand, nurture and sustain the productive and heterogeneous workforce of HIV researchers required to meet EHE goals. The budget request will foster innovative public-private partnerships with the technology industry to accelerate development of new diagnostic and therapeutic tools, potential game changers to reach HIV epidemic control more rapidly.

As noted above, the HRSA, through its Health Center Program and Ryan White HIV/AIDS Program (RWHAP), plays a critical role in diagnosing, treating, preventing, and responding to the HIV epidemic. As part of the EHE Initiative, the HRSA Health Center Program provides HIV testing and prevention services, delivers HIV care and treatment where appropriate, and assists with responding quickly to HIV cluster detection efforts. The Health Center Program's primary focus in the EHE Initiative is on expanding HIV prevention services, including outreach, care coordination, and access to pre-exposure prophylaxis (PrEP)-related services, to people at high risk for HIV transmission through selected health centers in the identified jurisdictions. In FY 2020, the first year of the EHE Initiative, HRSA provided \$54.0 million to 195 health centers that received Health Center/Ryan White Program funding and/or were located in close proximity to a Ryan White Program where no jointly funded health center currently existed in the target jurisdiction. For calendar year 2020, these health centers reported that over 151,000 patients received PrEP services in the first year of the EHE Initiative. Overall, health centers provide PrEP related services to nearly 400,000 patients, provided testing to more 2 million, and linked 81% of patients with first-ever HIV diagnosis to care within 30 days.

In FY 2021, HRSA awarded approximately \$48 million to support the participation of 108 additional health centers in the targeted jurisdictions and in FY 2022, HRSA will increase its investment in the EHE Initiative by \$20 million to include an additional 60 health centers.

The FY 2023 budget request includes \$172.0 million to support the EHE Initiative, an increase of \$50.0 million above the FY 2022 enacted level, which will support participation of an additional 40 health centers, resulting in the participation of approximately 400 health centers.

Based on lessons learned from the first three years of the EHE Initiative in targeted jurisdictions, the Health Center Program will continue to scale up its HIV prevention services and develop technical assistance and training resources for health centers across the nation on effective HIV prevention services.

The FY 2023 Budget provides an additional \$165.0 million above FY 2022 Enacted, for a total of \$290 million for HRSA's RWHAP. Funding will support HIV care and treatment for over

76,000 clients in the 50 geographic locations that currently have more than 50 percent of new HIV diagnoses nationally and the seven states with substantial rural HIV burden. With additional resources, HRSA's RWHAP will increase current efforts to support the EHE jurisdictions, technical assistance (TA) cooperative agreements, and RWHAP AIDS Education and Training (AETC) Programs. Providing additional resources to EHE recipients will result in increased HIV care, treatment, and support service delivery to more clients, increased innovative models of services, and increase community engagement to better inform their efforts to reach disproportionately impacted communities. EHE-funded jurisdictions will also be encouraged to support the AIDS Drug Assistance Program (ADAP) as increasing the number of newly diagnosed and re-engaged people with HIV is anticipated to strain the resources of the ADAPs. The TAP and SCP will increase the amount of TA provided to individual jurisdictions and through national technical assistance. The RWHAP AETC Program will be able to expand trainings, develop more tools and materials for service providers while building connections between the providers, jurisdictions and the Technical Assistance Provider (TAP) and System Coordination Provider (SCP) to leverage their resources. Additional resources will be used to fund the current jurisdictions, the TAP and SCP, as well as the RWHAP AETC Programs.

HRSA is committed to curing hepatitis C among the co-infected patients served by the RWHAP. People with HIV are also disproportionately impacted by substance use disorder. Substance use services are currently provided under both EHE and the Ryan White HIV/AIDS Program and are utilized by EHE clients. Additional resources would also provide an increase in the promotion of these services and others which address social determinants of health, such as housing.

### **33. Question:**

What benefits have individuals gained access to over the last few months with increased and expanded subsidies under the American Rescue Plan? How has access to HIV, hepatitis, and/or harm reduction services been improved, if at all?

### **Response:**

During the first full year of the Biden-Harris Administration, nearly 6 million new consumers signed up for coverage through the Marketplaces nationwide through the 2021 Special Enrollment Period (SEP) and the 2022 Open Enrollment Period (OEP). This includes 2.8 million people who enrolled through the SEP and more than 3 million who enrolled during the OEP. Thanks to the American Rescue Plan, Marketplace plans were more affordable than ever, contributing to a record-breaking 14.5 million consumers nationwide signing up for Marketplace health care coverage – a 21 percent increase from last year.

All plans offered through the Marketplaces are required to cover essential health benefits, including coverage of preventive services, prescription drugs, and mental health and substance use disorder services. This means the millions of consumers who were previously uninsured or underinsured now have access to comprehensive coverage of screening, diagnostic, and treatment services, including services for HIV and hepatitis, along with behavioral health services, which can play an important role in harm reduction.

***HIV/AIDS – At Home Testing*****34. Question:**

Due to the COVID-19 pandemic, the U.S. has seen increased demand for HIV and STI at-home testing options. Are there plans to increase these at home testing services? How can funding be used to support this initiative? The COVID-19 pandemic caused significant disruptions in the public health response to HIV, specifically HIV testing. As a result, in May 2020, CDC issued guidance to programs experiencing a disruption in HIV testing and PrEP clinical services. As part of this guidance, CDC encourages programs to use self-testing via a home specimen self-collection kit or an oral swab-based test whenever lab visits are unfeasible. Innovative strategies that provide at-home testing work to make HIV prevention services equitable and provide an opportunity for vulnerable populations to receive better health outcomes.

**Response:** CDC plans to continue to expand on innovative strategies, including self-testing for HIV, that make prevention services more equitable and provide an opportunity to improve health outcomes in people most affected by HIV. CDC successfully distributed 100,000 HIV self-testing kits in 2021 and plans to significantly increase that number in 2022. CDC EHE funding will also support the integration of rapid HIV self-testing into established HIV prevention venues, as well as novel physical and virtual environments, such as CBOs, LGBTQ-focused clinics, pharmacies, mobile units, correctional facilities, and syringe services programs.

***HHS Intra-agency Taskforce on Reproductive Health***

I am pleased to see investments in maternal and reproductive health in the FY 23 budget to address maternal mortality rate and family planning. As Co-Chair of the Pro-Choice Caucus, I was pleased to see the announcement of the new HHS taskforce on reproductive health a few months ago.

**35. Question:**

What steps are you and the taskforce taking to support abortion access in light of the onslaught of state-level restrictions like Texas' SB 8 and legal challenges at the Supreme Court?

**Response:**

In response to Texas' SB8 law last fall, the Secretary announced a three-pronged Department-wide response from HHS focused on protecting Texas patients and health care providers, including Title X family planning grants to support providers, enforcement of nondiscrimination against providers, and enforcement of Emergency Medical Treatment and Labor Act (EMTALA) and Medicare conditions of participation. The Task Force, which was announced in January 2022 and is co-chaired by the Assistant Secretary for Health and the Assistant Secretary for Global Affairs, serves as the primary entity for coordination across the Department on sexual and reproductive health, rights, and justice and was established to provide feedback and specific recommendations to the Secretary on action-oriented approaches. Task force members include principal and senior-level representatives from the HHS operating and staff divisions that represent their respective Operating and Staff Divisions at meetings, including their views and perspectives, as well as communicating activities of the Task Force to their respective divisions.

Following five key guiding principles for its operation, the Task Force is working to coordinate additional potential activities across the Department, including development by each HHS agency, develop a plan outlining measurable actions the agency is considering or will take to protect and bolster access to sexual and reproductive health care.

### ***Poverty***

In the FY 2016 House Labor/HHS Appropriations Bill, I partnered with Congresswoman Roybal-Allard to secure funding for a National Academy of Sciences (NAS) study on child poverty. Entitled A Roadmap to Reducing Child Poverty. This landmark 2019 study reviewed the research on linkages between child poverty and child well-being and analyzes the poverty-reducing effects of major assistance programs directed at children and families, such as the child tax credit.

With the strong support of Chair DeLauro, we successfully included language in the FY 2022 House Labor/HHS Appropriations Bill directing HHS Office of the Secretary to convene an interagency coordinating council focusing on both child poverty and comprehensive supports.

#### **36. Question:**

Would you give the subcommittee an update on the department's implementation of the congressional directive to convene a children's interagency coordinating council including funds and staffing dedicated to the council?

#### **Response:**

We have several initiatives underway to help federal agencies better work together to increase economic stability and wellbeing across generations, and look forward to the opportunity the children's interagency coordinating council provides to help identify and address gaps and misalignments in supports for children.

Non-reimbursable detailee staff from HHS's Office of the Secretary who worked on the 2019 NAS report and have significant experience with cross-government coordination on child and youth well-being will be leading this work. We anticipate that the children's interagency coordinating council will be strengthened by collaboration with groups such as the Interagency Working Group on Youth Programs and the Interagency Council on Economic Mobility. Work will include assessing the 2019 NAS report to identify any possible administrative strategies as well as additional reporting on child poverty and wellbeing.

#### **37. Question:**

Also, would you agree with me that there is a need for a permanent, ongoing mechanism to assess the effect of federal policymaking on the health, safety, education, and nutrition of children in Hispanic, African American, Asian American, Native Hawaiian, and Pacific Islander, and American Indian/Alaska Native families?

**Response:**

Assessing the outcomes and effects of federal policy for children in Hispanic, African American, Asian American, Native Hawaiian, and Pacific Islander, and American Indian/Alaska Native families is critically important to understanding and increasing equity and wellbeing. Through its equity action plan, HHS has committed to integrating equity assessments into its policy development and improvement efforts to ensure we are identifying opportunities to ensure HHS services benefit all groups, including these populations.

HHS is working to advance equity in data production and collection. Several current activities to address this are:

1. The development of an equity research agenda for identifying methods for disparities/equity research that are appropriately community-centered, strengths based and do not pathologize populations that are marginalized and to establish ways to appropriately generate new, and build on existing, evidence to identify and reduce disparities and understand the opportunity and impact of HHS programs on underserved/resourced communities.
2. The National Committee on Vital and Health Statistics (NCVHS) has created a committee to analyze and generate recommendations specific to social determinants of health (SDOH) data
3. The HHS Data Council is currently assessing the availability and use of administrative data related to equity in HHS service programs. HHS will use this information to address challenges faced by HHS-funded service programs in collecting, using, and reporting equity-related administrative data elements in program evaluation.

In addition, the Office of the Assistant Secretary for Planning and Evaluation and the HRSA Maternal and Child Health Bureau have partnered on the Early Childhood Systems Collective Impact Project, to promote a coordinated approach to advancing equitable early childhood and family health, development, and well-being by improving the collective impact of federal programs that support young children and their families. This project is developing recommendations to improve alignment and coordination across federal programs that serve expectant parents, children ages 0-8, and their families. This project is also assessing opportunities for eligibility requirements, needs assessments, measures and indicators of program success, well-being metrics, and program equity goals and actions to support equity and well-being, and address systemic barriers to access.

***Food As Medicine***

Around the country, underserved communities face a daily struggle with food insecurity and chronic disease. In fact, an unhealthy diet causes an estimated half a million deaths per year in America. I led a recent letter with twenty-five of my colleagues asking HHS to lead a national Food as Medicine pilot program using food as medicine in a clinical setting, to help our healthcare system improve health outcomes for the underserved. This pilot would be modeled

after work being done in my home, Alameda County, California as part of the county's ALL IN **Recipe4Health** initiative, which is an integrative model for healthcare that addresses food insecurity, social isolation, and chronic disease to advance health and racial equity.

This model transforms the healthcare system's capacity to increase access to and utilization of affordable healthy foods to improve the overall health of communities:

- **Food Pharmacy:** Patients receive a prescription for 16 weeks of regeneratively grown (local, pesticide-free, seasonal, nutrient dense) produce via ALL IN Eats providing weekly doorstep delivery to their homes.
- **Food as Medicine Training:** Healthcare clinic staff receive clinical nutrition training and workflow integration support. Healthcare clinics increase their capacity to treat, prevent, and reverse chronic disease and food insecurity.
- **Behavioral Pharmacy:** Patients receive nutritional and behavioral support (e.g., cooking demos, recipes, nutrition education, mindful eating and stress reduction) to integrate food interventions into daily habits.

I ask that HHS implement a national pilot program that could expand the efforts of programs such as Recipe4Health that intentionally connect healthcare, regenerative agriculture, economics, and the environment together, to improve health and racial equity, and food security.

**38. Question:**

Would you update the Subcommittee on your plans for this program?

**Response:**

The human and economic costs of diet-related diseases are staggering. Good nutrition helps cut down on chronic disease, which disproportionately hurts our most vulnerable communities. Improving the quality of food and nutrition is not only important to boost individual health outcomes – it is an essential step towards tackling widespread health disparities. I look forward to working with my federal partners across HHS, along with Congress and other stakeholders, to examine innovative ways to improve the health and nutrition of Americans across the country.

*Addressing the Shortage of Primary Care Physicians*

**39. Question:**

The National Academies of Sciences, Engineering, and Medicine recently issued a report on primary care that estimates 85 deaths per day in the US are the result of declining access to primary care. Your budget proposes a \$5 million increase for training in primary care medicine. Is the proposed investment in primary care part of a larger strategy to address the growing shortage of primary care?

**Response:**

The \$5 million increase in the Primary Care Training and Enhancement Program is part of the Administration's strategy to increase access to primary care, as well as to integrate primary care and behavioral health services. It is part of HRSA's larger focus on growing the capacity of the

primary care workforce to meet increasing demand. HRSA primary care workforce programs include not only the Primary Care Training and Enhancement Program, but also the Teaching Health Center Graduate Medical Education (THCGME) Program. This program focuses on supporting the training of residents in primary care residency training programs in community settings and enhances the supply of primary care physician residents. The FY 2023 budget request is projected to support up to 801 FTE slots in addition to the substantial investment in this program through the American Rescue Plan.

In addition, the National Health Service Corps (NHSC) provides scholarships and loan repayment for clinicians who commit to practice in underserved communities. As of September 30, 2021, there are nearly 20,000 primary care medical, dental, and mental health and substance use disorder practitioners working in the communities that need them most thanks to this program. HRSA also supports the primary care workforce through the Children's Hospitals Graduate Medical Education (CHGME) Payment Program that makes payments to eligible children's hospitals for expenses associated with operating approved graduate medical residency training programs. CHGME supports the training of residents to care for the pediatric population and enhances the supply of primary care and pediatric medical and surgical subspecialties. The FY 2023 budget request for the CHGME enables HRSA to continue to support approximately 7,700 physician FTEs for direct and indirect expenses for graduate medical education.

The Biden-Harris Administration is committed to addressing the growing workforce shortage in health care, including among primary care providers. HHS welcomes input on ways to improve our programs, and we review thousands of comments and suggestions from stakeholders across the health care industry, such as the National Academies of Sciences, Engineering, and Medicine. HHS relies on this stakeholder feedback to inform our decision-making process across the Department.

To help alleviate the nation's health care workforce shortage, in December 2021, CMS issued a final rule that will fund additional medical residency positions in hospitals serving rural and underserved communities, including areas with a shortage of mental health care providers. The Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) final rule with comment period establishes policies to distribute 1,000 new Medicare-funded physician residency slots to qualifying hospitals, phasing in 200 slots per year over five years. CMS estimates that funding for the additional residency slots, once fully phased in, will total approximately \$1.8 billion over the next 10 years. In implementing a section of the Consolidated Appropriations Act (CAA), 2021, this is the largest increase in Medicare-funded residency slots in over 25 years. In allocating these new residency slots, CMS will prioritize hospitals with training programs in areas demonstrating the greatest need for providers, as determined by Health Professional Shortage Areas (HPSAs). The first round of 200 residency slots will be announced by January 31, 2023, and will become effective July 1, 2023. In addition, under the HPSA Physician Bonus Program, CMS pays a 10 percent bonus to psychiatrists who deliver services to Medicare patients in the areas that have a geographic mental health HPSA designation.

The training and retention of physicians and other health care professionals is critical to ensuring access to critical health care services, including primary care. I look forward to working with

Congress and other stakeholders to examine innovative ways to address the ongoing workforce shortage across the health care system.

**40. Question:**

Are you considering other recommendations from the National Academies Report, Implementing High Quality Primary Care: Rebuilding the Foundation of Healthcare and the findings of the Roundtable on Black Men and Black Women in Science, Engineering, and Medicine outline racism and bias as significant reasons for this disparity in science, engineering, and medicine, with detrimental implications on individuals, health care organizations, and the nation as a whole?

**Response:**

Yes, HRSA is actively reviewing the recommendations and will incorporate as appropriate in future funding opportunities. The Committee recommendations include a focus on education and training of primary care clinicians to serve in medically underserved communities. HRSA shares this commitment to diversity in the workforce and has a number of investments to continue to support students from diverse communities entering the health professions. HRSA will continue to support this work and build on the Committee's recommendations as appropriate.

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Congress and other stakeholders to examine innovative ways to address the ongoing workforce shortage across the health care system.

### ***Gun Violence***

Federal firearms data are housed in many federal agencies. For example, the Department of Health and Human Services collects health data describing the victims of firearms injuries and mortality, and the Department of Justice collects criminal justice data describing the circumstances of shootings and characteristics of gun violence perpetrators. Significant efforts to share data across different government agencies have substantially contributed to remediating and preventing many major public health crises, but we have not seen meaningful federal efforts to better integrate firearms-related data.

#### **41. Question:**

As Secretary, how will you integrate HHS firearms data with data from other agencies, and what steps are you taking to ensure that linked data is accessible to bona fide researchers for further analysis?

#### **Response:**

CDC continues to identify opportunities for sharing firearm data across federal agencies. For example, CDC has ongoing collaborations with the Departments of Defense (DoD) and Veterans Affairs (VA) to strengthen suicide-related data. Because an overwhelming number of suicides in the military and veteran populations are by firearm, CDC is collaborating with the Department of Defense to link and analyze data from the DoD's Suicide Event Report and CDC's National Violent Death Reporting System (NVDRS). This project leverages these two unique data systems to collect information on Veteran, active-duty, and civilian suicides for a unique opportunity to better understand the contributors to suicide in these populations. Combining different data elements from each system creates a more holistic picture to inform upstream prevention.

NVDRS data (which includes death by firearms) are stored in an incident-based database. Descriptive data can be accessed free of charge from the Web-based Injury Statistics and Query System (WISQARS). CDC's WISQARS™ is an interactive, online database that provides fatal and nonfatal injury, violent death, and cost of injury data from a variety of trusted sources. Researchers, the media, public health professionals, and the public can use WISQARS™ data to learn more about the public health and economic burden associated with unintentional and violence-related injury in the United States, including firearm-related violence.

More detailed data from NVDRS is available through the NVDRS Restricted Access Database (RAD), including information from medical examiner and coroner reports as well as law enforcement reports. The data set is available to researchers who meet specific criteria. The RAD database also includes short narratives to describe violent deaths, including descriptions abstracted from law enforcement and coroner/medical examiner reports. There is no cost for accessing the NVDRS RAD.

**Submitted by Rep. Mark Pocan*****National Child Abuse Hotline*****42. Question:**

In the recently enacted FY22 omnibus, the National Child Abuse Hotline received \$2 million. Can you provide a timeline estimate for when these funds will be distributed to the Hotline?

**Response:**

HHS anticipates the funds being distributed in the third quarter of the fiscal year.

**43. Question:**

Given the critical need for the Hotline, especially during the COVID-19 pandemic, would HHS support the inclusion of dedicated funding in future budgets?

**Response:**

Over a four-year project period, the Hotline project expanded text and live-chat services to help seekers, targeting youth ages 13 to 24, who are looking for information, support, and resources related to child abuse or neglect. Data collected suggests young people are more inclined to seek help over text and chat. Project evaluation has provided rich data on the technical and clinical capabilities of adding text and chat-based technology to a national child abuse hotline as well as provided a deeper understanding of the help-seeking behavior and demographics of youth across the country. Should Congress continue to appropriate funding for the hotline, HHS will ensure it continues to be used for the intended purpose.

***CDC Data Modernization Initiative*****44. Question:**

Could you please provide additional details on how the \$200 million investment in the data modernization initiative will put the nation on a more solid foundation in terms of establishing modern, interoperable, real-time and seamless immunization data?

**Response:**

CDC's Data Modernization Initiative (DMI) drives improvements in access to actionable intelligence for decision-makers at all levels of public health by establishing modern, interoperable, and real-time public health data and surveillance systems to protect the American people. With this investment, CDC will build upon existing work with state, tribal, local, and territorial public health jurisdictions and our public and private sector partners to implement solutions that will allow data to flow more seamlessly across healthcare and public health, as well as between jurisdictions and the agency, core data needed for essential public health activities from the local to the national level.

CDC will work with our partners to develop and implement technologies and policies needed to improve the exchange of clinical and public health data, the advancement and adoption of

standards-based interoperability, and the ability of public health agencies to share and link data through new approaches like privacy-preserving record linkage.

**45. Question:**

How does the CDC's data modernization initiative work align with HHS Protect?

**Response:**

CDC's Data Modernization Initiative (DMI) supports agency readiness for rapid outbreak response by preparing pandemic-prone programs to scale up in emergencies and modernizing the core data systems that provide surveillance data for national public health. Core components to ensure capabilities for rapid outbreak response include work to enhance CDC services and systems through adoption of enterprise-wide infrastructure and services that enable data linking, sharing, analysis and visualization. Integrating HHS Protect into public health practice supports these aims, with a pandemic-ready system for data sharing and integration.

The HHS Protect ecosystem is a secure platform for authentication, amalgamation, and sharing of healthcare and public health information, so that the U.S. government can harness the full power of public health data, including for the COVID-19 response. With HHS Protect, more than 200 disparate data sources are brought together into one ecosystem that integrates data across federal, state, and local governments and the healthcare industry. It provides a holistic view of the U.S. healthcare system and other public health indicators, so decision makers informed by HHS Protect have information to guide action and save lives. This system will be central to CDC's and HHS's preparedness for other threats beyond COVID-19, serving as a proven system to provide modern, interoperable, real-time data available across the US government and public health system.

DMI work aligns with and supports HHS Protect by increasing access to high-quality, complete data that can be integrated into the HHS Protect platform by enhancing the flow of real-time, interoperable public health data, advancing CDC program response readiness and use of shared services with ability to more quickly and easily connect to and leverage the HHS Protect platform, and expanding CDC capacity to perform advanced analytics and modelling on the data made available through HHS Protect.

***Diabetes***

**46. Question:**

Can you provide us with additional information on how ARPA-H might prioritize the diabetes community especially when looking at the increased number of diagnoses, how expensive diabetes treatments and everyday living is relative to other conditions, and the impact of the pandemic?

**Response:**

Diabetes is an area of urgent need and scientific opportunity, and as highlighted in the President's Budget for Fiscal Year 2023, ARPA-H will strive to build capabilities, platforms, and technologies that will be applicable across a range of diseases and conditions, including diabetes,

cancer, and Alzheimer's disease. While NIDDK's ongoing investments will continue to provide an essential foundation for diabetes therapy development in both public and the private sector, ARPA-H could complement current NIDDK-supported efforts to accelerate the pace of preventing and treating diabetes for all Americans. It is important to note that ARPA-H's research agenda will be determined independently by the Director and program managers of ARPA-H.

**47. Question:**

Just this week a new study showed that prediabetes in young Americans more than doubled in a span of 20 years. Will ARPA-H prioritize prediabetes research, treatments, and innovations especially when it comes to children and young adults?

**Response:**

The pediatric obesity epidemic has had enormous public health implications, including the escalating incidence of prediabetes and type 2 diabetes mellitus (T2D) in youth, particularly those from racial/ethnic minority groups. In addition, T2D in youth and adolescents is more difficult to control and less responsive to medications known to be more effective in adults. In addition, complications occur early in youth-onset T2D and accumulate rapidly. NIDDK's ongoing investments will continue to provide an essential foundation for diabetes prevention and treatment, and could be supplemented by ARPA-H. It is important to note that ARPA-H's research agenda will be determined independently by the Director and program managers of ARPA-H.

***Pressure Injuries/Ulcers***

**48. Question:**

Pressure Injuries/ulcers impact over 2.5 million Americans annually and cause over 60,000 patient deaths, many of which occur in our VA hospitals and many of which could and should be avoided. Would the agency consider utilizing some of the additional funding in the FY22 omnibus and potential additional FY23 funding to expand NIH research into preventing and treating pressure wounds?

**Response:**

NIH shares your concern on this issue and recognizes that pressure injuries affect more than 2.5 million people per year and are one of the five most common harms experienced by patients. Public health need is one of the key factors that drives NIH priority setting. Other factors taken into consideration include scientific opportunities because not all areas are equally ripe for advancement. NIH also strives to maintain a balanced and diverse research portfolio across different research areas and stages in addition to balancing research and training. In addition, NIH only funds research judged highly meritorious through a two-stage peer review process.

**49. Question:**

Can the NIH Director work closely with the US National Pressure Injury Advisory Panel to prioritize, expand and better fund research into this area of science?

**Response:**

NIH is committed to fostering and supporting innovative research strategies and applications to address pressure injuries, supporting projects focused on new technological advances and strategies to improve pressure ulcer prevention. NIH is willing to collaborate with interagency partners and the biomedical research community on this topic to improve research strategies, fundamental knowledge, and applications to address this issue in alignment with the NIH mission.

**50. Question:**

Can the agency provide the committee a summary of the “state of science” and the specific steps being taken by HHS and NIH to expand research opportunities in the area of wound care and pressure injury research?

**Response:**

The National Institute on Aging (NIA) supports research on the prevention and treatment of skin injuries, including pressure ulcers, in older individuals. Ongoing projects include:

- Development of smartphone-based technology that allows wheelchair users to self-monitor their own seating pressure and in-seat movement patterns, providing an effective tool to prevent development of many pressure injuries. (5R01AG056255)<sup>1</sup>
- Development of a direct 3D mobile imaging-based foot orthotics optimization system to prevent ulcers in persons with diabetes, a population in whom foot ulcers are common. (1R44AG069564)<sup>2</sup>
- Development and testing of improved wound treatment and care, including a bioengineered form of fibronectin—a protein critical to tissue repair—combined with therapeutic ultrasound (5R01058746)<sup>3</sup> and a hydrogel formulation of a different protein, MG53, which is also essential to cell membrane repair and wound healing. (5R01AG056919)<sup>4</sup>

In addition, in 2021, NIA issued a contract solicitation for development of a new geroscience-based treatment for chronic wounds that targets relevant mechanisms of wound healing including stem cell therapies, cell senescence, inflammation, or others. An award is anticipated by the end of FY2022.

NIA also supports research on the molecular and cellular properties of aging skin and how changes in skin over time may contribute to impaired wound healing and increased risk of pressure ulcers. For example, an ongoing project (5R03AG067983)<sup>5</sup> focuses on the role of cellular senescence in impaired wound healing that occurs with aging and explores the potential of senolytics (agents that selectively clear senescent cells) in wound care and tissue repair.

**Submitted by Rep. Katherine Clark**

***Medicaid Drug Rebate Program in the U.S. Territories***

Secretary Becerra, in the Fiscal Year 2023 HHS Budget in Brief, there is a proposal to modify the Medicaid Drug Rebate Program in the U.S. territories (pg. 97).

**51. Question:**

Can HHS elaborate on this proposal (regulatory or legislative change), the implementation timeline, and which territories are considered ready to participate?

**52. Question:**

What issues are facing the territories considered not ready to participate and what is HHS' plan for assisting those territories to get them to a position where they are ready to participate?

**53. Question:**

Please describe in detail HHS' efforts to support the U.S. territories in providing medication access for vulnerable populations.

**Response to 51-53:**

As discussed below, HHS seeks a statutory change to provide flexibility for Territory Medicaid drug programs, given limitations under current law which may lead to an increase in drug prices for certain Territories. We look forward to working with Congress to enact this important change for Territory Medicaid programs, and HHS is available to provide technical assistance.

The definitions of "State" and "United States" in section 1101(a) of the Social Security Act (the Act) include the U.S. Territories (American Samoa, Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands), when used in title XIX (Medicaid) and in title XXI (the Children's Health Insurance Program (CHIP)) except where otherwise provided, which means that the territories should have been included in the use of the term "State" and "United States" in section 1927 of the Act, Payment for Covered Outpatient Drugs, since the inception of the Medicaid Drug Rebate Program (MDRP) in 1991.

However, participation in the MDRP has always been limited to the 50 states and the District of Columbia. Over the years the U.S. Territories have expressed interest in joining the MDRP and benefitting from the rebates on covered outpatient drugs. As a result, on February 1, 2016, CMS published in the Federal Register a final rule with comment period, titled "Medicaid Program; Covered Outpatient Drugs", to amend the regulatory definitions of "State" at 42 C.F.R. §447.502 to include the five U.S. Territories beginning April 1, 2017, and to finalize the definition of "United States" also to include the territories beginning April 1, 2017. Additionally, the 2016 Final Rule stated that territories may use existing waiver authority, as applicable, under section 1902(j) and section 1115(a)(1) of the Act to elect not to participate in the MDRP consistent with statutory requirements. Once the 2016 Final Rule became effective, CMS began discussions with the U.S. Territories regarding their participation in the MDRP and whether or not they would seek a waiver from participation.

Based on those discussions, it became evident that the interested territories could not be ready to implement the MDRP by April 1, 2017. As a result, CMS issued two Interim Final Rules with Comment Periods (IFCs). The first IFC was issued on November 15, 2016, and delayed the inclusion date of the Territories in the regulatory definitions of “State” and “United States” from April 1, 2017 to April 1, 2020. The second IFC was published on November 25, 2019, and further delayed the inclusion date for territories to April 1, 2022. This second delay was implemented after further discussions with the U.S. Territories indicated that, although they were making progress toward developing the necessary systems, only one territory was prepared to implement the MDRP by April 1, 2020. As a result of the IFCs, on May 28, 2021, CMS published a proposed rule and sought public comments on two proposals to further delay the effective date of the territories’ inclusion in these regulatory definitions. CMS finalized this rule on November 17, 2021, delaying for nine months the effective date for the inclusion of the U.S. Territories in the regulatory definition of “States” and “United States” for purposes of the MDRP. Under this rule, this provision will be effective January 1, 2023 instead of April 1, 2022.

Currently, each of the U.S. Territories’ readiness to implement the MDRP varies. It is expected that American Samoa, Northern Mariana Islands and Guam will likely seek waiver authority not to participate in the MDRP regardless of how long the inclusion date in the amended regulatory definitions is delayed. These territories indicate that the cost of adding the additional drugs to their formulary, as would be required under MDRP, would likely far outweigh any savings that would be generated from rebates.

Puerto Rico has indicated that it needs more time to develop a rebate system, but it might be ready to participate in mid-2022. Further, Puerto Rico indicated it expects to see a reduction in its total Medicaid drug costs once it participates in the Medicaid Drug Rebate Program. At this time, only the U.S. Virgin Islands is likely ready to participate because they have a contract to utilize West Virginia’s Medicaid Management Information System, which is necessary for them to participate in the MDRP. Given the variability, the Biden-Harris Administration believes participation in the MDRP should be made optional for the territories without requiring them to complete the necessary waiver application, which would continually have to be re-submitted, reviewed and approved. In addition, when the U.S. Territories become part of the definition of “State” and “United States,” effective January 1, 2023, the drug manufacturers will be required to include sales to the U.S. Territories in their determination of average manufacturer price and best price, which are reported to the MDRP. The inclusion of territory sales in these metrics is likely to affect the discounted prices on drugs that have traditionally been provided to the Territories.

While there is limited data on the drug prices paid by the territories, information from manufacturers indicates that they do provide drug discounts to the Territories, which could be reduced or eliminated if they were counted in a manufacturer’s AMP and best price calculations. Because manufacturers do not currently have to consider the applicable sales prices made available in the U.S. Territories in their calculation of AMP and best price, drug manufacturers are likely providing deeply discounted prices to the territories. When the U.S. Territories are included in the regulatory definitions of “State” and “United States,” and the MDRP is extended to the territories’ Medicaid programs, it is likely that drug manufacturers may charge higher

prices to the pharmacies in the territories to maintain a similar net price for drugs (after accounting for the rebates) in order to avoid establishing a lower best price. This would reduce the net impact of extending the MDRP rebates to the territory programs. CMS is unable to address these issues through regulatory changes given that the current statutory definitions of “State” and “United States” in section 1101(a) of the Act includes the U.S. Territories. As a result, legislative changes are needed to address these issues. Specifically, the proposal seeks statutory changes to exempt sales from the manufacturer calculation of average manufacturer price and best price in territories to ensure continued discounted drug prices for territories, and make it optional for territories to participate in the Medicaid Drug Rebate Program.

The proposed changes will allow the territories flexibility to determine whether they will participate in the MDRP and may help ensure that territories continue to have access to discounted drug prices from manufacturers.

**Submitted by Rep. Cheri Bustos**

***Social Determinants of Health Council***

**54. Question:**

The Fiscal Years (FY) 2021 and 2022 House-passed Labor, Health & Human Services, and Education Subcommittee bills included language that would create a Social Determinants Council. This interagency-intergovernmental Council would, among other responsibilities, provide technical assistance to State, local, and tribal jurisdictions seeking to develop Social Determinants Accelerator Plans, which the Committee appropriated in FY21 \$3 million in funds for grants and \$8 million for FY22. The Council would also develop a report on federal cross-agency opportunities to address social determinants of health. The interagency Council is a critical component towards improving how the federal government looks to approach social determinants of health. Agencies and departments in different policy areas have operated for so long in silos, and it is essential that they develop stronger relationships and work together on intersectional projects like the Accelerator Plans grants to better address social determinants of health. In the absence of an interagency-intergovernmental Council, what federal entity (a Department, Agency, Agency Center, Task Force, Council, or other convening group) is leading and centralizing federal government efforts to address social determinants of health and break down silos among federal departments and agencies? If the Administration does not plan to create a similar council, how would the \$153 million requested again within the President's budget be used to improve intergovernmental coordination if the Committee were to appropriate funding matching the President's request?

**Response:**

HHS agrees that addressing the Social Determinants of Health (SDOH, which we are beginning to refer to as Social Drivers of Health to acknowledge that SDOH conditions can be mitigated to improve outcomes) is very important for the health and wellbeing of the nation and that addressing SDOH requires engagement and coordination across HHS, as well as with other Departments within the federal government.

Within HHS, we have adopted a strategic approach to addressing SDOH to advance health and wellbeing over the life course. ASPE recently posted a series of documents that describe this approach: <https://aspe.hhs.gov/topics/health-health-care/addressing-social-determinants-health-federal-programs>. The approach includes three goals to:

1. advance the data infrastructure needed to support care coordination and evidence-based policy making;
2. improve access to equitably delivered health care services and support partnerships between health care providers, human service providers, and other community-based partners; and
3. adopt a whole-of-government approach that supports public-private partnerships and leverages community engagement to address SDOH.

Work is ongoing within HHS to implement and further develop strategies to address Goals 1 and 2 which mostly fit within HHS' policy portfolio. HHS also has work underway to address Goal 3 both internally and with other federal partners. For instance, HHS has a long standing engagement working across the government with the U.S. Interagency Council on Homelessness that is developing a homelessness prevention strategy that will be part of the Federal Strategic Plan to Prevent and End Homelessness. In addition, we are working on a number of initiatives to coordinate HHS programs regarding safe and affordable housing with HUD, food and nutrition services with USDA, and accessible transportation with DOT.

To further propel efforts to address Goal 3, HHS has been engaged in discussions with the White House through an Interagency Policy Council regarding opportunities to facilitate cross-Department collaboration on key topics. In addition to HHS, the Council includes representatives from Departments of Interior, Labor, Treasury, Education, Housing and Urban Development, Agriculture, and Veterans Affairs. The charge to the group is to support a federal framework to address SDOH. These discussions are still in their early phase.

Given the CDC's implementation of the SDOH Accelerator Plans, they have been a key partner in all of this planning. As you are probably already aware, CDC has awarded 20 grants to accelerate actions in state, local, tribal, and territorial jurisdictions that prevent and reduce chronic diseases among people experiencing health disparities. More information regarding CDC and the SDOH Accelerator Plans is available at the following link: <https://www.cdc.gov/chronicdisease/programs-impact/sdoh/accelerator-plans.htm>. With the additional \$153 million requested in FY23 to help further support this work, CDC would award funds to additional jurisdictions to develop SDOH accelerator action plans, to fund communities to implement and evaluate action plans, and to continue building the SDOH evidence base through a targeted research agenda, including allocating funds to CDC's own internal researchers, and improved data collection. Additionally, CDC will continue to leverage and coordinate efforts currently underway across the agency to ensure that drivers of health inequity are addressed in their scientific and intervention planning, implementation, and evaluation activities.

### ***Rural Health Provider Shortages***

#### **55. Question:**

I was pleased to see the budget request \$502 million for the National Health Service Corps program. The Committee included under the Fiscal Year 2022 Omnibus \$25 million for NHSC to develop a pilot program to evaluate the benefit to patient access and practitioner recruitment and retention of extending loan repayment for five years and \$200,000 for providers serving in rural areas that are part of a Health Professional Shortage Area. As the administration looks to address healthcare provider shortages nationwide and in rural areas, how does the administration foresee this pilot program improving access to care in rural areas? What type of targeted outreach does the administration plan to do to ensure a sufficient number of practitioners participate in the pilot?

**Response:**

HRSA will continue to build on the success of the NHSC's mobilization of primary care providers to rural areas. As of September 30, 2021, over 7,000 primary care medical, dental, and behavioral health clinicians have dedicated their practice to caring for rural communities. Every year this cadre of providers offer access to primary care services to over seven million patients experiencing chronic illnesses, at-risk pregnancy, challenges with substance use disorder morbidity and mortality, and geographical barriers to accessing quality health care.

Although the FY 2022 House bill and report provided an increase of \$25 million to the National Health Service Corps to implement a pilot program to evaluate the benefit to patient access and practitioner recruitment and retention of extending loan repayment for five years and \$200,000 for providers serving in rural areas that are part of a Health Professional Shortage Area, the FY 2022 Consolidated Appropriations Act did not include these additional resources to implement the pilot program. However, HRSA currently funds the National Health Service Corps Rural Community Loan Repayment Program, a three-year program dedicated to the retention of a substance use disorder workforce focused on the opioid epidemic in rural communities. The National Health Service Corps Rural Community Loan Repayment Program has made loan repayment awards in coordination with the Rural Communities Opioid Response Program to provide evidence-based substance use treatment, assist in recovery, and to prevent overdose deaths across the nation.

***Mental Health Block Grant Crisis Care Set-Aside*****56. Question:**

I want to thank the Biden Administration for requesting an increase in the crisis care set-aside from five percent to ten percent. This is in line with my Crisis Care Improvement and Suicide Prevention Act and the House-passed Fiscal Year 2022 Labor, Health & Human Services, and Education Subcommittee bill. As you prepare to implement the 988 program, for which the Budget requested \$696.9 million, how does the administration foresee utilizing the five percent crisis care set-aside to mitigate challenges in standing up the 988 program? By increasing the set-aside to ten percent, what specific challenges would the administration mitigate in implementing the 988 program?

**Response:**

Realizing the full potential of 988 requires both strengthening the Lifeline contact center network as well as transforming broader crisis services in communities across the country. While the \$696.6 million proposed in this request will focus predominantly on building contact center capacity, the Community Mental Health Services Block Grant (MHBG) crisis set-aside plays an instrumental role in supporting state efforts to strengthen a wider array of crisis services across the crisis continuum.

Extensive investments are critical to ensuring that all states and territories have robust crisis services in place, ranging from mobile crisis response to crisis receiving and stabilizing facilities to community-based crisis care. A more substantial set aside would help mitigate gaps that currently exist in local crisis ecosystems beyond the initial call, chat, or text.

Increasing the crisis set aside in the MHBG will also support state readiness for 988 implementation and will complement funding made available through the 988 program. This could include building capacity for volume surges and/or developing related systems which can reduce demand on the 988 system. Additionally, for states with more mature 988 systems, the MHBG funding, along with other federal sources, can support related functions within the crisis continuum such as mobile crisis services.

### ***Medicaid Redeterminations***

#### **57. Question:**

By some estimates, the state of Illinois is projected to lose twenty percent in Medicaid enrollment when the public health emergency (PHE) ends. Medicaid Managed Care Organizations (MCOs) play an important role in Illinois and nationwide in providing coverage to Medicaid beneficiaries, and MCOs can play an important role in collaborating with state agencies to provide outreach and assistance to beneficiaries with transitions from Medicaid when members lose coverage. What additional guidance does the Centers for Medicare and Medicaid Services (CMS) plan to share with state agencies and MCOs regarding authorization of approval for marketing documents, outreach to transitioning beneficiaries, and other components necessary to redeterminations when the PHE ends?

#### **Response:**

The Biden-Harris Administration has worked to ensure that every eligible person can access the coverage and care to which they are entitled, and is committed to working with states to make sure they have the tools and resources they need to prepare for the end of the public health emergency. It is a top priority at CMS to ensure, when the PHE eventually ends and states resume routine operations, including terminations of Medicaid eligibility, that renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage.

CMS is dedicated to supporting states in this process, known as “unwinding.” CMS has taken many steps to promote continuity of coverage, including planning tools to support state decision-making and advance planning, issuing updated guidance to state Medicaid directors, state reporting requirements and templates, communications tools to help states with consumer outreach, and providing ongoing technical assistance and resources.

Managed care plans can support states in their efforts to promote continuity of coverage for eligible individuals by helping individuals enrolled in their Medicaid managed care plan complete the renewal process, minimizing churn on and off of coverage due to procedural reasons, and facilitating transitions from Medicaid to the Marketplace where appropriate. In March, CMS issued an updated presentation outlining key strategies, which are permissible and consistent with federal policies, that states can employ in working with managed care plans. These are: 1) partnering with plans to obtain and update beneficiary contact information; 2) sharing renewal files with plans to conduct outreach and provide support to individuals enrolled in Medicaid during their renewal period; 3) enabling plans to conduct outreach to individuals

who have recently lost coverage for procedural reasons; and 4) permitting plans to assist individuals to transition to and enroll in Marketplace coverage if ineligible for Medicaid and CHIP.

CMS has launched a landing page—[Medicaid.gov/unwinding](https://www.medicaid.gov/unwinding)—dedicated to providing resources to supporting states and other stakeholders during the unwinding process, and continues to provide updated guidance to states. CMS has already conducted calls with every state to discuss and support them in developing their unwinding plans, and continues to be available to provide technical assistance. CMS also will monitor states' progress in meeting the timelines and completing required eligibility and enrollment actions described in guidance.

CMS also has highlighted the policy options available to states to ensure continuity of coverage for families when they need it most. For example, in April 2021, CMS approved Illinois' section 1115 Medicaid demonstration, allowing the state to receive federal matching funds to provide 12 months of continuous postpartum coverage for Medicaid and Children's Health Insurance Program (CHIP) enrollees. As many as 720,000 pregnant and postpartum individuals across the United States could be guaranteed Medicaid and CHIP coverage for 12 months after pregnancy thanks to the American Rescue Plan.

I look forward to working with Congress and partners across the federal government to expand on this important work and connect eligible children, parents, and pregnant individuals to health care coverage through Medicaid and CHIP.

**Submitted by Rep. Brenda Lawrence*****Maternal Health Outcomes*****58. Question:**

The pandemic worsened America's maternal mortality crisis. However, I am encouraged by the fact that the President's budget includes historic investments to combat maternal mortality. We must do more to save the lives of our mothers and children, but this is progress. Can you explain how the new initiatives and increases in the budget will improve maternal outcomes, especially for mothers of color?

**Response:**

The Title X Family Planning Program, administered by the Office of Population Affairs (OPA) in the Office of the Assistant Secretary for Health (OASH), is the only federal grant program dedicated to providing individuals with comprehensive family planning and related health services. Title X authorizing legislation requires that projects provide a broad range of effective and acceptable family planning methods and services, including natural family planning methods, infertility services and services for adolescents. By law, priority is given to persons from low-income families.

The Department and OPA are committed to advancing equity for all, including people from low-income families, people of color, and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. OPA's key maternal health priority is to expand access to family planning services, including preconception health care and contraception. The program will also expand the number of highly qualified family planning providers by 10% in three years by providing additional resources, technical assistance, and training that support the program's priorities on quality, access, and equity.

The new initiatives and increases in the budget for OASH will improve maternal outcomes for mothers of color by training providers on implicit biases and on culturally and linguistically appropriate care. Those initiatives and budget increases will improve outcomes for all mothers by increasing attention to the behavioral health needs of pregnant and postpartum people, including screening and referral for abuse and maltreatment and for environmental risks; by expanding access to family planning services, including preconception health and contraception; by reducing the stigma of postpartum depression and other mental health disorders; by improving perinatal data collection and using data to improve maternal health; and improving understanding of conditions that impact pregnancy such as fibroids, endometriosis, and polycystic ovary syndrome (PCOS).

We share your commitment to addressing the maternal mortality crisis and are pleased that the FY 2023 budget request dedicates \$276 million for HRSA to focus on initiatives to improve maternal health, which is \$202 million above the FY 2022 enacted funding level. This includes programs that prioritize reducing maternal mortality and addressing the disproportionate burden of poor maternal outcomes on women of color. Initiatives aim to reduce health disparities and improve maternal health outcomes by increasing access to equitable, quality care, for all

pregnant and postpartum individuals; expanding and diversifying the perinatal workforce; and supporting strategies that impact maternal health.

To expand and diversify the perinatal workforce:

- The Budget includes new investments to expand and diversify the **doula** (\$20 million) and **certified nurse midwife** (\$25 million) workforces to expand services to communities affected by high rates of adverse maternal health outcomes or with racial and ethnic disparities in maternal health outcomes, and rural and underserved communities.
- The Budget also includes funding to create a research network for **minority-serving institutions** to advance maternal health research and practice that focuses on addressing health disparities and equity. (\$10 million).

To address social and structural determinants of health that affect women's health:

- The Budget provides funding for a new program, **Addressing Emerging Issues and Social Determinants of Maternal Health** (\$55 million), that will:
  - Support communities in addressing social determinants of maternal health for pregnant and postpartum individuals to address racial and ethnic disparities;
  - Expand access to behavioral health services;
  - Promote equitable access to care through digital tools; and
  - Support technology-enabled collaborative learning to build provider capacity to improve maternal health outcomes.
- The Budget also provides increased funding for **Healthy Start** (\$145 million, \$13.2 million above 2022 Enacted), to support new programs in communities with the highest rates of disparities to address the unique structural, environmental, and systemic factors that contribute to disparities in poor outcomes for mothers and their babies, including mothers of color.

To improve access to care:

- The **Pregnancy Medical Home Demonstration Project** (\$25 million) will support the development and delivery of integrated, comprehensive care for pregnant and postpartum individuals at risk for adverse maternal health outcomes and racial disparities in maternal mortality and morbidity to improve care management and reduce poor outcomes.
- The **Implicit Bias Training Grants for Health Care Providers** program (\$5 million) to reduce and prevent implicit bias, racism, and discrimination in maternity care settings.
- A new **National Academy of Medicine Study** (\$1 million) to study and make recommendations for incorporating bias recognition in clinical skills testing for accredited schools of medicine.

In addition to the new investments, the budget proposes increases in several existing programs that help expand access and improve quality of maternal health for women of color. These include the **State Maternal Health Innovation Grants** (\$55 million, \$26 million increase from FY 2022 enacted) that implement state specific innovative action plans to improve access to maternal care services and address workforce needs and the **Alliance for Innovation on Maternal Health** (\$15 million, \$3.3 million above FY 2022 enacted) to expand the implementation of maternal safety bundles. To increase access in areas with health care shortages, the budget increases funding for **Rural Maternity and Obstetrics Management**

**Strategies** (\$10.4 million, \$5 million above FY 2022 enacted) and **Maternity Care Target Areas** (\$5 million, \$4 million above FY 2022 Enacted) that will help HRSA better identify areas in need of provider capacity.

The budget focuses on expanding access to behavioral health care for pregnant and postpartum women through increased investment in the **Screening and Treatment for Maternal Depression** program (\$10 million, \$3.5 million above FY 2022 enacted) and **Maternal Mental Health Hotline** (\$7 million, \$3 million above FY 2022 enacted).

The FY 2023 President's Budget includes an increase of \$81 million over the FY22 appropriations act for Safe Motherhood and Infant Health Activities at CDC. This increase would provide the opportunity to optimize the public health infrastructure to improve maternal outcomes in the United States and eliminate persistent racial/ethnic and geographic disparities in care and outcomes.

This investment in the public health infrastructure in states, localities, and territories would dramatically improve timely and relevant clinical, non-clinical, and systems level data that could drive implementation and evaluation of policies and programs to improve maternal and infant health. The President's Budget for FY 2023 includes funding that would greatly build this key public health infrastructure, including:

- **Expanding Maternal Mortality Review Committees (MMRCs) to every state**, as well as Tribes and territories.
- **Expand Perinatal Quality Collaboratives (PQCs) to every state** to improve the quality of care for mothers and babies.
- **Modernize the Pregnancy Risk Assessment Monitoring System (PRAMS)** to test and implement strategies for rapid-data collection and dissemination, including facility-based data collections; real time weighting; data linkages (e.g. individual, facility, and community level linkages); improved response rates and representativeness; and the development of querable data system.
- **Directly support states to implement the CDC Levels of Care Assessment Tool (CDC LOCATe)** and develop coordinated regional systems of maternal and neonatal care.

With these data and systems as the bedrock of public health infrastructure, respectful community engagements, including expanded communications campaigns, can drive multi-level community-informed initiatives that address the drivers of poor maternal and infant outcomes and eliminate disparities. As a result, the FY 2023 President's Budget also includes:

- **Significant expansion the Hear Her Campaign.** The Hear Her campaign supports CDC's efforts to prevent pregnancy-related deaths by sharing potentially life-saving messages about urgent warning signs.

These investments would improve the nation's ability to address the drivers of maternal mortality and associated disparities, as well as enhance quality improvement, implementation, and evaluation to better understand and disseminate what works to eliminate preventable maternal mortality and increase equitable care and outcomes in maternal health.

*Access to Health Professions***59. Question:**

I want to commend President Biden for investing in a robust health workforce, including efforts to diversify it. One way to address the shortage and create a pathway to the middle class is to create a pipeline for underrepresented minorities to become healthcare professionals. How will the President's budget help ensure that they can become health professionals?

**Response:**

The President's Budget includes \$160.22 million to support several programs that develop a pathway for underrepresented minorities to become healthcare professionals, including the following:

- The Scholarships for Disadvantaged Students Program provides grants to eligible health professions and nursing schools for use in awarding scholarships to students from disadvantaged backgrounds who have financial need, many of whom are underrepresented minorities. The program connects students to retention services and activities that support their progression through the health professions pipeline program. The President's Budget requests \$51.97 million to support this program.
- The National Health Careers Opportunity Program (HCOP) Academies provides individuals from economically and educationally disadvantaged backgrounds, including under-represented minorities, an opportunity to develop the skills needed to successfully compete for, enter, and graduate from schools of health professions or allied health professions. The National HCOP Academies provide academic and social supports through formal academic and research training, programming, and student enhancement or support services. The support provided includes tailored academic counseling and highly focused mentoring services, student financial assistance in the form of scholarships and stipends, financial planning resources, and health care careers and training information. The ultimate goal of HCOP is to provide a pathway for individuals to enter the health professions and equip them to deliver high quality, culturally competent care to underserved individuals. The President's Budget requests \$18.5 million to support HCOP.
- The Centers of Excellence (COE) Program strengthens the national capacity to produce a health care workforce whose racial and ethnic diversity more closely represents the U.S. population. The program provides grants to health professions schools and other public and nonprofit health or educational entities to serve as innovative resource and education centers for the recruitment, training, and retention of underrepresented minority (URM) students and faculty. These award recipients also focus on facilitating faculty and student research on health issues particularly affecting URM groups. In addition, the COE Program aims to improve clinical education and cultural competence for minority health issues and social determinants of health. Through strategic partnerships, grant recipients increase the applicant pool of URM students within health professions schools, establish and expand programs to enhance academic performance of these students, and utilize stipends to assist

URM students and faculty with financial support. The President's Budget requests \$36.7 million for this program.

- The Area Health Education Centers (AHEC) Program develops and enhances pre-pipeline, pipeline, and continuing education and training networks within communities, academic institutions, and community-based organizations. The AHEC Program focuses on the recruitment of individuals from underrepresented minority populations and from disadvantaged and rural backgrounds. In turn, these networks develop the health care workforce, broaden the distribution of the health workforce, enhance health care quality, and improve health care delivery to rural and underserved areas and populations. AHECs establish and maintain community-based training programs with an emphasis on primary care in rural and underserved areas. The AHEC program invests in interprofessional networks that address social determinants of health impacting the populations in the communities they serve and incorporate field placement programs. The AHEC program also provides continuing education and information dissemination to practicing health professionals to increase their effectiveness in providing quality health care. The President's Budget requests \$43.25 million to support the AHEC Program.
- The Practice Improvement and Training program provides additional funding to the Historically Black Colleges and Universities-Center for Excellence program to network with HBCUs throughout the United States and promote behavioral health workforce development in substance use disorder treatment and mental health professions. The President's Budget requests \$9.8 million to support this program.

### ***Telehealth***

#### **60. Question:**

Throughout the COVID-19 pandemic, we have seen the increased use of telehealth, which can greatly reduce barriers to seeking health care. However, too many people across the country lack access to broadband. In my home town of Detroit, one-in-four residents still lack access to the internet. How can the Department increase access to telehealth for patients who lack access to broadband?

#### **Response:**

There are a number of efforts underway to help underserved communities and individuals utilize telehealth services through access to broadband internet connections. HRSA's Office for the Advancement of Telehealth serves as HHS's focal point on telehealth, which includes the management of the Telehealth.HHS.gov website and improving collaboration across HHS and federal agencies. For example, HRSA's Office for the Advancement of Telehealth leads a Rural Telehealth Initiative, with the Federal Communications Commission (FCC), and the U.S. Department of Agriculture, to increase access to affordable broadband services, which is the foundation for improving access to telehealth services. FCC's Affordable Connectivity Program provides access to broadband for households. HRSA's Office for the Advancement of Telehealth also supports grants such as a Telehealth Broadband Pilot Program to measure access to high-speed internet in rural and underserved communities as well as programs to support the

provision of direct telehealth services, telementoring, research, licensure portability, and technical assistance to providers and patients through the Telehealth Resource Centers Program.

***Racial Disparities in Healthcare Algorithms***

**61. Question:**

This January, the Agency for Healthcare Research and Quality (AHRQ) released a research protocol called the “Impact of Healthcare Algorithms on Racial and Ethnic Disparities in Health and Healthcare.” It is concerning that some healthcare algorithms use race-correction factors, as seen in the estimated glomerular filtration rate (eGFR) that has now been recommended to be discontinued by the National Kidney Foundation and American Society of Nephrology in 2021. I am encouraged by AHRQ starting an evidence review, but there needs to be additional steps taken to root out the misuse of race in clinical algorithms. Are there further actions AHRQ—and others throughout the Department—could take to address these harmful practices?

**Response:**

AHRQ shares your concern that some healthcare algorithms use race-correction factors. As you point out, the Agency is supporting an evidence-review on this issue. AHRQ is planning a multistakeholder meeting in collaboration with NIMHD, CMS, OASH, and the HHS Office of Minority Health (OMH) in Fall 2022 to discuss findings from the current evidence review and come to consensus on actionable best practices and future directions to address this important issue. In preparation for this event, AHRQ has reached out to numerous other groups including: Federal agencies such as ONC, NIH, and FDA; Electronic Health Record vendors such as EPIC; and groups supporting clinical care such as NYC Health Department, Sutter Health, and the Council of Medical Specialty Societies. We appreciate your interest in this area and will share with the Committee any findings that demonstrate how best to alleviate these harmful practices.

**Submitted by Rep. Tom Cole*****National Cancer Institute***

On February 2, 2022, President Biden announced his Cancer Moonshot, which HHS's FY2023 Budget in Brief notes has the "ambitious goal of reducing the death rate from cancer by at least 50 percent over the next 25 years." Curiously, the President's proposed FY2023 budget includes a counterproductive reduction in funding for the National Cancer Institute (NCI). Congress has diligently worked to increase NCI funding by providing \$250,000,000 and \$150,000,000 in FY2021 and FY2022, respectively, for the sole purpose of increasing grant application success rates.

**62. Question:**

What is the anticipated effect of the proposed budget reduction on the number and percentage of grant applications funded?

**Response:**

The FY 2023 President's Budget proposes an increase over the FY 2022 Continuing Resolution for all of NIH's 27 Institutes and Centers, including the National Cancer Institute (NCI). To ensure adequate time for review, development of the President's Budget and supporting materials began several months before its release; because appropriations for FY 2022 had not yet been finalized, HHS used the FY 2022 Continuing Resolution as the base for all discretionary budget decisions. Rather than delay the release of the FY 2023 President's Budget to adjust funding levels following the enactment of the Consolidated Appropriations Act of 2022, the Budget was released with the goal of launching vital conversations around the next year of federal funding for biomedical research and other health priorities.

Increasing the percentage of applications selected for funding remains a top priority for NCI. Advances in the scientific understanding of genetic drivers of cancer, the ability to identify subtypes of cancer that are likely to respond to certain therapies, and the development of immunotherapies are just a few of the ongoing breakthroughs that are attracting researchers to study cancer.

The growth in NCI's budget has allowed the Institute to steadily increase grant success rates in recent years, as well as increase the total number of awards NCI funds. When making decisions on grants, NCI works to balance awards for research project grants – essential drivers of progress – with critically important investments to the nation's cancer research infrastructure, such as NCI-designated cancer centers, training, and national clinical trials networks. NCI will continue to leverage all available resources to maintain and increase success rates, while also acknowledging ongoing financial commitments, including awardees who were selected for funding in previous fiscal years. Supporting investigator-initiated research remains a top priority for NCI.

**63. Question:**

How does this proposed budget cut work to further the goals of the Cancer Moonshot?

**Response:**

The FY 2023 President's Budget proposes \$216 million for the Cancer Moonshot<sup>SM</sup>. This request is consistent with the funding level authorized for the final year of the Cancer Moonshot in the 21<sup>st</sup> Century Cures Act.

The Moonshot is a bold effort to accelerate progress in cancer research and aims to make more therapies available to more patients. As part of this administration priority, NIH will work with other agencies to coordinate the collective efforts of the National Cancer Institute Cancer Centers<sup>6</sup> and other networks to identify barriers to broader cancer screening and investigate the most effective means of delivering screening. In partnership with other federal agencies, NIH also will dedicate FY2023 funding to develop a focused program to expeditiously study and evaluate multicancer early detection tests, which could help detect cancers at an earlier stage when there may be more effective treatment options available.

NCI remains committed to accelerating cancer progress for all patients. As one example of how NCI will advance this goal, NCI will work with other federal agencies to promote a return to cancer screening following delays caused by the pandemic, prevent and detect the most lethal cancers, and ensure equitable access to care.

***National Institute on Aging***

The National Institute on Aging (NIA) is responsible for overseeing research on Alzheimer's Disease and Related Dementias (ADRD), and a significant portion of its budget is dedicated to funding research on ADRD, which affects more than 6.5 million Americans. The FY2023 President's Budget Request envisions a \$208,000,000 reduction in funding for NIA while NIH's Professional Bypass Budget requests an additional \$226,000,000 for ADRD research. While not all ADRD research is funded by NIA, a substantial portion is. These two requests are deeply at odds with each other.

**64. Question:**

What is the anticipated spending on Alzheimer's disease research under the President's FY2023 budget proposal?

**Response:**

The President's Budget for FY 2023 used the FY 2022 Continuing Resolution as the base for all discretionary budget decisions and proposes an increase over the Continuing Resolution for NIA and each of NIH's other Institutes and Centers.

The administration developed the FY 2023 Budget in this way because appropriations were significantly delayed this year. It typically takes the administration months to prepare and submit the President's Budget, so pivoting to update the President's Budget for FY 2022 enacted appropriations would have significantly delayed its release.

In this situation, in which the proposed funding level for NIA in the President's Budget for FY 2023 is less than the appropriations enacted for FY 2022, the difference can be explained by the

size of the Congressional increase in the Consolidated Appropriations Act, 2022, and not the administration's intent to reduce the funding of NIH ICs, including NIA.

The NIH Professional Bypass Budget for Alzheimer's Disease and Related Dementias outlines the projected costs of new resources needed in a given fiscal year to advance NIH-supported research closer to the National Plan to Address Alzheimer's Disease goal to prevent and effectively treat Alzheimer's Disease (AD) by 2025. This includes support of basic, translational, and clinical research to better understand Alzheimer's disease and related dementias (AD/ADRD) and develop therapies, as well as research on care and caregiving to better support those currently living with dementia and their care partners. NIH approaches research on AD/ADRD from multiple angles, including newly identified and other promising opportunities. A few examples of promising areas include:

- **Advancing our understanding of AD/ADRD mechanisms:** AD/ADRDs are complex diseases. An expanded understanding of how these diseases arise is critical for the development of new treatments and therapies. For example, recent research suggests that changes to and interactions between lipids – oily or waxy molecules that have several key functions, including helping form the outer layer of brain cells – may play a role in brain aging and the onset of AD/ADRD. Likewise, researchers have discovered several genetic regions, once considered to be “junk” (non-functional), that may play a role in the development of AD/ADRD. NIH seeks to build on these new insights and others to advance our understanding of AD/ADRD and potentially uncover new therapeutic targets.
- **Developing novel biomarkers for Alzheimer's disease-related dementias:** While recent developments in imaging and biomarkers have made it possible to diagnose AD in living individuals, there are few or no biomarkers for several forms of Alzheimer's related dementias. NIH will support research to drive the characterization and development of such biomarkers, essential for the conduct of clinical trials of potentially disease-modifying therapies, in diverse populations.
- **Growing the therapeutic target portfolio:** NIH will continue to diversify its robust portfolio of therapeutics research for AD/ADRD beyond those that target amyloid or tau proteins in the brain. To catalyze these efforts, NIH will renew the Alzheimer's Drug Development Program, which has helped identify dozens of promising therapeutics in recent years. NIH is also pursuing drug repurposing, in which drugs already deemed safe and effective for other conditions by the Food and Drug Administration are tested for efficacy against AD/ADRD. This approach may offer a potentially faster, less expensive way to identify promising drugs to treat and prevent AD/ADRD.
- **Enhancing care and caregiving research:** NIH will continue to expand its portfolio of pragmatic trials — rigorous clinical trials conducted in real-world settings — of interventions meant to improve care and caregiving for those living with dementia and their care partners. Pragmatic trials enable older adults to take part in this important research where they already live and receive care, which should facilitate the inclusion of more diverse older adult populations by removing some barriers to participation.

**65. Question:**

What effect will the proposed reduction to the National Institute on Aging's budget have on the number of awarded grants for AD/ADRD?

**Response:**

A reduction to the National Institute on Aging (NIA)'s budget would mean a reduction in the number of AD/ADRD research grants that NIA could award. This would be reflected in a lower pay line for AD/ADRD research award applications, which currently stands at 28 percent. However, the President's Budget for FY 2023 used the FY 2022 Continuing Resolution as the base for all discretionary budget decisions and proposes an increase over the Continuing Resolution for NIA and each of NIH's other Institutes and Centers. The administration developed the FY 2023 Budget in this way because appropriations were significantly delayed this year. It typically takes the administration months to prepare and submit the President's Budget, so pivoting to update the President's Budget for FY 2022 enacted appropriations would have significantly delayed its release.

In this situation, in which the proposed spending level for NIA in the President's Budget for FY2023 is less than the appropriations enacted for FY2022, the difference can be explained by the size of the Congressional increase in the Consolidated Appropriations Act, 2022, and not the administration's intent to reduce the funding of NIH ICs, including NIA.

***Medical Student Education Program*****66. Question:**

The FY2023 President's Budget Request proposes to eliminate funding for the Medical Student Education Program under the Health Resources and Services Administration (HRSA). In its FY2023 request, HRSA noted this program supports the training of nearly 1,100 medical students, 38% of whom were from rural or disadvantaged backgrounds, in underserved states.

**67. Question:**

What is the reasoning for this program's elimination, and how do the secretary and president propose to continue supporting the education and retention of medical providers in underserved states in its absence?

**Response to 66 & 67:**

In FY 2023, HRSA plans to support the Medical School Education Program with funds appropriated in prior fiscal years, and to continue to work with Congress on strategies to assist grantees in implementing their funded projects.

HRSA is dedicated to supporting health care professional training that encourages and incentivizes practice in communities where providers are needed most. For example, through the National Health Service Corps, HRSA has worked to increase access to care in underserved areas by supporting qualified health care providers dedicated to working in underserved communities in urban, rural, and tribal areas in return for scholarships and loan repayment assistance.

HRSA also funds the Nurse Corps Program which supports nurses and nursing students committed to working in high need communities, scholarships and loan repayment assistance for behavioral health training and service for Nurse Practitioners specializing in psychiatric mental health; and access to women's and maternal health services by increasing funding for

scholarships and loan repayment assistance to scholars pursuing degrees and clinicians serving in this specialty area. In exchange for scholarship support or educational loan repayment, Nurse Corps members fulfill their service obligation by working in Critical Shortage Facilities located in underserved communities throughout the nation, which include rural communities and other identified geographic areas, populations, or facilities.

**68. Question:**

What alternative efforts, whether existing or proposed, are the secretary and president pursuing to address the shortage of physicians in states experiencing the most severe provider shortages?

**Response:**

HHS shares your commitment to supporting the health care workforce in underserved and geographically isolated communities, and HHS is investing through a variety of programs in growing and incentivizing the workforce to practice in the communities that need them most. The FY 2023 President's Budget request invests in a robust health workforce by providing \$2.1 billion to support HRSA workforce programs. This includes an \$88 million increase above FY 2022 for a total of \$502 million to support the National Health Service Corps.

Since its inception in 1972, HRSA's National Health Service Corps has worked to increase access to care in underserved areas by supporting qualified health care providers dedicated to working in underserved communities in urban, rural, and tribal areas. The National Health Service Corps provides scholarships and loan repayment for clinicians who commit to practice in underserved communities.

HRSA currently supports more than 22,700 primary care clinicians now serving in the nation's underserved tribal, rural and urban communities, including nearly 20,000 National Health Service Corps members, more than 2,500 Nurse Corps nurses, and approximately 250 awardees under a new program, the Substance Use Disorder Treatment and Recovery Loan Repayment Program.

***Child Care and Development Block Grant Tribal Set-Aside***

The Child Care and Development Block Grant was created to provide access to affordable, high-quality childcare programs to low-income Americans. Congress has historically maintained a 3% set-aside for Indian tribes and tribal organizations. While the FY2023 President's Budget Request proposes to increase funding to the non-Tribal part of the program by \$1,404,630,000 – a 23.5% increase – it proposes lowering the tribal set-aside to 2.3%, which would result in a reduction of \$7,630,000, or 4.1%.

**69. Question:**

Given President Biden's stated support of childcare, why is HHS proposing cuts to Native American childcare dollars, particularly as it requests increases in resources for non-Tribal populations?

**Response:**

The Biden-Harris Administration supports increased funding for tribes, particularly in light of the COVID-19 pandemic's devastating impact on tribal communities. Due to timing, the FY 2023 budget request was built off the FY 2022 Annualized Continuing Resolution rate rather than the enacted FY 2022 appropriations. As such, the budget request did not factor in the increase that was enacted in the final FY 2022 appropriation. The intent of the request is that the FY 2023 tribal set-aside for the Child Care and Development Block Grant (CCDBG) will be maintained at 3% in addition to the amount that Congress specifies in the final FY 2023 appropriation. By law, a minimum of 2 percent of CCDBG funding must be reserved for tribes. Prior to FY 2022, HHS reserved 2.75 percent for tribes, but the Biden-Harris Administration increased this amount to 3 percent for the American Rescue Plan Act funding and for the FY 2022 CCDBG appropriations.

**Submitted by Rep. Andy Harris**

***Covid Therapeutic Funding***

**70. Question:**

Mr. Secretary, in your testimony, you cited HHS support for the emergency use authorization (EUs) of 3 vaccines, 7 therapeutics, and 29 diagnostics. Congress provided significant funding for the advanced development and research and procurement of medical countermeasures. Why was \$3.2 billion of ARP COVID funding transferred from the Biomedical Advanced Research and Development Authority that has 62 FDA product authorizations or approvals to its name in their 15 years, to the NIH Division of AIDS? Is that why BARDA's Broad Agency Announcements for Covid vaccines and therapeutics have been closed for well over a year now? How many of the COVID EUs you referenced were byproducts of the NIH ACTIV trials to date

**Response:**

The Biomedical Advanced Research and Development Authority (BARDA) within the Office of the Assistant Secretary for Preparedness and Response (ASPR) has worked and continues to work with partners across the Federal government to invest in the advanced development and procurement of medical countermeasures (MCMs), including COVID-19 therapeutics. BARDA and the National Institutes of Health (NIH) work closely together to advance MCM development from discovery through advanced research and development and FDA licensure.

Since the declaration of a Public Health Emergency on January 31, 2020, \$62.8 billion in COVID-19 supplemental funding has been allocated to BARDA for advanced development and procurement of MCMs, including more than \$26 billion for COVID-19 therapeutics. Of the \$62.8 billion allocated to BARDA, \$3.4 billion has been issued to NIH Institutes, Centers, and Offices— including the Office of the Director, the National Institute of Allergy and Infectious Diseases (NIAID), the National Heart, Lung, and Blood Institute (NHLBI), the National Institute of Biomedical Imaging and Bioengineering (NIBIB), and the National Center for Advancing Translational Sciences (NCATS)—for vaccines, therapeutics, and diagnostics activities. This includes \$1.7 billion specifically for NIH therapeutics activities. BARDA's partnership with other federal agencies enhances its ability to make safe and effective medical countermeasures available rapidly to combat the COVID-19 pandemic.

NIH used funds allocated by the Administration to capitalize on decades of groundbreaking fundamental research and to quickly pivot to address the COVID-19 pandemic. NIH, in collaboration with BARDA, has conducted multiple clinical trials to support the development of MCMs against COVID-19. NIH initiated these trials with creative and adaptive designs, allowing the evaluation of the safety and efficacy of multiple new and existing therapeutics, as well as multiple vaccine candidates, for the treatment and prevention of COVID-19. The critical data from these trials have been used by the FDA to support authorization and licensure of these products, moving them from bench to bedside in record time.

Since January 2021, the federal government has invested in development of multiple therapeutic candidates and the ACTIV public-private partnership was established early in the pandemic to

facilitate the development of therapeutics. Through ACTIV, NIH has been able to collaborate with FDA, BARDA, CDC, DOD, and multiple private partners to test a number of additional therapeutics. We commit to keeping Congress informed of these activities. In addition, information is posted in real-time as products come online and are approved for use (<https://aspr.hhs.gov/COVID-19/Therapeutics/Pages/default.aspx>). Therapeutic products that have been procured by the federal government include AstraZeneca's Evusheld, a long-acting monoclonal antibody cocktail that received an EUA for pre-exposure prophylaxis; Eli Lilly's Bamlanivimab/Etesivimab and Bebtolovimab, two monoclonal antibodies that were co-discovered through NIAID's Vaccine Research Center and AbCellar; and NIAID in collaboration with the DOD Defense Threat Reduction Agency, supported basic research and product development for the oral antiviral drug molnupiravir, which was further developed by Merck and Ridgeback Biotherapeutics. Other therapeutic development includes GlaxoSmithKline's Sotrovimab; Pfizer's Paxlovid; and Regeneron's REGEN-COV. The development of these candidates have benefited from funding of NIH's ACTIV trials.

### ***Health Security Funding and Preparedness***

Historically, the emergency medical countermeasures enterprise has been underfunded relative to the government-established requirements designed to protect the population from validated threats that span pandemic, chemical, biological, radiological, and nuclear spectrum. As we saw during the COVID pandemic, Congress had to provide significant multiples of annual ASPR funding (BARDA, SNS, and SRF) to ensure the rapid and successful response to COVID.

Recently Andrew Weber, a former assistant secretary of defense under President Obama, described the growing risk of chemical and biological weapons given Russia's aggression in Ukraine. He worries Russia could deploy biological weapons in Ukraine, stating: *"Biological weapons would be different. They might use something like anthrax, for example, which is not contagious and wouldn't spread back to Russia. But the Russian illegal biological weapons program includes things like plague, tularemia - a rare infectious disease - and even smallpox."*

#### **71. Question:**

Unfortunately, as the threat environment natural or otherwise, is expanding rather than diminishing, what steps are you taking to ensure the countermeasure and related preparedness enterprise is adequately funded? As we saw with COVID, the importance of the public-private partnership is paramount to response. How are you engaging industry to partner in the preparedness, especially in the countermeasure development and sustainment to ensure we are best positioned against these expanding threats? As HHS is again revising the Public Health Emergency Medical Countermeasure Enterprise (PHEMCE), how will you assure it achieves timely reviews to match the changing health security environment? What sort of guardrails will you include to validate the timely review and promulgation of the PHEMCE recommendations?

#### **Response:**

ASPR recently relaunched the PHEMCE, with the first meeting of the newly reconstituted PHEMCE Advisory Council on February 24, 2022. The strategy has been to lead with the

relaunch of the Advisory Council, which allows us to build connection, coordination, and momentum among the federal interagency on timely and relevant issues as we continue to build out the other elements of the PHEMCE, including engagement with key industry partners. We are pleased to see strong Advisory Council engagement and participation through the first two meetings, and look forward to continuing to drive progress through this forum.

### ***Pandemic Influenza Preparedness***

Prior to the SARS-CoV-2 pandemic, the United States regularly suffered 36,000 average annual flu related deaths, and hundreds of thousands of hospitalizations. Understandably, since 2020 the SNS has focused on COVID-19, but regrettably it appears to have lost focus on its long-term objective of improving readiness to battle endemic severe flu outbreaks. The SNS stockpiled Tamiflu in 2006, 2008 and 2009. Since at least as early as 2015, CDC/SNS has been concerned about distributing product that is labeled as expired. Anticipating public distrust and hesitancy to take such aged medicine, they were actively seeking a cost-effective means to replenish the flu antivirals in the stockpile. In an attempt to address issues that arose with distribution in the 2009 pandemic, SNS also sought a private partner to devise a modernized distribution system to deliver freshly dated antivirals in commercial packaging through normal pharmacy channels within 48 hours of a call to action.

As you know, the FY2022 Omnibus provided \$845M for SNS, which is a \$140M increase over the FY2021 enacted amount. ASPR's FY2022 Budget Request for SNS specifically identified influenza antivirals as a priority, stating: *"[a]dditional funds requested in this budget would be used to support pandemic readiness gaps, including antivirals necessary to treat pandemic influenza."*

ASPR's FY2022 request further stated: "Product procurement in FY 2022 will be guided by the Public Health Emergency Medical Countermeasure Enterprise (PHEMCE) and related multiyear prioritization as coordinated by ASPR." Furthermore, FY18-22 Public Health and Emergency Medical Countermeasure Enterprise (PHEMCE) Multiyear included \$222.7M for influenza antivirals for each of the FY21 and FY22 Budgets.

Yet, despite Congress having provided increased funding of \$845M--more than sufficient for the SNS to achieve its long-term goal of replenishing the flu antiviral stockpile--SNS has indicated that it does not have sufficient funds to purchase Oseltamivir in FY2022.

We note that the President's FY23 budget request would provide \$975 million for the Strategic National Stockpile, which is an additional increase of \$130 million above FY 2022 enacted, to sustain and expand the current inventory of supplies to ensure readiness for potential future pandemics and other threats

We commend ASPR for initiating modernization efforts to ensure it is prepared for any future public health emergency, bolster the U.S. industrial base, and to reduce America's reliance on foreign suppliers and manufacturers.

**72. Question:**

Can we have your assurance that if Congress provides the SNS with resources equal to or greater than the increase it received in this fiscal year that it will follow through with its long-established multi-year plan to replenish our very aged stockpile of flu antivirals? Please also indicate if the agency will use the increased funding Congress provided the SNS in FY22 to replenish our aging flu antiviral stockpile?

**Response:**

SNS plans to procure a limited quantity of influenza antivirals in FY 2022 using appropriated funding. These planned procurements will support the following recommendations included in the FY 2021 SNS Annual Review:

- Procure additional quantities of oral antivirals, including oral suspensions, for treatment in all populations to meet the requirements of 54,000,000 for adults, and 31,000,000 for pediatrics.
- Procure additional quantities of parenteral antivirals for treatment in hospital or ICU settings to meet the requirement of 1,200,000.

ASPR is committed to using available resources to ensure that SNS is prepared to respond to pandemic influenza. In addition to procuring limited quantities of influenza antivirals in FY 2022, SNS continues to work with FDA to extend the dating influenza antivirals for products where the science supports continued potency/effectiveness. SNS has also significantly increased its inventory of PPE during the COVID response, meeting some of the stockpiling goals for pandemic influenza.

***Centers for Disease Control and Prevention Antimicrobial Resistance***

Multi drug-resistant infections sicken at least 2.8 million people and kill at least 35,000 people in the United States each year. Addressing antimicrobial resistance (AMR) is important to preparedness, as resistant secondary infections complicate public health emergencies and may lead to new emergencies. The President's Budget Proposal included antimicrobial resistance efforts, including funding to expand CDC efforts to prevent, detect, respond to, and contain antibiotic resistant infections.

**73. Question:**

Are you able to provide a detailed breakdown of the Administration's \$1 billion request for AMR efforts at the CDC? Specifically, does it include the \$15 million increase that was requested for the Antibiotic Resistance Solutions Initiative? Could I get more information regarding how the FY'23 budget aligns with the Department's other discretionary AMR proposals?

**Response:**

The \$15 million increase in discretionary resources for the Antibiotic Resistance Solutions Initiative is not part of the Administration's \$1 billion 5 year request for AMR efforts proposed in the Pandemic Preparedness Plan. The funding proposed in the Pandemic Preparedness plan

will complement discretionary resources and will support domestic and global capacity to control antibiotic resistance. CDC would increase funding to jurisdictional health departments; increase national healthcare safety network reporting for antibiotic resistance and increase the number of facilities and providers that implement CDC's antibiotic use best practices.

### ***ACA Qualified Health Plans***

Section 1311(e)(1) of the ACA states that Exchanges may certify a health plan as a Qualified Health Plan (QHP) if the plan meets the requirements for certification promulgated by the Secretary of Health and Human Services (HHS) and the Exchange determines that making available such plan through such Exchange is in the interest of qualified individuals and qualified employers. In the regulation affirming this authority, HHS determined that Section 1311(e)(1)(B) affords Exchanges the discretion to deny certification of QHPs that meet minimum QHP certification standards but are not ultimately in the interests of qualified individuals and qualified employers. HHS indicated it would focus denials of certification in the FFEs based on the "interest of the qualified individuals and qualified employers" standard on cases involving the integrity of the FFEs and the plans offered through them. At the time, the regulation included examples that could result in non-certification of a plan such as "concerns related to an issuer's material non-compliance with applicable requirements, an issuer's financial insolvency, or data errors related to QHP applications and data submissions." In exercising this authority, HHS said it intended to adopt a measured approach that would "take into consideration several factors, including available market competition and the availability of operational resources."

#### **74. Question:**

Since the promulgation of this regulation, how many times has the HHS Secretary decided not to certify a health plan as a QHP because it was deemed not "in the interest of qualified individuals and qualified employers"? Can you please elaborate on how this standard has been applied in practice? For states that either operate their own state-based exchange or handle their own plan management functions of an exchange, does the Secretary defer to a state's best judgment of what is in the interest of qualified individuals and qualified employers?

#### **Response:**

Making sure that all Americans have access to quality, affordable health care is one of the Biden-Harris Administration's top priorities. Patients and their families deserve the security of knowing that the insurance they buy will be there for them when they need it, and we need to make sure consumers are protected and understand the health insurance they are buying. This is why CMS ensures that all health plans, including stand-alone dental plans, must meet a number of statutory and regulatory standards in order to be certified as QHPs in the Federally-facilitated Marketplaces (FFMs). States that operate their own Marketplaces are responsible for certification of QHPs on those Marketplaces. For States that perform plan management functions for the FFMs in those States, CMS works collaboratively with the State but CMS makes final determinations regarding QHP certification.

## ***FDA and HHS Cooperation in Supply Chain Resiliency***

### **75. Question:**

How are components of HHS, including in ASPR (BARDA, SNS, and Strategic Innovations) working with FDA to ensure that the agency is advancing the regulatory goals of the Administration to implement a framework for pharmaceutical product and manufacturing platforms that keeps pace with the speed of science and innovation and advances our nations preparedness and biopharmaceutical supply chain resilience?

### **Response:**

As you are aware, the pandemic severely strained our public health and medical supply chains. The medical supply chain ecosystem is complex, with different private sector players and market dynamics across multiple domains of medical equipment and supplies. The Office of the Assistant Secretary for Preparedness and Response (ASPR) has been focused on revitalizing and rebuilding our nation's domestic manufacturing capacity.

ASPR is examining ways to strengthen the nation's supply chain to ensure a robust and resilient public health supply chain is in place to support any national response to public health emergencies. Specifically, ASPR has established an Industrial Base Management and Supply Chain Office with focus on building the nation's capacity to manufacture personal protective equipment (PPE), essential medicines/chemicals, diagnostic tests and vaccines and bring these critical activities back to American shores. The Office also includes a support division focused exclusively on the applicability and, when appropriate, the use of Defense Production Act authorities to advance U.S. interests in this space. This office is also supported by a "Supply Chain Control Tower" that utilizes new data management and analytical teams to generate real time insights into issues impacting these areas within the public health supply chain and helps ASPR anticipate challenges and identify opportunities for investments that will bolster the public health supply chain and better prepare the country for future public health emergencies.

On June 8, 2021, as part of the Executive Order 14017 effort, the Biden-Harris Administration announced<sup>2</sup> a set of actions designed to ensure the U.S. has access to the pharmaceuticals necessary for economic security, health security, and national defense. These actions are centered on four pillars:

- boosting local production and fostering international cooperation;
- promoting research and development that establishes innovative manufacturing processes and production technologies to strengthen supply chain resilience;
- creating robust quality management maturity to ensure consistent and reliable drug manufacturing and quality performance; and
- leveraging data to improve supply chain resilience.

HHS led the development<sup>3</sup> of the *100-Day Review of Pharmaceuticals and API*, which was published in a report<sup>4</sup> by the White House on June 8, 2021. An HHS summary of the review can be found at: <https://www.phe.gov/Preparedness/mcm/Pages/supply-chain-100-days.aspx>. HHS and FDA continue to work with the private sector and Congress to implement the report's recommendations and develop a strategy to create a robust and resilient pharmaceutical and

active pharmaceutical ingredient (API) supply chain, including facilitating adoption of novel methods for commercial production of pharmaceuticals and biologics.

The COVID-19 pandemic has shown the importance of a nimble supply chain that is flexible enough to rapidly change manufacturing volumes and products in response to fluctuations in consumer demand during a crisis. As this 100-day review highlighted, the pharmaceutical supply chain is complex, global, and vulnerable to disruptions and is highly influenced by certain market factors that have led to an increasing reliance on foreign countries to manufacture the medicines, API, and their key starting materials that serve the American public.

### ***Incorrect Lab Requirements***

Since 1996, CMS has used its National Correct Coding Initiative (NCCI) to help ensure correct coding for reimbursement of claims. According to the NCCI webpage, “CMS developed its coding policies based on coding conventions defined in the American Medical Association’s (AMA) CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.”

However, CMS and the NCCI contractor adopted significant changes to their manuals in 2019 that have ignored the AMA CPT coding guidelines that laboratories are required by law to follow with little transparency or input from stakeholders while increasing the burden on laboratory providers and resulting in denial of claims which have been coded correctly under the AMA CPT guidelines. Despite stakeholders expressing concerns with the changes, the 2020 and 2021 manuals retained the changes. Again, the concerning language appears in the 2022 NCCI Manuals released just two weeks prior to their January 1, 2022 effective date. Industry stakeholders have sent formal letters of concern to both CMS and the contractor and held follow-up meetings with both. Unfortunately, neither has been sufficiently responsive to any of the concerns mentioned.

So far, many large commercial payers have adopted the coding changes, resulting in denial of claims for critical and medically necessary laboratory testing for patients, and claim denials are also occurring in some state Medicaid programs. The industry is concerned that Medicare contractors will soon follow suit.

### **76. Question:**

Will HHS/CMS commit to immediate withdrawal of these NCCI manual changes and the provision of at least six months’ notice of any future NCCI manual changes?

### **Response:**

The purpose of the National Correct Coding Initiative (NCCI) is to promote national correct coding methodologies and control improper coding that leads to inappropriate payment of Part B claims. CMS updates NCCI manuals annually to reflect current coding practices and CMS policies. The NCCI program also undergoes continuous refinement with revised edit tables

published quarterly. Other sources of refinement are implemented in collaboration between CMS; stakeholder associations; national medical, surgical, and other healthcare societies/organizations; Medicare contractor medical directors; providers/suppliers; consultants; other third-party payors; and other interested parties. Prior to implementing new NCCI edits on a quarterly basis, CMS generally provides a 60-day review and comment period to representative national organizations that may be impacted by the NCCI edits. Prior to finalizing and implementing proposed NCCI edits, CMS reviews all submitted comments. CMS also meets with stakeholders to respond to specific questions as they arise. CMS remains committed to providing an open and collaborative process, as appropriate, when making changes to the NCCI program.

### ***CDC Issues Tracking COVID-19 Pediatric Mortality***

On March 14th, CDC updated its COVID Data Tracker's mortality data resulting in a 24% reduction in total reported pediatric COVID deaths by 24% (as of March 18). When asked the reason for the change by media outlets, the CDC reportedly blamed a "coding logic error". In October, you signed off on passing off our largest pandemic data tracking system from HHS to CDC.

#### **77. Question:**

How will the Administration ensure that CDC does not commit more "coding logic errors" and that the data remains available in real-time to all necessary HHS partners?

#### **Response:**

Providing timely and accurate data on the COVID-19 pandemic has been a priority of the CDC throughout the pandemic. CDC collects real-time data from its jurisdictional partners to monitor the impact of the pandemic on the U.S. population. As part of this process, the CDC works with its jurisdictional partners to clarify any questions about the data that are collected and make corrections when necessary. The CDC also continues to improve and modernize the data collection systems and processes to collect high quality data.

### ***University of Vermont Medical Center Investigation***

#### **78. Question:**

Mr. Secretary, I raised the conscience rights issue in our hearing and want to ensure that we get a more thorough answer as the details of your agency's handling of the University of Vermont Medical Center case. Specifically, members of the House and Senate sent you a letter in August demanding an explanation to the quiet dismissal of the lawsuit by DOJ. Unfortunately, your written response in November was wholly inadequate in addressing our concerns. Therefore, I ask again: After a detailed investigation by HHS found that multiple nurses at UVMMC had been forced to participate in abortion procedures despite their registered and legally protected conscience or moral objections, what new underlying evidence or legal interpretation can you provide for the dismissal of the DOJ lawsuit? Has UVMMC agreed to change their practices to ensure that registered conscience objections are protected and so that employees of the medical

center will not face adverse employment or disciplinary actions for invoking their legal rights? You claimed in your response letter dated November 4<sup>th</sup> that HHS would “continue to evaluate the underlying complaint.” Please detail all the actions your agency has taken since the lawsuit dismissal, in an effort to continue to evaluate the underlying complaint.

**1. Question:** After a detailed investigation by HHS found that multiple nurses at UVMMC had been forced to participate in abortion procedures despite their registered and legally protected conscience or moral objections, what new underlying evidence or legal interpretation can you provide for the dismissal of the DOJ lawsuit?

**Response:**

As stated in our letter to the University of Vermont Medical Center, “Based on these subsequent legal developments and concurrent with the Department of Justice filing today, we are withdrawing the August 28, 2019 NOV and will continue to evaluate the underlying complaint. OCR takes seriously its role in protecting the rights of medical providers, including those protected by federal conscience laws. We are taking these actions to ensure the statutes protecting providers are applied in accordance with applicable law.”<sup>1</sup>

**2. Question:** Has UVMMC agreed to change their practices to ensure that registered conscience objections are protected and so that employees of the medical center will not face adverse employment or disciplinary actions for invoking their legal rights?

**Response:**

As stated in our letter to the University of Vermont Medical Center, “Based on these subsequent legal developments and concurrent with the Department of Justice filing today, we are withdrawing the August 28, 2019 NOV and will continue to evaluate the underlying complaint. OCR takes seriously its role in protecting the rights of medical providers, including those protected by federal conscience laws. We are taking these actions to ensure the statutes protecting providers are applied in accordance with applicable law.”<sup>2</sup> Given this, to protect the integrity of our work we cannot provide you additional information.

**3. Question:** You claimed in your response letter dated November 4<sup>th</sup> that HHS would “continue to evaluate the underlying complaint.” Please detail all the actions your agency has taken since the lawsuit dismissal, in an effort to continue to evaluate the underlying complaint.

**Response:**

As stated in our letter to the University of Vermont Medical Center, “Based on these subsequent legal developments and concurrent with the Department of Justice filing today, we are withdrawing the August 28, 2019 NOV and will continue to evaluate the underlying complaint. OCR takes seriously its role in protecting the rights of medical providers, including those protected by federal conscience laws. We are taking these actions to ensure the statutes protecting providers are applied in accordance with applicable law.”<sup>3</sup> Given this, to protect the integrity of our work we cannot provide you additional information.

**Submitted by Rep. Jaime Herrera Beutler**

***Maternal and Child Health Block Grants (Title V)***

The Maternal and Child Health block grants fund public health and health care services that currently reach approximately 93 percent of pregnant women, 98 percent of infants, and 60 percent of children. These public health services are critical in my district in SW Washington, where two of my counties - Pacific County and Skamania County - are considered maternity care deserts.

**79. Question:**

What would a \$24 million increase mean in terms of expanding the reach of the program or in meeting maternal and child health outcomes goals – more specifically as it relates to expanding services for maternal mental health and substance use disorder?

**Response:**

The FY 2023 Budget includes an increase of \$24 million to support states' in meeting their most pressing needs. As a federal-state partnership, the State Maternal and Child Health (MCH) Block Grant program gives states the opportunity to set priorities based on a comprehensive five-year needs assessment of maternal and child health. Based on these findings, states identify priority needs and establish a State Action Plan to assist them in targeting funds to address the unique health needs of their children and families.

Access to behavioral health care, including integration of behavioral health and primary care, is a priority for many states. States are also prioritizing the need for protective factors such as promoting resiliency, social connectedness, and positive youth development as well as using more a holistic framing of approach to health that includes emotional and mental health across the life course. While states have always used their Block Grant funds to address mental health and substance use disorder related needs, there was a dramatic increase in the number of states listing it as a priority need in the past 2 reporting years from 36 states in 2015 to 51 states in 2020. Increases in funding can support Title V MCH Block Grant strategies including promotion of screening and referral for mental health and substance use disorder services among pregnant individuals, and training providers on maternal mental health needs.

***HRSA Uninsured Program***

Community pharmacists have been vital to rural communities in SW Washington, especially during the pandemic. Pharmacists responded to the needs of patients by performing critical services like testing, vaccinations, and treatments for vulnerable communities, including the uninsured. HRSA announced that it will no longer accept claims for testing and treatment under the COVID-19 Uninsured Program. Pharmacies who supplied vaccines to the uninsured may not be reimbursed and pharmacies may still be required to provide vaccines to the uninsured with no reimbursement.

**80. Question:**

How is HRSA prioritizing payment of claims to providers who have administered vaccines and treatments under the HRSA uninsured program?

**Response:**

Due to the lack of congressional action on the proposed COVID funding measure, HRSA had to stop accepting claims for COVID-related testing and treatment on March 22, 2022 and for vaccine administration on April 5, 2022. Claims are paid in the order that they are submitted and adjudicated, subject to the availability of funds.

**81. Question:**

Is there a plan to address payment to providers who have already administered the vaccine or treatment to a patient?

**Response:**

Due to the lack of congressional action on the proposed COVID funding measure, HRSA stopped accepting claims for COVID-related testing and treatment on March 22, 2022 and for vaccine administration on April 5, 2022. Claims are paid in the order that they are submitted and adjudicated, subject to the availability of funds.

**82. Question:**

Could you provide some clarification for providers on whether to administer vaccinations without reimbursement? Will they still be required to administer vaccines if no funding is available to pay claims?

**Response:**

Due to the lack of congressional action on the proposed COVID funding measure, HRSA stopped accepting claims for reimbursement of costs associated with administering COVID-19 vaccines to uninsured and underinsured individuals as of 11:59 PM ET on April 5, 2022. CDC strongly encourages participating providers to continue to administer these lifesaving vaccines through the COVID-19 Vaccination Program, at no cost to patients to ensure equitable access for all individuals.

If CDC becomes aware of providers violating the current agreement, we will consider taking any and all appropriate measures, including the possibility of rescinding the CDC provider agreement.

***Pharmacists***

Local pharmacies and pharmacists have long been a trusted and vital part of our local health care community. 9 in 10 Americans live within 5 miles of a pharmacy, many of which have been providing access to testing, vaccinations, and treatments for the flu, strep throat, and RSV long before the COVID-19 pandemic. Pharmacists continue to play a vital role in combating COVID-19, providing more than 229 million vaccine doses. However, pharmacists are not being treated

equally within CMS and do not have a structure to be appropriately reimbursed like other health professionals providing the same services.

**83. Question:**

Can you layout what HHS is currently doing or can do to provide a long-term solution that ensures access to services, including testing, vaccinations, and treatments through pharmacies?

**Response:**

Through the Test to Treat initiative, launched in March 2022, people can get tested and – if they test positive and treatments are appropriate for them – receive a prescription from a health care provider as well as have their prescription filled, all at one location at “One-Stop Test to Treat” sites. This initiative builds on the prior allocation and distribution strategy HHS has led over the last two years for COVID-19 therapeutics. The goal of the Test to Treat initiative is to make more treatments available to more people in more locations nationwide. Pfizer’s Paxlovid and Merck’s Molnupiravir oral antiviral pills are sent directly to pharmacy partners for use in the Test to Treat Program. Some of the nation’s largest pharmacy chains are participating.

***Head Start***

In the state of Washington, we're proud of the Head Start programs that have been leading safe and critical early learning services for our most at-risk preschoolers during the COVID-19 pandemic. We also know that Head Start is experiencing a workforce crisis; one that threatens the ability of children and families to access these vital learning services.

Unfortunately, we know that this is not an isolated incident. A recent survey conducted by the Washington State Association of Head Start & ECEA had found that the average Head Start program in Washington State can only fill two-thirds of their classroom staffing needs. They simply cannot afford to pay their staff competitive wages and benefits. Unfortunately, staffing shortages have directly led to kids losing access to high-quality child care. This is making it particularly tough on parents trying to work as they scramble to find alternative arrangements for their kids. Head Start staff and teachers provide unparalleled value in our communities and ensure that every child has access to quality care and early learning.

Without investing in the Head Start workforce, we risk seeing this crisis worsen, and risk losing consistent and stable care to families so they can go to work; so that all children can arrive at kindergarten ready for school.

**84. Question:**

Would you please share how President Biden’s budget will address the Head Start workforce crisis?

**Response:**

The FY 2023 President’s Budget includes a request for funding to provide for a cost-of-living adjustment to allow programs to keep pace with inflation. This Administration has raised and continues to support the goal of improving wages of Head Start staff.

### ***COVID and Influenza Threat***

As COVID-19 becomes more endemic, providers and patients will need to deal with the dual threat of COVID-19 and Influenza.

#### **85. Question:**

Is HHS equipped with the appropriate diagnostics and treatment options to address the potential dual threats of COVID-19 and influenza?

#### **Response:**

There are four FDA-approved influenza antivirals recommended by CDC for use against recently circulating influenza viruses: oseltamivir, baloxavir-marboxil, peramivir and zanamivir. Oseltamivir is the most widely used oral antiviral for the treatment of influenza and is also widely available in generic form with at least 10 different manufacturers approved by FDA to provide drug on the U.S. market. The broad manufacturing capacity ensures that even large waves of influenza infections can be sufficiently covered by the commercial market. In the event of pandemic influenza, HHS could activate influenza antivirals that are stored in the SNS.

Early in the COVID-19 pandemic, ASPR/BARDA recognized the negative impact that needing influenza testing would have on national COVID-19 testing capacity during Flu season. As such, we began supporting the development of multiplexed panels to test for both diseases in one testing operation. BARDA is supporting the development and regulatory approval for 17 test panels for use in laboratory and limited testing resource settings such as homes, nursing facilities, tribal clinics, doctors' offices and temporary testing centers. Four of these panels have received FDA EUA so far, with the remaining 13 awaiting FDA review of their submissions or finalizing test development. BARDA is supporting most of these test panel developments through FDA 510(k) approval in preparation for extended circulation of SARS-CoV-2 beyond the end of the declared Public Health Emergency.

#### **86. Question:**

Beyond testing and preventative steps like vaccination, what steps has HHS taken to proactively treat vulnerable populations like the elderly or others who may be at risk for and are likely to spread communicable diseases like Covid and the flu?

**Response:** To proactively support vulnerable populations living in these settings, CDC has developed guidance documents for long-term residents and health personnel to control exposure to COVID-19. These guidance documents include: Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2<sup>4</sup>; Strategies to Mitigate Healthcare Personnel Staffing Shortages<sup>5</sup>; Source control and physical distancing measures: Interim Infection Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic. For additional information please visit: [Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes.](#)<sup>6</sup>

<sup>4</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>

<sup>5</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

<sup>6</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

Additionally, CDC provides technical assistance across HHS to incorporate health equity-related considerations and implications in treatment activities. For example, CDC has provided input on equity principles to inform distribution of treatments. In addition, CDC is researching inequities in access to and uptake of indicated treatment, including among older adults. A recently published MMWR shows that a lower proportion of persons of racial and ethnic minority groups received monoclonal antibodies outpatient treatment for preventing severe COVID-19.<sup>7</sup> Similar studies could inform decisions on equitable and accessible distribution of treatments where needed most.

### ***FDA and Therapeutics***

I understand that the FDA might have some emergency use authorization (EUA) fatigue after the last two years, but I am concerned that we are seeing few therapeutics for COVID-19 approved for the sake of vaccines.

#### **87. Question:**

What is HHS doing to ensure that it continues to review as many safe therapeutic choices as possible so that we will have every available tool in the fight against the next variants?

#### **Response:**

Since the beginning of the COVID-19 pandemic, FDA has worked to facilitate the development and availability of therapeutics as expeditiously and safely as possible for use by patients, health care providers, and health systems. As of March 31, 2022, FDA has approved 1, and authorized 15, therapeutics related to COVID-19.

As part of our efforts, FDA has created a special emergency program, the Coronavirus Treatment Acceleration Program (CTAP), to expedite the development of new treatments and provide them to patients as quickly as possible by using every tool at the Agency's disposal to determine if they may be safe and effective for their intended uses. The CTAP program provides information and key resources on the development of treatments for various stakeholders, including researchers, developers, sponsors, patients, and consumers. As of March 31, 2022, there were more than 470 trials of therapeutic agents reviewed by FDA, and more than 680 development programs for therapeutic agents in the planning stages. FDA and other government partners are also working with industry to make treatment options available to patients and providers who are not able to participate in clinical trials, including through expanded access under investigational new drug (IND) applications.

### ***Clinical Trials***

The pandemic has posed several challenges in conducting clinical trials. One area is the difficulty faced by CMS of certifying international diagnostic reference laboratories during the public health emergency due to safety concerns and international travel restrictions. For example,

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<sup>7</sup> [Racial and Ethnic Disparities in Receipt of Medications for Treatment of COVID-19 — United States, March 2020–August 2021 | MMWR \(cdc.gov\)](#)

a clinical trial that has been affected by this situation is the investigational drug trial for a rare maternal fetal disease with high unmet need: early onset severe hemolytic disease of the fetus and newborn (HDFN).

Because the condition is rare, there are not, at present, any CLIA-certified laboratories that offer the comprehensive set of clinically validated, non-invasive diagnostic tests required for enrollment purposes in this study. These capabilities currently exist at high quality laboratories outside the US; however, CMS is not accepting CLIA certification applications from foreign-based laboratories due to the on-going COVID-19 pandemic.

The net result is an inability to enroll US subjects into this critical maternal fetal clinical trial. This issue could also affect any rare disease clinical trial study in which the diagnostic testing performed to enroll participants until the trial is performed at a foreign, non-CLIA laboratory. FDA has announced plans to resume foreign inspections.

**88. Question:**

When does CMS expect to resume the processing of CLIA certification applications from foreign-based labs and how will the agency address an inevitable backlog?

**Response:**

An international laboratory is required to obtain a CLIA certificate if it performs laboratory testing for the assessment of the health of human beings when such tests are referred by, and the results are returned to, a facility or authorized person in the United States and its territories. The CLIA certification process for any initial international laboratory initial applicant requires CMS to perform an on-site survey/visit to the testing facility. CMS has found in our previous experience that the on-site survey is the most effective method of ensuring the laboratory is meeting CLIA requirements.

CMS resumed accepting inquiries and application packages on April 1, 2022 and are processing inquiries and application packages in order of receipt. We are in the process of contacting laboratories that made inquiries during our pause in operations. The timeframe for getting CLIA certified depends on when the laboratory contacts the International Laboratory mailbox (CLIA-IOIntake@cms.hhs.gov) with an inquiry about CLIA certification. Once CMS determines that the international laboratory is eligible for a CLIA certificate, an application package is sent. Once a complete application package has been received from the laboratory, it is put in the queue for review.

***Pharmacy Benefit Managers***

Pharmacy benefit managers (PBMs) in the pharmaceutical supply chain are often compensated based on a percentage of the list price of a medicine. That means that they make more money when prices go up, which raises serious questions about whether insurers and PBMs are more focused on the size of rebates than on achieving the lowest possible costs and best outcomes for patients.

**89. Question:**

What policy changes can be made to ensure that the system is aligned with the patient's best interests?

**Response:**

The Biden Administration is committed to cutting costs of prescription drugs for patients. As part of the CY 2023 Medicare Advantage and Part D Proposed Rule, CMS is proposing to require Part D plans to apply all price concessions they receive from network pharmacies to the negotiated price at the point of sale. This policy would reduce beneficiary out-of-pocket costs, and improve price transparency as well as market competition. Often, the Part D sponsor or its PBM receives compensation after the point of sale that serves to lower the final amount paid by the sponsor to the pharmacy for the drug. The amount of these post-point of sale price concessions has grown in recent years. When the point-of-sale price of a drug does not include such price concessions, it is rendered less transparent and less representative of the actual cost of the drug for the sponsor. In late 2018, CMS sought comment on a policy that would require Part D plans to apply all price concessions they receive from network pharmacies to the negotiated price at the point of sale, which would reduce beneficiary cost-sharing. Having considered those comments, CMS proposed this policy to reduce beneficiaries' Medicare Part D out-of-pocket costs and improve price transparency and market competition in the Part D program.

*Cybersecurity***90. Question:**

How is HHS approaching the increased threat of cybersecurity to the safety net and demand for increased cybersecurity expertise within healthcare entities?

**Response:****The HHS 405(d) Program**

The 405(d) program began as a congressional mandate under the Cybersecurity Act of 2015 (CSA), section 405(d), to strengthen the cybersecurity posture of the Healthcare and Public Health Sector (HPH). HHS' 405(d) Program and Task Group are collaborative efforts between industry and the federal government to raise awareness, provide vetted cybersecurity practices and move organizations toward consistency in mitigating the most pertinent threats to the sector. The program develops consensus-based guidelines, practices, and methodologies to strengthen the HPH's cybersecurity posture against cyber threats.

As a result, the 405(d) Task Group, legislatively known as Task Group 1F, is a collaborative effort of members from the U.S. Department of Health and Human Services, Department of Homeland Security's Cybersecurity and Infrastructure Security Agency, Health Sector Coordinating Council, and 200+ cybersecurity and healthcare experts which developed and published the Health Industry Cybersecurity Practices (HICP): Managing Threats and Protecting Patients<sup>1</sup>.

More information about HHS' 405(d) program and products developed for the HPH sector can be found on its [website](#).

### **Health Sector Cybersecurity Coordination Center (HC3)**

The HC3 was created by HHS to support the defense of the HPH sector's information technology infrastructure by strengthening coordination and information sharing within the sector and by cultivating cybersecurity resilience, regardless of organization's technical capacity. HC3 focuses on providing sector entities with actionable threat information to better defend against cybersecurity threats and ultimately reduce the threats to those organizations. All of these activities are undertaken in coordination with the Department of Homeland Security's Cybersecurity and Infrastructure Security Agency to improve the defense of all critical infrastructure. Among the activities HC3 undertakes to inform the sector, key products include:

- **Sector Alerts** which provide high-level situational background information and context for technical and executive audiences, designed to assist the sector to defend against large-scale vulnerabilities.
- **Analyst Notes** which contain analyses of threats to the sector and provide high-level executive summaries, in-depth technical analyses and mitigations to specific threats.
- **Threat Briefings** which provide actionable information on threats and corresponding mitigations.

In FY 2021, the HC3 developed and distributed 18 analyst notes, 14 sector alerts and 34 threat briefings while also reviewing 149,377 COVID-19 related websites for malicious activity, ultimately referring 15,522 to DHS shared services to have the malicious website removed from the internet.

Additional information about HC3 as well as all products created to date can be found on the center's [website](#).

The HHS Office of the Chief Information Officer is continually exploring new ways to reach additional sector entities and support the identification and remediation of cybersecurity threats.

**Submitted by Rep. John R. Moolenaar**

***COVID Vaccine Mandate***

I believe continuing to enforce the CMS vaccine mandate is wrong, and I'm concerned about the negative impact it's having on health care workers, particularly at a time when our nation is facing an unprecedented shortage of health care workers.

**91. Question:**

So, why does the administration continue to enforce this mandate on our heroic health care workers, when they have shown to safely perform their duties and deliver care during the height of the pandemic before there was a vaccine on the market?

**92. Question:**

Do you know how many health care workers has been forced out of the workforce due to the vaccine mandate?

**Response to 91 & 92:**

Implementation of the rule that requires health care facilities to ensure that their workers are vaccinated will undoubtedly save lives. This is an important requirement to protect patients. Health care workers are giving their all, every day, to battle this pandemic and save lives, and the rule helps ensure that our hospitals and health care facilities are safer environments. CMS believes that the vaccination rule helps to stabilize the health care system and eliminate potential incentives for staff to migrate to different care settings or across state lines. This will also ensure that a significant number of health care staff are vaccinated across settings, reducing staff quarantines and improving safety no matter where patients seek care. Early research indicates that many COVID-19 vaccine mandates have already been successfully initiated in a variety of health care settings, systems, and states, with few resignations among staff. As cited within a recent White House Report, two large health systems in Texas (Houston Methodist) and Michigan (Henry Ford Health System) instituted a vaccine mandate and both reported a 98 percent vaccination rate among staff. Similar evidence exists in North Carolina, New York, Maine, and Kentucky.

***Alzheimer's Treatment/Recent CMS Coverage Decision***

As we're well aware, there continues to be a large unmet need for treatments for Alzheimer's, a devastating and fatal neurodegenerative disease. A number of my congressional colleagues on both sides of the aisle in both the House and Senate have shared our concerns with the recently proposed National Coverage Determination memo for an Alzheimer's drug and its impact on similar treatments currently in development.

**93. Question:**

Could you point out other examples where CMS has required Medicare beneficiaries to participate in clinical trials sponsored by CMS and/or NIH for the purpose of gaining coverage to an FDA-approved treatment?

There are 22 states representing nearly 54 million people where there would be no trial sites that would comply with CMS's requirements. Many other states have a single site located in major cities, but for people who live in another part of the state, or those living in more rural parts of the country, they would have great difficulty traveling to these sites or just feel it's not accessible.

**94. Question:**

Why would CMS issue a coverage with evidence development (CED) policy that would leave exclude a large swath of the country to this crucial class of treatments?

**Response to 93 & 94:**

CMS works to ensure that all beneficiaries have access to needed care as rapidly as possible, with items and services based on accurate, reliable information that demonstrates a clear clinical benefit. We appreciate the over 10,000 comments we received on our proposed National Coverage Determination (NCD) and look forward to publishing the final decision.

***Transparent Health Plans***

I'm hearing troubling reports that the Consumer Information and Insurance Oversight (CCIIO) at CMS has gone to great lengths to force new and innovative health plans trying to offer affordable and comprehensive coverage to jump through bureaucratic red tape. I'm worried CMS is actively working to shut down new options for consumers on the exchange. Compounding my worry, I learned CMS may deny these plans to consumers even though states ensured the plans meets the criteria for consumer protections in the exchange.

**95. Question:**

Why is the agency denying access to these plans despite their meeting all statutory requirements, particularly for plan year 2022?

**Response:**

Making sure that all Americans have access to quality, affordable health care is one of the Biden-Harris Administration's top priorities. Patients and their families deserve the security of knowing that the insurance they buy will be there for them when they need it, and we need to make sure consumers are protected and understand the health insurance they are buying. This is why CMS ensures that all health plans, including stand-alone dental plans, must meet a number of statutory and regulatory standards in order to be certified as QHPs in the Federally-facilitated Marketplaces (FFMs).

***Future Emerging/Biological Threats***

Annual budgets for our preparedness enterprise have always been woefully underfunded. We saw how problematic this lack of funding for ASPR, BARDA, and SNS can be during the COVID pandemic when Congress had to provide HHS over \$70 billion to develop and procure

vaccines, drugs, and emergency supplies. Here is an alarming fact to consider – the combined annual budgets for BARDA (\$745 million), SNS (\$845 million), and the SRF (\$770 million) represent just 3% of the funding Congress provided to ASPR for the COVID-19 response! With that in mind, ASPR is charged with protecting the American people against a myriad of very real threats – CBRN, emerging infectious diseases, pandemic influenza, and more.

**96. Question:**

So, what are you doing as Secretary to ensure our preparedness enterprise has the necessary funds to protect Americans for these threats?

**Response:**

As you may be aware, \$81.7 billion was requested in the FY 2023 President’s Budget, to be available over five years, across the Office of the Assistant Secretary for Preparedness and Response (ASPR), Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and Food and Drug Administration (FDA) to support efforts to transform U.S. capabilities to prepare for and respond rapidly and effectively to future pandemics and other high consequence biological threats.

Using this funding, HHS is proposing to take strong action now to make transformational advances within all pillars of preparedness and response, tighten coordination across the Department and continue in its leading role in responding to public health emergencies. HHS would develop the systems, infrastructure, research and medical countermeasures that will be required within a whole of Government response to emerging public health emergencies and threats. A critical lesson learned from the COVID-19 response is that a gap in any one of these critical defenses results in increased disease, death, and an unsustainable burden on the health care system - this funding request supports broad preparedness efforts. In addition, these efforts are highly aligned with *American Pandemic Preparedness: Transforming our Capabilities* published by the White House Office of Science and Technology Policy (OSTP) and the National Security Council (NSC) on September 2, 2021, and builds on knowledge and experience gained during the COVID-19 pandemic and through prior domestic and global pandemic preparedness efforts.

**97. Question:**

How are you supporting the critical work of ASPR in preparing against the other threats we face as nation, including CBRN threats?

**Response:**

ASPR’s mission is to prepare and respond to public health emergencies. As part of the mission, ASPR supports the late-stage research and development, as well as the acquisition and stockpiling of medical countermeasures, for chemical, biological, radiological, and nuclear threats as identified by the Department of Homeland Security.

**98. Question:**

If you agree in doing so, what additional investments in ASPR, BARDA, and the SNS should we make to ensure the U.S. is better prepared for the next pandemic?

Under an international agreement, there are two WHO-designated repositories for smallpox – one within the United States (CDC in Atlanta) and one within Russia (Novosibirsk). Just this week Andrew Weber, a former assistant secretary of defense under President Obama, described the growing risk of chemical and biological weapons given Russia's military aggression in Ukraine. He worries Russia could deploy biological weapons in Ukraine, stating: "Biological weapons would be different. They might use something like anthrax, for example, which is not contagious and wouldn't spread back to Russia. But the Russian illegal biological weapons program includes things like plague, tularemia – a rare infectious disease – and even smallpox."

**Response:**

ASPR's mission is to prepare and respond to public health emergencies. ASPR recently relaunched the PHEMCE, with the first meeting on the newly reconstituted PHEMCE Advisory Council on February 24, 2022. During the first meeting, Secretary Becerra shared his medical countermeasure (MCM) priorities, re-engaged our federal partners, and began discussing MCM priorities to ensure preparedness for all threats to public and medical health. As the PHEMCE continues to meet and set priorities for MCM acquisition strategies, information will be provided to Congress on required funding.

To ensure that BARDA and the SNS have sufficient resources to continue supporting ongoing efforts to mitigate and prepare for future threats, significant increases were requested in the FY 2023 President's Budget. Specific to BARDA, an additional \$232 million above FY 2021 enacted is requested for FY 2023 to support the advanced development of the highest priority MCMs against threats identified by the Department of Homeland Security (DHS) and prioritized in the PHEMCE Strategy and Implementation Plan. Specifically, such funding would support investments in new projects in the following programs:

- new therapeutic and vaccine candidates against Ebola Sudan and Marburg viruses;
- new antidotes for treatment of injuries induced by chemical agents (for example, sulfur mustard and chlorine gas exposure);
- diagnostic devices to confirm infection with biological agents, some of which will be suitable for use in point-of-care and near patient settings;
- innovations for advanced, portable extracorporeal membrane oxygenation (ECMO) devices;
- innovations in early stage MCM research and development focusing on sepsis, wearable diagnostics, and distributed manufacturing technologies;
- new candidate products to address the pathologies caused by radiological or nuclear events, including blast injuries caused by nuclear detonation;
- new diagnostic devices to help reduce the emergence of antimicrobial resistant bacteria by identifying the appropriate treatment sooner;
- multi-tissue human microphysiological models ("body-on-a-chip") that incorporate immune system models for screening of vaccines and therapeutics;
- novel patient triage technologies, including phone apps, for rapid patient assessment and information sharing within first responder and hospital networks;

- novel host-based therapeutic approaches that are agnostic to pathogen and address severe forms of disease and sepsis;
- novel host-based diagnostic approaches to address disease severity and identify health deterioration in a number of clinical settings (pre-hospital, hospital, post-discharge);
- novel antibacterial drugs, diagnostics, and vaccines;
- patient behavior modification approaches as an MCM;
- diagnostic technologies suitable for use in limited healthcare resource settings, such as nursing homes, temporary treatment centers, tribal clinics, and even homes, by minimally trained personnel;
- antifungals intended for prophylactic and empiric therapy for invasive *Candida* and *Aspergillus* infections;
- two new technologies (one biomarker based and one non-invasive imaging) to advance treatment of Traumatic Brain Injury (TBI) that is seen both in routine trauma as well as mass-casualty scenarios; and
- threat-agnostic diagnostics for use in the early days of novel disease outbreak.

Specific to the SNS, an additional \$270 million is requested above FY 2021 enacted to support sustainment of current product lines and procurement of several products previously supported by BARDA that lack a significant commercial market. Product procurement in FY 2023 will be guided by the PHEMCE and related multiyear prioritization as coordinated by ASPR to ensure strategies are developed and activities are implemented to meet the national priorities for federal stockpiling and to maintain SNS capabilities and address inventory gaps with available funding. Priorities identified in this budget request may shift pending additional guidance from PHEMCE.

Under an international agreement, there are two WHO-designated repositories for smallpox – one within the United States (CDC in Atlanta) and one within Russia (Novosibirsk). Just this week, Andrew Weber, a former assistant secretary of defense under President Obama, described the growing risk of chemical and biological weapons given Russia’s military aggression in Ukraine. He worries Russia could deploy biological weapons in Ukraine, stating: “Biological weapons would be different. They might use something like anthrax, for example, which is not contagious and wouldn’t spread back to Russia. But the Russian illegal biological weapons program includes things like plague, tularemia – a rare infectious disease – and even smallpox.”

**99. Question:**

Given the unprecedented nature of these threats, what is HHS doing to re-prioritize the U.S. stockpile of vaccines and drugs that protect against such CBRN weapons?

**Response:**

ASPR’s mission is to prepare and respond to public health emergencies. As part of the mission, ASPR supports the late-stage research and development as well as the acquisition and stockpiling of medical countermeasures for chemical, biological, radiological, and nuclear threats as identified by the Department of Homeland Security.

ASPR recently relaunched the PHEMCE, with the first meeting on the newly reconstituted PHEMCE Advisory Council on February 24, 2022. During the first meeting, Secretary Becerra shared his medical countermeasure (MCM) priorities, re-engaged our federal partners, and began discussing priorities to ensure preparedness for all threats to public and medical health.



WEDNESDAY, APRIL 6, 2022.

**SOCIAL AND EMOTIONAL LEARNING AND WHOLE CHILD  
APPROACHES IN K-12 EDUCATION**

**WITNESSES**

**PAMELA CANTOR, FOUNDER AND SENIOR SCIENCE ADVISER, TURN-  
AROUND FOR CHILDREN**

**LINDA DARLING-HAMMOND, PRESIDENT AND CEO, LEARNING POLICY  
INSTITUTE**

**MAX EDEN, RESEARCH FELLOW, AMERICAN ENTERPRISE INSTITUTE**

**TIM SHRIVER, COFOUNDER AND BOARD CHAIR, COLLABORATIVE FOR  
ACADEMIC, SOCIAL, AND EMOTIONAL LEARNING**

The CHAIR. The hearing is fully virtual this morning, so we do have a few housekeeping matters.

For today's meeting, the chair, or staff designated by the chair, may mute participants' microphones when they are not under recognition for the purposes of eliminating inadvertent background noise. Members are responsible for muting and unmuting themselves.

If I notice when you are recognized that you haven't unmuted yourself, I will ask the staff to send you a request to unmute yourself. Please then accept that request so you are no longer muted.

I remind all members and witnesses that the 5-minute clock still applies. If there is a technology issue, we will move to the next member until the issue is resolved, and you will retain the balance of your time.

You will notice a clock on your screen that will show how much time is remaining. At 1 minute remaining, the clock will turn yellow. With 30 seconds remaining, I will gently tap the gavel to remind members that their time is almost expired. When your time has expired, the clock will turn red, and I will begin to recognize the next member.

In terms of speaking order, we will begin with the chair and ranking member, then members who are present at the time the hearing is called to order. They will be recognized in order of seniority. And finally, members not present at the time the hearing is called to order.

Finally, the House Rules require me to remind you that we have set up an email address to which members can send anything they wish to submit in writing at any of our hearings or markups. That email address has been provided in advance to your staff.

My gosh, there are so many rules and regulations here, as we move forward.

I really want to welcome everyone this morning and want to acknowledge Ranking Member Cole and all of my colleagues for joining.

And a particular thank you to our witnesses for testifying. Very, very excited about all of you this morning—Dr. Pamela Cantor, Dr. Linda Darling-Hammond, Mr. Max Eden, and Dr. Timothy Shriver. I will provide a more fulsome introduction before their testimony, but so delighted that you could all join us this morning for this hearing.

American author, social critic, and educator Neil Postman once said, and I quote, “Children are the living messages we send to a time we will not see.” They are quite literally the legacy we leave behind—the legacy we leave behind us and the surety that everything we do continues onward, making the world a better place when we are gone.

Which is why it is not only incumbent on parents and educators to ensure our Nation’s children are primed to meet the challenges of the future, it is also incumbent on all of us, especially legislators, to ensure they are sufficiently prepared not only intellectually, but emotionally and socially as well.

Decades of adolescent development research have shown that all aspects of a child’s well-being must be supported if we are to ensure their success. The Learning Policy Institute, which states that, and I quote, “A whole child approach to education is premised on the fact that children’s learning depends on a combination of instructional, relational, and environmental factors the child experiences, along with the cognitive, social, and emotional approaches that influence one another as they shape the child’s growth and development.”

Fortunately, there are a variety of strategies that instructional and school leaders can employ to support the whole child, including social and emotional learning interventions. The evidence base behind these interventions is overwhelming. High-quality SEL programs that support students’ social, emotional, and cognitive development result in lasting positive academic and life outcomes.

Four meta-analyses conducted by CASEL and researchers over the past decade found that students participating in SEL programs showed significantly more positive outcomes related to academic performance and cognitive behavior. A 2021 evidence review by the Early Intervention Foundation found that SEL interventions are effective at enhancing students’ social and emotional skills while reducing symptoms of depression and anxiety.

And RAND Corporation found that there are at least 60 SEL interventions that have been evaluated that meet the evidence requirements for the Every Student Succeeds Act, ESSA, the elementary and secondary education law we authorized in 2015.

In fact, the evidence in support of these interventions is so strong that a 2015 bipartisan report from American Enterprise Institute and Brookings concluded that, and I quote, “The Federal Government should provide resources for State and local education authorities to implement and scale evidence-based social and emotional learning practices and policies.”

I could not agree more. For too long, education policymakers at the Federal level have been slow to focus necessary attention and resources on approaches that adequately address the holistic needs of students to drive stronger achievement in school and beyond. And in light of the extreme stress and hardship our country’s most

vulnerable students have faced during the COVID-19 pandemic, these effective strategies are needed more than ever.

Which is why in the first year of chairing this subcommittee, in fiscal year 2020, we created an initiative in the Labor-H bill on SEL and whole child approaches in K through 12 education. In the recently passed bipartisan fiscal year 2022 omnibus appropriations package, this includes \$82,000,000 for evidence-based, field-initiated SEL grants that address students' social, emotional, and cognitive needs within the Education Innovation and Research Program. It includes \$85,000,000 for the Supporting Effective Educator Development Program, with a priority for professional development and pathways into teaching and school leadership that provide a strong foundation in implementing SEL and the whole child strategy.

And further, \$100,000,000 in set-asides for school-based mental health professional training to help local education agencies directly increase the number of mental health professionals in schools. And finally, there is \$75,000,000 for full-service community schools, providing comprehensive services and expanding evidence-based models that meet the holistic needs of children, families, and communities.

The subcommittee's work is a direct response to what has been recommended strategies and approaches that are championed by our witnesses today and was significantly influence by the landmark National Commission on Social, Emotional, and Academic Development report. We started from nearly zero for these SEL and whole child approaches just a couple of years ago, and we now have secured resources which have been, as I said, a long time in coming.

And I am so pleased to have been able to work with Ranking Member Cole, my colleagues in the House and Senate, to be able to get this done. And so many of these efforts about promoting social and emotional learning have come from members of this subcommittee.

Appropriations legislation requires negotiations and agreements from both parties in the chambers of Congress. So I am proud that our bipartisan legislation has included the SEL and whole child approaches initiative for the past 2 years.

The initiative was inspired by Dr. James Comer, a psychiatrist at Yale Child Study Center, who worked with New Haven Public Schools starting in 1968. His model for child learning demonstrates focusing on positive school environment and students' social and emotional needs as necessary to promote their cognitive development and academic success.

I hope that in this hearing today, we can learn more about the overwhelming body of evidence in support of these programs and the Federal support that is needed. Especially eager to ask our witnesses where it is that we need to go and where the resources are best used.

But before we turn to our witnesses, let me yield to my colleague, the ranking member of the subcommittee, Congressman Cole, for any opening remarks that he may have.

Congressman Cole.

Mr. COLE. Thank you very much, Madam Chair.

And just for the purposes of housekeeping before I get into my prepared remarks, I need to let you and the committee know I have to leave by about 11:00 a.m. or a little before. We have a Rules Committee meeting so we can get some stuff on the floor and, hopefully, get home reasonably—at a reasonable time this week. So I am sure you would rather me be there than here anyway.

So, again, good morning, members of the subcommittee and certainly to our testifying witnesses. I want to thank you for being here today and look forward, as always, to our discussion.

I will admit up front that I don't know a great deal about the topic being discussed today. From what I have learned, social and emotional learning is a curriculum or teaching methodology that is intended to help students to better comprehend their emotions and demonstrate empathy for others. That sounds like a good thing, indeed.

But I also have a concern as to whether or not the Federal Government or this committee has any role to play in encouraging specific curriculum or teaching methodologies. In fact, the U.S. Department of Education is explicitly prohibited from dictating local school curriculum in its underlying statutes.

And I think that is a wise decision, regardless of where one falls on the political spectrum. Decisions about what to teach and how to teach should be made at the State and local level by professional educators and parents who know the children in their communities personally, not by bureaucrats in Washington, DC, or by advocates outside the classroom with a political agenda to advance.

Parents and children across the country are still reeling from what I believe was one of the biggest policy missteps of this pandemic. That is the decision of many, if not most, of our Nation's public schools to close for nearly 2 years.

The school closures hit the most vulnerable children the hardest—those with disabilities, those without access to technology, or parents who could not help them in a virtual environment. Children in minority communities and those who have a difficult time learning through a computer screen also suffered. The lasting impact of the pandemic on these children has been profound.

Now we have also seen concerning rates of mental health issues, missed preventive care, self-harm, and ongoing lack of engagement, not to mention lost academic and study skills. I am glad that the importance of in-person learning is now being recognized, and I am glad to see children back in the classroom. Perhaps this focus on social and emotional learning can help these children regain ground and develop a love of learning again.

So, to that point, I am interested in learning from our witnesses today exactly what is meant, more specifically what social and emotional learning activities in the classroom look like. Because from what I have been reading, there are some critics of this particular approach.

I have read the concerns that social and emotional learning is being used as a way to advance radical ideas about race, gender, and sexuality that may not be welcomed by all parents. And that even if some of the material is not objectionable, some parents continue to raise concerns about the amount of time that discussing

feelings and current social issues as contrasted with the time spent focused on academic subjects and recovering lost ground.

Again, I do not believe the Federal Government should be involved in these decisions. They properly belong with parents, teachers, and local school boards. But as we have this hearing today, I am interested in learning more about it from our witnesses and seeing what role the Federal Government can appropriately play.

I want to thank all of our witnesses for coming before us today, sharing their time and expertise.

Thank you, Madam Chair, and I yield back the balance of my time.

The CHAIR. Thank you very much, Congressman Cole.

And with that, I am delighted to welcome and introduce our witnesses.

Dr. Pamela Cantor, founder and senior science adviser of Turnaround for Children. And I will just make a quick comment here. I have worked with Dr. Cantor in the past, and I can recall, if I have got this right, Dr. Cantor, you were tasked with taking a look at the mental health issues with regard to children after 9/11.

And the work that you did—and while 9/11 certainly had impact on the children, but what you found, and I think the term you used when we spoke at that time was that it was about grinding poverty that had much more an effect on our children than almost anything else.

So thank you for being here.

Dr. Linda Darling-Hammond, who is president and CEO of the Learning Policy Institute, thank you. Thank you for your body of work in this area.

Mr. Max Eden, research fellow at the American Enterprise Institute, and welcome to you, Mr. Eden.

And Dr. Timothy Shriver, cofounder and board chair of the Collaborative for Academic, Social, and Emotional Learning.

And I will just also say I have years and years of a friendship with Dr. Shriver from his days in New Haven, CT, and he could almost be regarded as a “townie,” he spent so much time there and working with Dr. Comer and devoted on his career to dealing with educating our children.

So thank you very much for being here.

I am going to remind our witnesses that the entirety of their written testimony will be entered into the record.

And our first witness for today will be Dr. Cantor, and again, your full written testimony will be included, and you are now recognized for 5 minutes for your opening statement.

Dr. CANTOR. Thank you, Chairman DeLauro.

If I were to ask any teacher today, “What are the biggest challenges you are facing?” the answer might be lost learning time or the physical and emotional wellness of your students. Or that you are just exhausted from the pandemic.

What is being asked of us today are solutions to more than one of these challenges at the same time. Not a choice between them, which would be a false choice. Our education system was not designed to meet this moment.

One lecture in medical school forever changed the way that I looked at human beings, especially children. I was taught that

there are 20,000 genes in the human genome, yet in our lifetime, fewer than 10 percent will ever be expressed. Well, what determines what is in that 10 percent? It is context—the environments, experiences, and relationships in our lives. Context determines who we become, how and what we learn, and even the expression of our genes.

The risks and opportunities in development sit inside this one profoundly important point, that there is no separation of nature and nurture, biology and environment, or brain and behavior, only a collaboration between them. This is why developmental and learning science paints an optimistic story of what is possible.

Children's brains and bodies and abilities are malleable to experience because the human brain is a dynamic living structure made up of tissue that is the most susceptible to change from experience in the entire human body. The brain is also malleable over time. Most of its growth happens after we are born. So there are multiple opportunities to catch up along the way.

The message in the science is clear. We need a new design for our schools mapped to the way the brain grows and children learn, a design that recognizes children as whole people, values their assets, and supports them to master critical knowledge and skills and to excel in many different ways.

Whole child design combines five things—positive developmental relationships, environments filled with safety and belonging, rich learning experiences so that students discover what they are capable of, the intentional development of the 21st century skills, mindsets, and habits that all successful learners have, and integrated supports.

But when we use each of these five components together in reinforcing in integrated ways, whole child design will accelerate recovery from the pandemic, but also promote growth, learning, and wellness for each and every child at the same time. This is a context for learning that is greater than the sum of its parts, personalized, empowering, affirming, and transformative for each student.

Let us take this idea into the classroom. If educators teach a math skill like long division, just a skill, some children will learn it. But if they teach to the whole child, educators can support students to understand it, be curious to learn more, and be able to apply it to new situations. Students will build analytic skills and even discover parts of themselves they didn't know they had, like maybe I am a math person after all.

When we ask the question, what can we do that will work optimally for this child in this context, that question gets you to fundamentally different answers about the way our schools and our education system of the future needs to be designed. This vision constitutes a transformational shift in the purpose and potential of our learning systems and a shift in the policies and laws that would constrain this vision.

To conclude, the message in the science and in this testimony is optimistic. Context shapes the expression of our development and our genetic attributes. This is the biologic truth. And schools designed using this knowledge will be able to see and unleash talent and potential and ensure that each and every young person can thrive.

Thank you so much for allowing me to talk to you today.

The CHAIR. Thank you so much, Dr. Cantor, for your testimony.

And our next witness is Dr. Linda Darling-Hammond. And again, your full written testimony will be included in the record, and you are now recognized for 5 minutes for an opening statement.

Ms. DARLING-HAMMOND. Thank you very much, Chair DeLauro, Ranking Member Cole, members of the subcommittee, for your invitation to participate in this hearing. I am honored to be here today to discuss the Federal role in supporting whole child practices that can support children's learning.

As Dr. Cantor noted, the latest research for neuroscience and other disciplines shows that emotions and relationships influence learning. Positive emotions, such as interest, excitement, and trust in a teacher, facilitate learning. Negative emotions, such as caused by trauma, anxiety, or self-doubt, reduce the capacity of the brain to process information and to learn.

Students' interpersonal skills, their ability to interact positively with peers and adults, resolve conflicts, and work in teams, all contribute to effective learning and lifelong behaviors.

The Collaborative for Academic, Social, and Emotional Learning identifies five main areas of social-emotional competence—self-awareness, self-management, social awareness, relationship skills, and responsible decision-making. In addition, traits such as a growth mindset that allow us to understand that we can improve our work with effort and that we should not give up when we experience setbacks create perseverance and resilience. These are skills that employers say are among the most important for success in work and that research demonstrates are important for success in life.

As Chair DeLauro noted, and as I describe in my written testimony, among the hundreds of studies on this topic are several meta-analyses that show the benefits of social-emotional learning for students' behavior, school safety, attitudes, grades, and test scores.

Social-emotional learning is not a specific curriculum. Just as teachers focus on adding and subtracting in math, regardless of what curriculum they use, they can focus on helping students learn to work well with others and manage themselves in many different ways from many different curricular starting points.

A recent study from the Fordham Foundation also shows that parents, regardless of their party affiliation, recognize the importance of these skills. They want their children to learn how to set and achieve goals, navigate social situations, empathize with others, respond ethically, and manage their emotions. The study concluded that when such programs are described without jargon, support soars on both sides of the aisle.

Because of this broad support, all 50 States and DC have social-emotional learning standards for preschool students, and at least 18 have standards for K–12 students. Teaching these skills does not detract from academics but supports it. They can be folded into all aspects of school, including how conflicts are resolved on the playground, how students learn to take a deep breath and calm themselves when something disturbing has happened, how students develop a growth mindset as they revise their essays in

English class, and how they learn to collaborate effectively in their science investigations.

Research also shows that in order to thrive and learn, children need stability in their lives, good nutrition, healthcare, and supports when they have trauma, which creates a toxic stress reaction that affects brain development, physical health, learning, and behavior.

Even before the pandemic, 46 million children were exposed each year to violence, crime, abuse, homelessness, or food insecurity. These experiences, of course, have been exacerbated by the pandemic, but many States and districts are, fortunately, investing in community school approaches, including California, Maryland, New Mexico, New York, Vermont.

These initiatives integrate education and health, mental health, and social welfare supports. They offer expanded and enriched learning time. They involve parents and community organizations and wrapping around children and their needs. A recent review of more than 140 studies found that well-implemented community schools support improved attendance, achievement, and attainment.

As Chair DeLauro has already noted, Congress has reported many aspects of a whole child framework in its last annual spending bills. To build on these foundations, I will mention four things the Congress can do.

First, continue efforts to support States and districts implementing social-emotional learning and whole child approaches to education by expanding funding for the School Safety and National Activities Program and creating competitive grants to redesign schools around the principles that Dr. Cantor outlined.

Second, catalyze the expansion of community school initiatives to sustain increases in additional funding under ESSA Titles I and IV, among other sources.

Third, increase investments in preparation and ongoing professional development for educators under Title II of ESSA and HEA so they can support safe, inclusive, and positive learning environments.

And finally, promote alignment and interagency coordination of Federal funds across the 10 departments and hundreds of programs that are currently administered in a fragmented manner.

Thank you for your focus on this issue and for the opportunity to share ideas for a path forward. I am happy to answer any questions that the members of the subcommittee have.

The CHAIR. Thank you very, very much, Dr. Hammond.

And our next witness is Mr. Max Eden, research fellow, and your full testimony will be included in the record. You are now recognized for 5 minutes for your opening statement.

Thank you, Mr. Eden, for being here.

Mr. EDEN. Yes, thank you. Good morning, and thank you all so much for the opportunity to address this very important issue.

Social-emotional learning is a burgeoning education industry. From November 2019 to April 2021, SEL spending increased by 45 percent to \$765,000,000. If it isn't already, it will likely soon become a \$1,000,000,000 education subsector.

Advocates claim that SEL holds great promise, and on its face, it sounds like a very sensible idea. But my research has led me to be more alarmed than optimistic. For four reasons, I fear that the costs of SEL may substantially outweigh the benefits.

The first reason, the evidence of the benefits has been substantially exaggerated. Advocates promote claims like \$1 of SEL spending yields \$11 in return. This would be astonishing if true, but is it really?

A clear-eyed view of the evidence suggests perhaps not. The 2017 RAND Corporation study, which examined the evidence base for SEL, separated it by tiers of evidence. Within the top tier for rigorous evidence, no studies demonstrated academic benefits—academic achievement benefits.

Now, to be sure, there are plenty of less rigorously designed studies that show positive results. Researchers can and have retroactively attached the label of SEL onto these studies, regardless of whether these studies involved what we now know as SEL implementations and practices.

The merits of these studies can be debated. We can talk about what conclusions we can and can't draw from them, but they certainly do not rise to the level of a settled social science that provides reliable predictive value.

Furthermore, the relevance of this literature may be categorically questionable because of the rise of what is called “transformative SEL,” and this leads us to the second cause for concern. The concern is that SEL has become an ideologically charged enterprise. In 2018 and 2019, SEL was bipartisan. The notion that schools should help kids develop competencies like self-awareness and self-management sounded good to folks on both sides of the aisle.

Back then, however, I was somewhat skeptical of the sustainability of what seemed to be an effort at values-free, immoral education. But in 2019 and 2020, the Collaborative for Academic, Social, and Emotional Learning embraced transformative SEL, infusing the project with values. Values derived from the left academic canon, commonly referred to as critical race theory.

Self-awareness now involves intersectionality. Self-management now involves resistance. CASEL's documents and its leaders have openly embraced antiracism. As commonly defined, antiracism amounts to an essentially totalizing ideological commitment.

A recent Washington Post article is titled, “In SEL, the Right Sees Critical Race Theory” and pointed to transformative SEL as the cause. The reason parents see it there is because they read it there.

Now it is, of course, an open question to what extent those words and those statements really do filter down into classroom practice, and it is very hard to draw an immediate generalization. But parents have a plain facial reason for concern that what is being called social and emotional could prove in practice to be political and ideological.

Another big concern for parents is data security. SEL implementation is frequently accompanied by school surveys that ask psychological and personal questions relating to students' mood, family life, and even their sexuality. The more extensive and sensitive this data becomes, the more valuable it becomes to potential hackers.

Last month, 820,000 students in New York City learned that their data was hacked. We should expect more of this as a matter of structural inevitability, given the increasing value of the data collected.

Now even if we could perfectly guarantee data security and also guarantee that no vestiges of political ideology seep into classroom practice around SEL, there remains a fourth and probably insuperable concern, and that concern is that SEL in practice can tend to resemble the practice of unlicensed therapy. My colleague Robert Pondiscio has addressed this concern at length in an excellent report, titled "The Unexamined Rise of Therapeutic Education."

Although it may not always be explicit within training materials, in practice, it does invite teachers to play the armchair psychologist, identifying root causes of trauma, providing students with a schema to understand themselves, and explaining how best to relate to others. In theory and in practice, it also tends to blend seamlessly with a rising emphasis on school-based mental health provision.

And while we certainly want students to be mentally healthy, there are very good reasons why medical ethics prohibits the practice of unlicensed therapy. Untrained adults trying to do good can do a great deal of damage. And this is my overriding concern with the entire SEL enterprise, that when schools, which are still struggling to effectively teach reading and math, extend their ambition to embrace the whole child, they may end up doing more harm than good.

The CHAIR. Thank you, Mr. Eden.

And now let me ask Dr. Timothy Shriver. And just once again, your written testimony, your full written testimony is included in the record, and you are recognized now for 5 minutes for an opening statement.

Mr. SHRIVER. Thank you, Madam Chair, and thank you, Ranking Member Cole, both of you, and all the members here.

And Congresswoman DeLauro, I am including in my background today a picture from your home district from the New Haven Public Schools taken some 30 years ago with Dr. James Comer in it because he is my mentor and, in some ways, the founder of this field.

And then, Congressman Cole, I want you to know that your questions and concerns are valid, but these faces behind me are the ones we, I hope, will see most in this hearing today.

I want to thank you, Madam Chair, for your longtime support for broad, bipartisan education initiatives. Head Start, to name one, in some ways was a precursor to the field of social and emotional learning we are hearing about today. Parent engagement, supports for early childhood development, social and emotional and academic integration in these early childhood centers.

In some ways, we are 40, 50 years of trying to figure out how to capitalize on the broad bipartisan consensus that emerged way back in the 1960s, and Dr. Comer himself was a pioneer, and many others, in showing us that children develop through these malleable interlocking systems that Dr. Cantor and Dr. Darling-Hammond mentioned that we do not have a choice between whether or

not to support the social and emotional development and the cognitive development. There is no “either/or.”

Notwithstanding Mr. Eden’s comments about insuperability and the separation of these things, children—no brain ever came to school without a body. No mind ever came to school without wanting to matter. No search for knowledge was ever disconnected from the search for meaning or importance or a relevance in the world. There is no such thing as a child that learns purely cognitively or acquires only information.

The only question we have before us and the only question I dare say you have before you is how well we will support the social and emotional development of children? Because it is foundational, as Dr. Cantor has said and Dr. Darling-Hammond, the brain science, the learning science, and to common sense.

We know this as human beings. I have seen Representative Beutler’s child there. There is no question—hi—that that child, like all of us learns in an integrated way.

So the science is not settled. There is no question about that. This is an early days issue. There is lots of research to be done. There is every indication that social and emotional learning is promising, if not effective. Mr. Eden’s comments are fine as far as they go in challenging us to make the research more effective, but the idea that we have a choice to turn our back on the work because we have more research to do is, in my view, unsustainable.

In some ways, all of this comes down to how we support the day-to-day experiences of children. Congresswoman DeLauro, we have thought at times, I have talked about maybe we need social and emotional learning in Congress because what we teach our children when they have stress is we teach them how to turtle. We say, you know, put your arms across your shoulders and drop down into your shell and take three deep breaths, and experience some positive self-talk and don’t react too quickly.

And but you do, when you find it, you can teach this to a first grader, how to turtle, how to manage stress. And you find your responses are much more effective. We teach lessons on—and you learn more, to Mr. Eden’s point, and you are more capable of paying attention, and your brain is more locked in and your relationships are stronger.

Same thing, Congressman Cole, you brought up these very important questions about whether this belongs. But when we think about what it actually is, one of the lessons, for instance, we teach to high school children is how to disagree without being disagreeable, which is, in my understanding at least, an extraordinarily important skill in Congress, right?

How do we disagree in a productive, meaningful way? The citizens of this country are asking these questions of the adults in our communities, not just of children. They are asking it of all of us, not just of our fourth or sixth or eighth graders.

The last focus group I did with young people about a year ago, one of the kids said to me, you know, Mr. Shriver, we have gotten so much better at bullying in our school, but adults are still bullies. And so, in some ways, this field is seeding not just the supports for children and learning, but the shifting of the system that sur-

rounds children and learning so that they can be attentive to this great consensus that exists in America.

After the pandemic, I dare say we have a very robust consensus on the need to support the social and emotional and mental health of our children. Parents are starving. They are desperate. They are exhausted, and they are searching. "Can anyone help me support my kid? I don't know what to do next."

Our chance is to answer that affirmatively.

Thank you, Madam Chair.

The CHAIR. I am on mute. Okay, there we go.

Thank you very, very much for all of your testimony. Appreciate it, and we will get started with the questioning, and I will kick it off.

And Dr. Shriver, you made a couple of points in this direction that I want to ask Dr. Darling-Hammond and yourself, and in his written testimony, Mr. Eden claims that the evidence base for SEL has been "vastly oversold." Specifically, he called into question the validity of research supporting SEL.

Can you both respond to his assertion and speak to the evidence base supporting social, emotional, and cognitive learning? Dr. Hammond?

Ms. DARLING-HAMMOND. Well, there is a substantial evidence base, and the way we think about evidence in research is the accrual of triangulated evidence that comes from many difference sources that points in the same direction.

You mentioned in your earlier remarks the relatively famous meta-analysis of 213 studies that represent 270,000 students from urban, suburban, and rural schools that was done some years ago, that found that students who participated in social-emotional learning programs, that teach those things like self-management and collaborating with others, showed greater improvements than comparison students in their social-emotional skills, their attitudes about themselves and others and school, social and classroom behavior, school grades and test scores.

On average, across all those studies, averaging those that measured achievement, an average 11 percentile gain in achievement scores. But equally important is the fact that in their school, there was more safety, more affirmation, less bullying, which all of which also support the desire to go to school, the capacity to learn well there.

After that, there was another meta-analysis that found that benefits were sustained in the long term, showing how the learned skills and attitudes can endure and serve as a protective factor, both supporting academic success, but also protecting students from mental health difficulties.

Even more recently, there was a meta-analysis of 54 studies of classroom management programs that found that all of the approaches have positive effects, but the most positive, the most substantial were the interventions that focused on social-emotional development of students, helping them learn how to be responsible citizens of the classroom so that that could carry over into all of their other exchanges.

You can manage a classroom by saying if you do this, you get punished, and if you do the other thing, you will get rewarded. And

you can also manage a classroom by teaching students how to be knowledgeable about themselves, aware of other people, responsible citizens of the classroom. And the second of those is what lasts into one's life and future.

Mr. Eden noted that the RAND Corporation study did not find as much evidence of academic achievement, but I want to note that in that study, they explicitly excluded interventions that were focused on promoting academic achievement in disciplines such as reading and math. They intentionally focused on those that measured social-emotional learning outcomes.

So most of the studies they chose to review did not measure academic achievement, but they did find that all 60 studies improved outcomes in social-emotional learning competencies and also improved safety climate and civil engagement and academic achievement and attainment in about a quarter of those studies.

And ultimately, the authors of that study were confident that there were several reasons that schools and educators should view social and emotional learning as a priority based on the evidence that they reviewed. So I think that there is always more research to be done. As a researcher, I will always say that that is true, but there is a quite substantial evidence base already that points us in a direction that we can act on.

The CHAIR. I don't know, Dr. Shriver, if you want to make a comment about it? I also would like to try to get in a question for also Dr. Cantor.

Mr. SHRIVER. Yes, maybe just very briefly, Madam Chair. Just very briefly.

Just let me just also point out, because many members of this committee have also been big supporters of the Special Olympics movement and the work that Special Olympics does in schools. Special Olympics has designed, if you will, an intervention using social and emotional learning foundational principles—empathy, perspective taking, moral courage, universal values. The numbers are off the charts when you invite children into these experiences.

So the kinds of interventions that are using these strategies—Congressman Cole has been very supportive of this work—they are common sense American values. I mean, we teach Jefferson and the creativity of Franklin, and we teach the resilience of Tubman and the search for justice of Cesar Chavez. We ought to not just be teaching about those people, but teaching children to be those people and to have the skills and qualities and values that enable them to grow and develop and to be citizens of the country. These are citizenship skills as much as they are affective skills.

So I would just say that the data is very prominent, Madam Chair, not just in the core research areas that are being discussed here because that has all been mentioned here, but also in the related programs in youth-serving organizations that are using these principles for very positive outcomes.

The CHAIR. Thank you both. And what I will do because my time has expired, I will move—when we move to a second round, I want to engage with Dr. Cantor as well.

And with that, let me yield to my colleague Congressman Cole.  
Mr. COLE. Thank you, Madam Chair.

Let me just—and I would ask this of each of you, and we will just move right down the line. Just to help me get a better understanding, can you provide some examples of the types of exercises, what they would look like in classrooms to help students with social and emotional skills? What are some specific examples of techniques that an instructor would use with a student?

And I will start with you, if I may, Dr. Cantor, and we will just sort of move down the line. I think you are on mute.

The CHAIR. There we go.

Dr. CANTOR. So imagine that you give a student a challenging project, academic project, and they take a look at this project, and they have this feeling, “I can’t do it.” And let us say even that they shut down because they are nervous that they are not going to be able to do it or not going to be able to do it well. What does the teacher do in that moment that inspires that child to believe that they can not only do the project, but do it well?

So the pedagogical techniques of a teacher in that moment are to recognize how a student is struggling and to be able to do the thing at that moment that enables that student to persevere through it. Now you wouldn’t call that necessarily by the label social and emotional learning, but you would recognize that you are teaching at that moment a student to have a growth mindset, “I believe in myself,” to stick with it, perseverance; to be able to transfer the knowledge of this project that you have just succeeded at to other projects. So your confidence builds that you can do other things.

I think right now the labels could be getting in our way because I think the universals here are what do we want every single child to believe about themselves and to be able to do? I think that is what Tim Shriver said just a few minutes ago.

Mr. COLE. Okay. And if I can keep going, Dr. Darling-Hammond, what would be, again, some of the techniques that in a practical sense somebody would use in a classroom?

Ms. DARLING-HAMMOND. Well, one of the things that a lot of teachers use in a classroom is group work. Students get together, and they have a project or an activity or an inquiry that they are going into. And to do that effectively, there are specific ways to engage in that group work that allow students to take roles that will allow them to figure out who is doing what, to be respectful to one another. So it would teach specific ways to listen and to respond to each other, to be sure people are included.

Those—all of those skills of group work and collaboration are the social-emotional learning skills that teachers will teach in the context of helping kids do the academic work much more effectively. We have probably all had experiences of bad group work and good group work, and the difference is whether those skills were taught in the process.

Another one would be conflict resolution. Things come up. Somebody took somebody’s pencil, or something happened on the playground. So teaching students ways to stop, listen to each other, express their feelings or their views, and come to a resolution—and there are some specific strategies that people have used across schools to do that—is another example of teaching those skills that will go on through the classroom and into life with those students.

Mr. COLE. Well, to Dr. Shriver's point, we have plenty of examples of bad and good group work in Congress. [Laughter.]

The CHAIR. Amen, amen.

Mr. COLE. And I would say our recent omnibus was good group work. So, thank you, Madam Chair.

I don't have a lot of time left. Let me go quickly to you, Dr. Shriver, and then to you, Mr. Eden.

Mr. SHRIVER. Yes, well, first of all, thanks, Congressman Cole.

I mean, look, again some of this is common sense. I will just give you one good example on the conflict side of things.

So being able to disagree without being disagreeable assumes a series of skills that kids can learn. One of them is how to presume positive intent.

So Mr. Eden and I currently don't necessarily agree on all of these things, right? But we have spent the last 5 to 7 years as progressive and conservative-leaning educators, trying to learn how to presume positive intent. So that as I listen to him, I feel like I am trying to train my ear and my mind to identify what about his intent I can see is really in the interest of children.

I am just using this current example because it is right in front of us, right? So presuming positive intent is very powerful for kids, and it is a lifelong skill. And you can teach it.

Sorry, I am over time.

Mr. COLE. Madam Chairwoman, can I—

The CHAIR. That is okay.

Mr. COLE. Is it okay just to give Mr. Eden a quick chance to add?

Mr. EDEN. Yes, very quickly. I mean, one common technique is the technique of role-playing for conflict resolution, conflict management. The question of what is being played with in these roles is an important question. And just from this week talking to some educators, I came across an example of a school counselor doing role playing with middle school students on how to break up with a boyfriend or girlfriend.

This raises many questions about kind of the appropriate role for adults vis-a-vis students in guiding romantic relationships and is part and parcel of what I fear, with very good intent, Dr. Shriver, could be an encroaching and then passing over a boundary that parents would not want adults speaking to their students about, would not want adults training them with positive intent in for fear that what will be trained would not align with their values.

Mr. COLE. Thank you very much.

Thank you for the indulgence, Madam Chair. I yield back.

The CHAIR. Sure. Thank you. Thank you.

Mr. Pocan? And let me mention this, Mr. Pocan. I am going to jump off to do something in Mil-Con, which is meeting at the same time, and get back on. So asking you to take the gavel and to chair.

So, Congressman Pocan.

Mr. POCAN [presiding]. Absolutely, Madam Chair. Thank you, and thanks to our witnesses.

Especially good to see Dr. Shriver. Obviously, you know I am a big fan of Special Olympics and all the work you have done there. So, thank you.

Mr. SHRIVER. Yes, sir. Thank you.

Mr. POCAN. I think my biggest question, you have talked a lot about the effect on students, and one of the problems that I am hearing, you know it is a national problem in our districts, is teacher retention. Between some public policy attacks, the last couple years under COVID, a number of factors, we are having a hard time keeping teachers. We have had very good applicants for some open positions, including in the biggest city in my district, in Madison, Wisconsin.

I am just wondering how teachers look at this and if this could be perhaps something to help stop the slide of decline that we are having on teacher retention. So maybe for the three doctors if you could each—

Mr. SHRIVER. I think Dr. Darling-Hammond is—oh, sorry.

Ms. DARLING-HAMMOND. Maybe I will kick off because it is an area I have spent a lot of time on.

Mr. POCAN. Thank you.

Ms. DARLING-HAMMOND. Yes. The use of social-emotional learning strategies actually has been found to support teacher retention in work that has been done on that because as the classroom and the school become more calm, more safe, more organized, and managed through the use of those programs, teachers get the benefit of a class that is easier to teach.

They also learn strategies that help their social and emotional learning and confidence, which makes them more efficacious in their work, and they can benefit themselves by developing those strategies to maintain calm and to be able to focus their attention in the right ways. So it is a very helpful piece of the puzzle with respect to teacher retention.

Right now, a lot of kids are coming back to school having experienced trauma with dysregulated behavior that is a result of that, and it is especially important for what teachers and other educators are experiencing right now to have these supports.

Dr. CANTOR. Another example that I could add to this is a district that I happened to be visiting yesterday. It is outside of San Diego, El Cajon, and what was described to me was that this is a district with a waiting list of teachers who want to work there.

So when you dig into why, why does this district have a waiting list of people who want to work there? Underneath all of that is the culture, the culture that is district wide that is modeled by the adults and, therefore, also modeled by the kids.

So there is a very, very powerful effect, and we know this in other fields. The connection between culture and the satisfaction of employees and their retention.

Mr. POCAN. Thank you.

Mr. SHRIVER. And Mr. Pocan, I will just one slightly, well, related point. The great longitudinal study that some of you may be familiar with, the Grant Study, which studied what leads to happiness in life, you know? Now I think we are in the 80th year of the study.

The current principal investigator, in fact, Robert Waldinger, concludes that after millions of pages of data, they can conclude one thing, that the quality of the relationships is the only thing that matters to quality of life.

This work is designed to strengthen the relationships not just for kids, but for teachers. Most of us went into teaching because we care so deeply about children. Yes, some of us love the Civil War or Shakespeare or poetry or language arts or whatever, the periodic table. But most of us went into it because we wanted to connect with kids.

And when those relationships are broken and tense and fractured and angry and hostile, burnout is inevitable. And then when you add to that the layers of political conflict and aggression from outside forces, it is overwhelming. All right? You just can't survive it.

But when the relationships are strong, my goodness, you know, you find what you came there for, if you will. So just at a very basic level, if you can imagine work that helps teachers strengthen the quality of their relationships with children is almost directly related to the quality of their capacity to want to stay in the profession.

Mr. POCAN. Great. Thank you.

And I have 35 seconds, I don't know if one person could answer, and I know this is a longer question. But is there any kind of one type of student that benefits most? I know I can clearly see benefits for every type of student, but is there a type of student that benefits the most?

Ms. DARLING-HAMMOND. Well, I would just——

Mr. SHRIVER. I will take that one. Oh.

Ms. DARLING-HAMMOND [continuing]. Go ahead, Tim.

Mr. SHRIVER. I would just say the answer is this is about every child. This is, yes, there are children who benefit in outsized ways, but this is just good child development. It is for every child and, therefore, really for all of us.

Mr. POCAN. Gotcha. Great. Thank you, and we got it down to the perfect timing. Appreciate it.

Next up, I have Representative Harris. You are recognized for 5 minutes.

Mr. HARRIS. Thank you very much.

And Mr. Eden, I would like to delve a little bit into your testimony because it is interesting. You know, as a physician, we always look at the quality, these internal and external validations, the quality of the study and then whether it is actually appropriate to what we are thinking about. And when we do Preventive Services Task Force, you rate things good, fair, poor, and then you base your recommendations on that.

So, first, it is very concerning to me that none of the studies that have shown a benefit are highly rated. That is, and we learned during COVID that we know the quality of scientific information is very important. So as we approach a \$1,000,000,000 industry, it is very concerning that there are no high-quality studies, apparently, that show a benefit.

So is that—basically, is that what your testimony suggests?

Mr. EDEN. My testimony suggests that the kind of randomized control trial, the gold standard, what physicians recognize as proof-of-concept, are far fewer. They are fewer and farther between than what we are being presented, which is meta-analytical results, right?

Mr. HARRIS. Sure.

Mr. EDEN. This meta-analysis that is frequently referenced that has I think 215, 213 studies—

Mr. HARRIS. Absolutely. And again, I understand, and it appears that the vast majority of those, if not all of them, are not the highest quality. And then you are making conclusions based on relatively poor data, and this is the whole—again, the whole purpose behind the U.S. Preventive Services Task Force is to look at quality of data, sir.

Now of particular concern is the external validity, which is to say that in a medical treatment if you actually change the type of treatment or slightly modify the drug, then looking at past studies of the past therapies and then trying to extrapolate into the new version is absolutely scientifically invalid. I mean, it is just, look, it might be true, but it is scientifically invalid to extrapolate.

So your observation, which I think is borne out with what is going on at the school level, of a radical change in what SEL was all about occurring in the last 3 years is very worrisome.

For instance, we have a—and this is from my State because you actually mentioned the Parents Defending Education, I guess the name of the organization. You go to their website, and this is in my State, a third grade elementary school instruction team leader and Rainbow representative in that school system sent an email to colleagues full of excitement about plans to incorporate LGBTQ within our elementary curriculum, explicitly stating this would be integrated during SEL time. Well, now the Florida law looks more important when you have a third grader being taught LGBTQ during SEL time.

So this is kind of the camel's nose under the tent. I understand CRT. I didn't understand its extrapolation and other things into SEL, which is something we have to be very cautious about because, of course, the North Harford Public School System, again Parents Defending Education website, has gender literacy embedded in their SEL elementary school curriculum.

Like, I am sorry, we need to—and last, but not least, I want you to comment on this idea that we are urging—and an important part of this is to urge students to be community activists. Because in my district, we had a major problem a couple years ago when one of our school superintendents urged her students in the system to attend Black Lives Matter rallies—now, remember Black Lives Matter is a—was an institution founded on Marxist principles. To somehow, without putting it in full context, urged students to attend Black Lives Matter rallies.

Now is that the kind of community activism that you see creeping into the new definition of SEL that CASEL is promulgating?

Mr. EDEN. It certainly can be. When you look at CASEL documents, they say that they want a commitment to antiracism, which, as I said, is an ideological doctrine. They said they want justice-oriented citizens, which obviously begs the question that we know what justice is.

And I would like to just briefly draw attention to something Dr. Shriver said, which I think was offered with the best intent, but falls on other ears is very alarming, right? The question of meaning and the question of whether schools should be in the business of

providing students with meaning. And then the question of, well, what meaning will the school tell students their lives have?

And these concepts blend very, very subtly, right? You have a buzzword like SEL. You have studies of various quality that you use to validate it. You fill the buzzword with any given concept, and you don't know. It is very hard to tell how widespread is it that SEL is being used as a Trojan horse, but the vector by which it can be is clear, and there are examples of it. And it is not—it is not—it is not of a piece with the rest of what we are hearing in this testimony from other witnesses.

Mr. HARRIS. Thank you very much. We just got to get back to reading, writing, and arithmetic.

Thank you. I yield back.

Mr. POCAN. Thank you, Representative Harris.

Representative Frankel, you are recognized for 5 minutes of questioning.

Ms. FRANKEL. Yes, thank you. Good morning. Thank you to the panelists.

Well, I want to say I am glad there has been a lot of research on this, but I will just tell you, my common sense, as a mother and a grandmother—and I have been around lots of little kids my entire life and so forth. I can just say there is no question about the importance of a healthy emotional development.

And right now in Broward County, which is just south of me, there is the death penalty phase of someone who killed dozens and dozens of people in the Parkland shooting, the perfect example of a young man who did not have good emotional development. Now that is an extreme case, but I want to talk about my home State of Florida because, I am telling you, we are in a race with Texas for the craziest governor in legislature, in my opinion.

And so let us see what they did this year. Just to let you know, affordable housing has gone up. Flood insurance has gone up. But that wasn't dealt with. But they did do this. They enacted the "Don't Say Gay" bill and banning critical race theory.

And I—even there is no such thing as teaching critical race theory, but what the ban on—the "Don't Say Gay" bill bans any classroom discussion on gender, gender identity, and sexual orientation in grades K through 3, if there is any discussion that any parent might find inappropriate in grades K through 12, or the teachers are just all gagged up now in Florida. I would like to have any of the panelists, if you wanted to comment on this in terms of what that—is the potential threat for our children?

Dr. CANTOR. I would like to comment on that. One of the things that we know from many, many, many studies on positive youth development is that kids will struggle to learn and focus if they do not feel safe physically, safe emotionally, and frankly identity safe. When kids are "othered," you are setting in motion a process by which bullying can be promoted, where kids will walk into school and be afraid that they and their identities and their cultures are not welcomed and not affirmed.

So there are a couple of problems with that. One, it produces fear and anxiety walking in the school door. Second, when kids are anxious and fearful, they can't concentrate. And then, on top of that, you are not giving the classroom a language for tolerance, for being

able to know how to behave around people that are different than you.

So citizenship, something that we prize in this country, has a great deal to do with experiences with people that are different than us.

Mr. EDEN. Yes, I can——

Ms. FRANKEL. Yes, go ahead.

Mr. EDEN [continuing]. I can make a couple of comments on it.

I mean, that obviously was not the name of the bill at all. It was the Parental Rights in Education bill, and I have seen polling that suggests that the majority of Florida Democrats agree with it. They agree that it is not appropriate to teach sexuality, gender, gender orientation, and sexual orientation to 5- to 9-year-olds.

This is not something that we have historically done. And frankly, the best argument against the bill was this is not something that we are doing, but as Mr. Harris and I were discussing, this is something that can start to happen under the guise of SEL and raises profound questions about how developmentally appropriate it is to be teaching about gender identity to kids who believe the tooth fairy is real? Do we really know that this will help?

Do we have any studies whatsoever to suggest that this is in their best interest over the long term? I would be very interested in reading them. I don't believe it has. This is a very novel development.

And I think when you have most Democrats supporting the bill, I——

Ms. FRANKEL. But, Max, I would like to—listen, most Democrats do not support it. Most normal people, if would they understand and then be able to have discussion other than a 10-second poll.

But I would like to see if any of the other panelists would like to respond to your comments? And I thank you, Mr. Eden. I do appreciate your point of view. I don't agree with it. But would any of the panelists like to respond to that?

[No response.]

Ms. FRANKEL. Okay. They have given up. But anyway, thank you very much. It was an interesting discussion.

Be careful when you go to Florida. You know what not to say. I yield back.

The CHAIR [presiding]. Okay, thank you.

Let me thank Congressman Pocan for stepping in. I really appreciate it.

And let me now recognize Congresswoman Herrera Beutler. And who is our little friend here?

Ms. HERRERA BEUTLER. Oh, I was begging my husband to lock them all out.

The CHAIR. Oh, God, no. No, no, no.

Ms. HERRERA BEUTLER. They are driving me batty. I love them, but——

The CHAIR. What is his name?

Ms. HERRERA BEUTLER. That one was Ethan. Ethan that is my 5-year-old.

The CHAIR. Okay, lovely. That is great.

Ms. HERRERA BEUTLER. Thank you. I appreciate that.

I can so relate with parents and pandemics and academics and social and emotional well-being because in our house as it implodes on a daily basis. So I find this a really interesting conversation, and I have some questions.

Although just if I put—take my lawmaker hat off and I put my mom hat on, I will tell you one of the reasons I think parents are so attuned to these conversations and what policymakers are discussing is because even just the, I don't know, I feel like lack of just comity or graciousness with which we are addressing some of these things causes me to say "gosh." And these are—I mean, look, we are doctors and Members of Congress and chairs of—right? These, in theory, are the highest levels of attainment in our society, and yet we are having major disagreements. And if we disagree, rather than disagreeing, we are like digging at each other.

And so, when I look at that, I think how in the world could I expect an educator with a ton of kids in her classroom, and all those kids are like my kid, who I am like "Just sit still. Just, for the love of God, sit still." I just think that is part of why I do have a lot of questions about whether there is—so even if everybody agreed on what the curriculum or the teaching here was, whether there is the infrastructure to do it in the way that it is being proposed. So there is just a lot of—this raises a lot of question.

I mean, obviously, my observation is we are all striving for the same thing. We want our children to be poured into, to be nurtured, to learn how to do—the rigor of academia, to be able to compete on a global stage, right? They are not competing against kids down the street like I was. They are competing with kids in China and India who are hungry for achievement, and our kids are dealing with parents who can't decide what the classroom structure should be.

And I really wonder—I think we are wanting to do the right things, but sometimes I question whether we are going to—whether we are going to put aside our personal feelings about some of this and do what is in the best interest of kids, which is why I know all of you, as you have gotten into this line of work, why you have done it, because that is your heart.

I wanted to ask—I was really—and maybe this is for Dr. Cantor. And Mr. Eden, I think you probably also will have some thoughts on this—about the ability of teachers within the classroom to address the mental health issues that we know are there. When I talk with my educational—my directors, my school boards, they will tell you the number-one thing to worry about right now is the mental health of their kids. They can't even get to the academics because the mental health is in a pretty crisis state.

One of the concerns I have is how do we get them into mental health services, and do we think teachers really can be trained to do this? And do we want them doing it? I have educators who would tell me they don't.

And maybe for both of you? I would like to hear both of your comments on that. Dr. Cantor, could we start with you?

DR. CANTOR. Sure. One of the questions that I was often asked when I was practicing as a child psychiatrist, which I did for about 20 years, what is the active ingredient of a therapy? Okay, is it all the things I studied in medical school, or is it the experience I am

having with the child in the moment in my office as I build trust with them, as I build a relationship with them?

So if I were to say to you what can a teacher do on behalf of the emotional well-being of every student, it is to support knowing them, caring about them, and really having a classroom in which every child feels known, loved, and connected with.

Now you can do that in different ways because I have also had teachers say, "How can I have a relationship with 30 kids?" Well, okay. Very, very challenging. But there are advisories, there are structures that can be put in place. There is even group work that Linda was talking about where a student can feel known, cared for, and loved.

Relationships are the greatest preventive mental health intervention that there is, and they are also great for learning. So that is the no-brainer here. That is what I would say is in the province of teachers.

Ms. HERRERA BEUTLER. Thank you, Doctor. Mr. Eden?

Mr. EDEN. Yes, I think the distance between the studies that we have of programs that may or may not have been reliably evaluated and what really happens, as you said, is huge. Frequently, what happens when I talk to teachers is, oh, we are supposed to do SEL? Okay, let us go to Google. Let us go to Pinterest. Let us find some things that are labeled SEL, and let us try them.

Vast difference between whatever we might have validated and what is actually happening under the skies, and I have also talked to a lot of teachers who have said, "I just want to teach. I don't want this burden on my shoulders. I am not trained to do this."

Suicide prevention. That is not—what if it goes wrong? What if we are acclimating them to these thoughts?

I think that there is a large sentiment in teachers that just let us teach. Don't make us do more than we are already doing.

Ms. HERRERA BEUTLER. Thank you all very much. Appreciate it. Yield back, Madam Chair.

The CHAIR. Thank you. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you very much, Chairman and Ranking Member Cole. Thank you for this. It is really interesting. I am learning a lot, and I know I don't know a lot.

Dr. Shriver, let me just tell you, you said something that really stirred me, and that was presuming a positive intent and, therefore, presuming a positive outcome.

I am really—I want to know, first of all—first of all, I kind of agree that this is more of an approach of a teacher, how you teach, how you interact, and how you help students develop than it is actually being a thing that you set aside an hour a day and work on.

I want to know, are students who are being taught to be teachers now being taught this as a sort of a method of teaching, an approach to teaching? Dr. Shriver, do you know?

Mr. SHRIVER. Yes. Yes, well, I will yield to Dr. Darling-Hammond, whose scholarship and work in the field of teacher education is legendary around the world.

Mrs. WATSON COLEMAN. Okay.

Mr. SHRIVER. I will just say that when I was training to teach, the answer was no. I had in three degrees in education one class in child development, which is backwards, right? It is indicative of

a system that doesn't see the child as the primary goal. It sees information as the primary goal. You don't, as I said earlier, have to choose.

The next generation of teachers we believe the essential reform effort, if we can call it that, will be to equip teachers with intensive understanding of child development not so that they can get embroiled in political disputes, but so then they can adapt behavior—as Dr. Cantor said earlier—to the situations, context, the pedagogy, the skills necessary to help a child go from A to B in terms of their learning.

Dr. Darling-Hammond, I go to you.

Mrs. WATSON COLEMAN. I am watching the clock. Thank you. Thank you.

Ms. Darling-Hammond, do you have anything you want to add to that?

Ms. DARLING-HAMMOND. I would simply say that there is a lot of work going on right now to infuse this kind of knowledge base in teacher education and in leader preparation. Those are equally important, and those are areas where congressional investment could be helpful.

Mrs. WATSON COLEMAN. Are we investing in current teachers to sort of bring them up to date in this sort of holistic emotional and, what do you call it, social and emotional learning sort of paradigm into their—the way they teach? Are we supporting that sufficiently? Do we need greater investment in it?

Ms. DARLING-HAMMOND. We invest very little in educator preparation programs in this country from the Federal level, and there is a need to kind of move the curriculum of teacher and leader preparation programs to accommodate the science that has been developed around how people learn and ensure that that knowledge base gets to them, just in the same way as we do in medicine and that we do in other professions.

Mrs. WATSON COLEMAN. So I talk to you as a grandmother of a beautiful black 9-year-old, and I want to talk to you as a black person. The one thing I want is for children, irrespective of their race, their color, or whatever, to feel equally valued, to believe that they are as great and as accomplishable as anybody else. I also want those that are not black or of color or different to embrace the differences that they see as opportunities and not as a negative.

And so I am wondering, and Dr. Shriver, maybe in my few seconds left, you could tell me how we approach SEL to ensure that there is this equity, this appreciation that we overcome this sort of over-disciplining of black kids in schools, that we help them all to determine the outcome of disagreements in less disagreeable ways, how we can minimize the bullying, et cetera.

I am very concerned about what is happening in our schools and the kind of political pawns schools are being made under these false pretenses of teaching CRT or whatever. It is ridiculous. It is sickening, and I want to know how we overcome that with approaching the SEL.

Dr. Shriver.

Mr. SHRIVER. Thank you. Thank you. I am not sure I am the best to comment on it, but I will just mention very briefly that you men-

tioned discipline practices that have been disproportionately punitive toward children of color.

But discipline practices, again, this is back to the earlier question, that have been not so successful for any kid. We put too many kids out of school. We suspend kindergartners. I mean, these are not good strategies for promoting development.

So we have got things, strategies we call restorative practices. Some people don't like them as much as others because they think they are too lenient. But we can create discipline strategies that are not designed to segregate and eliminate children from the system, but rather to keep them in the system and help them heal.

Mrs. WATSON COLEMAN. Thank you.

Madam Chairwoman, thank you for the indulgence. I do hope to get a second reading opportunity here because I want to explore this beyond just the issue of discipline.

So, thank you. Thank you, Dr. Shriver.

I yield back.

The CHAIR. Thank you. Thank you very much.

Congressman Cline.

Mr. CLINE. Thank you, Madam Chair. I want to thank our witnesses for being with us and for the interesting conversations that we have had.

I have learned a lot as well, and I want to reflect the comments of Congresswoman Watson Coleman. I found it really interesting. I am learning a lot and don't know a lot. And that is why Members of Congress are probably in the least appropriate place to be making decisions about the allocation of hundreds of millions of taxpayer dollars for educational purposes.

I was in the State of Virginia House of Delegates for 16 years, and we were much more involved in making educational decisions about the content, about the standards of learning in our schools, about the standards of quality in Virginia schools. But recognizing that much of what was taught and much of what was decided was best left to the local level, local school boards, and to parents, ultimately, as they make the decisions.

As I was in the State House for 16 years, I remember when No Child Left Behind was passed, and the negative reaction not just on the part of State legislators at the infringement over the prerogatives of States to decide how best children should learn in their States, but with parents who were upset about teaching of Common Core and different concepts that were being pushed down on localities and on parents by an overarching Federal education bureaucracy being run out of Washington, DC.

And so I associate myself with the comments of many colleagues on my side who are questioning the role of the Federal Government in this process, and quite frankly, I am falling back on my old Ronald Reagan line, "Here we go again." Because this is a perfect example of what happens when the Washington bureaucracy creates a means by which you can hijack local instruction and use it to push overtly political social and emotional engineering down on students on a national level.

So I will ask Mr. Eden, at the very least, with this radical ideological being taught more regularly in schools, do you believe that if there is more transparency and if these topics are being dis-

cussed, that parents can be made aware of what is being taught and should be made aware of what is being taught in their child's schools?

Mr. EDEN. I think they can, should, and must, right? I mean, structurally, what SEL can do is come down as a mandate that you kind of fill these categories of instruction, ways of approaching children. That could be filled with unobjectionable, positive things or could be filled with things that many parents would object to.

And parents have a right to kind of know what is coming in. If it is objectionable, they should be able to speak from an informed perspective to what they object to. And if it is not, they should be put at ease that, hey, actually in my district, SEL doesn't do all these things. SEL is still kind of what it primarily involved 5 to 10 years ago.

But parents can't know that unless they know that. And local government doesn't work unless parents know what is going on at their schools.

Mr. CLINE. Well, I know that in one county in Virginia, Loudon County, they were requiring parents to sign nondisclosure agreements before they could review curriculum in those Loudon County schools. And there has been an earthquake in Virginia politics over the last year, and it has been centered around parental rights.

Our new Governor, Glenn Youngkin, has put that at the forefront of his administration and is pushing for more transparency in our schools. I would look to Ohio, where they have a Parents Right to Know Act that provides for full parental curricular review and opt-in by the parents, not opt-out.

So I think there are opportunities there, but they should be taken at the State level. They shouldn't be mandated at the Federal level unless you are talking about openness and making sure that parents are ultimately the ones who have the control, who have the responsibility, and not, again, a bureaucracy from DC pushing a certain mandate down on localities.

Mr. Eden, can you speak to how social and emotional learning may infringe on the privacy of students and families?

Mr. EDEN. Yes, I mean, the story that you gave from Loudon County, if I recall correctly, it was about access to a school survey, in addition to curriculum. What questions are kids being asked? Asking questions is not an inherently neutral act. What is being done with the question that is being asked might not be neutral.

When you ask students very personal questions to find out things in order to affect them, that is an invasion of privacy technically, and I think there is a role the Federal Government could play in shoring up parental notification, kind of shoring up the People's Protections Rights Act so that parents don't have a situation where they don't know what their kids are being asked and don't know what is being done with what they are being asked.

Mr. CLINE. Thank you. I yield back.

The CHAIR. Thank you. And I would hope at some point, our other witnesses will get an opportunity to speak to the issue of what is being done at the local level in a variety of States, which is under their own jurisdiction and the efforts that are being made that is not a Federal mandate.

Let me recognize Congressman—I have to move on to recognize Congresswoman Bustos, but we will get to your point. Congresswoman Bustos.

Mrs. BUSTOS. Thank you very much, Chair DeLauro, and thanks for holding this hearing today.

And I am going to get hyper local here, okay? So, Dr. Darling-Hammond, I am going to address my first question to you, but let me have a little bit of a lead-in, okay?

I held a series of economic roundtables throughout the district that I serve in Central and Northwestern Illinois. I have done this for a number of years, and the more recent ones, you know what I heard about at every single one of them? It was about teacher shortages, okay? Hyper, hyper local here.

So, so what I did, then I made a decision to bring together teachers, teachers aides, administrators, so we could drill down and have a deeper conversation on this issue. And you know what came up at every single one of them at the local level? Social-emotional learning.

All right? So there you go. It is local.

So, but part of it, I am going to drill down then even further about teachers, specifically. Do you know what happens when we don't pay teachers enough or if we don't provide a supportive environment? People don't become teachers.

Or if they do become teachers and we are not supportive or they are overworked and underpaid, they leave. And when they leave, we are losing staff members, and we are losing this experience. And that all takes a toll on our kids. So, again, drilling down further, that takes a toll on our kids.

So our schools really, as I see it, aren't equipped to provide our students the whole learning environment that they need. And as a result, students suffer.

So teacher shortages were worsening pre-pandemic. We knew that. We have all seen that. And they have been made even worse by the pandemic.

So, again, Dr. Darling-Hammond, can you please talk about the measurable impact of teacher shortages on the academic, social, and emotional development of children? And touch on how the pandemic has affected these issues as well.

Ms. DARLING-HAMMOND. Well, we know that teacher shortages result in several things. They result in several things. They result in courses getting canceled. They result in larger class sizes because you can't hire enough teachers. Or they result in people being hired into the classrooms who don't have training to teach, and that happens at a large level. It happens disproportionately in higher-need settings.

But I will say, for example, in California, about half the people coming in to teaching in the last few years have been coming in without preparation. And that means that they are coming in not knowing how to teach math and science and reading. It also means that they don't have the tools to understand child development. And quite often, the disproportionate disciplinary actions and problems like managing a classroom also bubble up.

So children are underserved when there are teacher shortages in substantial ways. And just to kind of loop it back around to the

questions we have been talking about, one of the things that we need to keep teachers in the classroom and to give them that support is the set of wraparound supports that community schools and other whole child education strategies can offer, which a number of districts and States are looking into and that Congress has begun to support.

When you have health and mental health services there in the school, when you have the social services to help kids, then teachers can create a much more positive environment, and they can help kids get what they need.

Teachers burn out also when they can't help kids, when they can't meet all of the needs that they see their students presenting because they want—that is why they are there. And if we wrap around the teachers and the students with these kinds of supports, you will see a much better result with respect to teacher retention and student learning.

Mrs. BUSTOS. Very good. Thank you.

I am going to try to squeeze in a last question here in the last minute.

Dr. Cantor and Dr. Shriver, if we have time for this, this will be addressed to you. We have seen this siloed approach to addressing certain elements of childhood development. So the whole child approach obviously is important towards breaking down these silos. With developing children's physical, mental, social support all together, we are able to create a more supportive learning environment and be able to address these social disparities that we talked about today.

But the approach of breaking down the silos and addressing disparities is really we see it as central to addressing social determinants of health, and I know Chair DeLauro knew I would try to squeeze this in. She has been incredibly supportive, as has Ranking Member Cole, in a bill that I have called the Social Determinants Accelerator Act.

We have got grants in that that look to empower communities to tailor their approach to addressing these local disparities, which may include better incorporating educational initiatives like the whole child program.

I am out of time now. I guess I plugged my Social Determinants Accelerator Act, and I guess I just want to make sure that our panelists know about this, and we will have to talk about this offline at another time.

Thank you, Chair DeLauro, for all of your support of such an important measure, and thanks for holding the hearing today.

I yield back.

The CHAIR. Thank you. Is Congresswoman Lee on?

[No response.]

The CHAIR. Okay. I guess not. And then what we will do is to move to a second round. And I don't know if—Congresswoman Bustos, and thank you for getting in the social determinants. I knew you would, but I would also like to have people respond to you because these are really experts in the field.

Let me, I think, as Mr. Cole has had to go to the Rules Committee, so let me ask about community schools. This is an issue that you have some familiarity with. You had one of the first in the

Nation in New Haven, the Dr. Harry Conte Community School, which I spent a lot of time working at and volunteering, really volunteering time there.

So, and I wanted to ask you, Dr. Cantor, Dr. Darling-Hammond, and Dr. Shriver, I want to ask you the question about how the community school model can play a role in really disrupting the effects of poverty so that our most vulnerable kids can learn and they can thrive. And if you will, let you talk about, Dr. Cantor, the positive environment in which kids can thrive in community schools in this space. So let me ask the three of you to respond.

Dr. CANTOR. Thank you for giving me the opportunity to talk about this. I am actually on the current task force for community schools and in this next generation.

First, it emphasizes the point that Congresswoman Bustos just mentioned, and that is that health and mental health and well-being are essential determinants about kids and their ability to learn in school. And we have known this forever.

And in the first generation of community schools, the big focus was access. Have the services in school and have those services easily available to parents, particularly parents who work, and to take the stigma out of many of those services, particularly mental health services.

But now community schools is doing something more. Okay, I spoke about whole child learning and the fact that integrated supports are an essential component of the five components of whole child learning. So the new focus of community schools is actually to connect the activities in support of kids, whether they are health and mental health, and learning, engagement in learning, in enhancing motivation, enhancing energy, and putting kids into a position where they can feel the full power of their capacities to learn and engage.

So the new generation of community schools is not even just about supports. It is about supports in service to powerful learning for each and every child.

The CHAIR. Dr. Darling-Hammond.

Ms. DARLING-HAMMOND. I will just piggyback on that. I will just say California has just invested almost \$3,000,000,000 in getting community schools launched in our highest-poverty schools. And about a third of our schools have more than 80 percent of students who live in poverty.

And what does that mean? It means to us that in these schools, we will have health clinics and mental health supports and mental health professionals. The health clinics will be sure that kids get the kind of healthcare that many of them don't get, that they get vision testing and hearing testing and all of the other supports.

But it will also mean that they get expanded learning time, that there will be tutoring after school, that there will be support for after school homework, for mentoring and a variety of other recreation and enrichment activities for students.

It will mean that they will be able to get support from social service providers. If a family is about to be evicted, we have a high homelessness rate all across the country for children, but certainly in my State. And the facilities to help families in those regards will be there. All of these things remove obstacles to learning.

And then we need inside the school for teachers to have enough knowledge base about how to recognize the needs that children have to connect them to those services that will be readily available, and that can be transformative to the teaching and learning process and for the retention of teachers, as I mentioned.

The CHAIR. Dr. Shriver, I am going to go over my time because I want you to have the opportunity to talk about some of these schools because I think we have similar experiences.

Mr. SHRIVER. Yes. Well, having also worked at Conte school, Congresswoman DeLauro, I think we know—again, I think there is not a really controversial issue here. I mean, there has been a lot of discussion on this hearing about Federal versus local. This is a movement that started as a local movement. It is not a top-down movement.

I mean, I don't want to disillusion Members of Congress, but this is a movement that has been built by parents and teachers and educators for the last 30, 40 years by communities that wanted to add tutorial services, that wanted to support. So I think we have like much more agreement here than we realize.

Parental engagement. Absolutely. The picture, again, behind me, Dr. Comer. First pillar of this work is parental engagement. I would agree with all the members of this committee and all the witnesses in saying that parents are completely critical and need to be in community schools and need to be valued and listened to and disclosed to in community schools.

The resources that children need are at the community level. They are not at the Federal level. So I mean, maybe there is a specter of a Federal takeover, but count me as a person not in favor of it. I am completely in favor of empowering parents and local communities to be at the center of all this work.

So I will stop there.

The CHAIR. Before we go on, let me just mention this. Just piggy-back on what you said, Dr. Shriver.

It was—I am just trying to think—it was in the 1960s at the Dr. Harry Conte Community School, and I had just finished a graduate degree at Columbia University. It may have been 1965, 1966, and I didn't have a job. So I went to volunteer my time at the Conte school. It is a community school.

And by the way, the initiation of community school and that concept came from Dr. Gerald Tirozzi, who wrote his doctoral dissertation in Ann Arbor about the role of community schools and locally what community schools could mean. That school was open from 6:00 in the morning until 9:00 or 10:00 at night. Everyone was in the school—mothers, fathers, grandparents. There were sports with older kids.

Tutorial services, health services, the whole 9 yards. And the benefit was really extraordinary. All locally based. No one was dictating what was taught, what extracurricular activities were, what the after school programs were, et cetera. It was all based on local efforts.

It was almost—well, we really went backwards in terms of education when we stopped dealing with community schools, which is why that we are now moving to looking to the future with community—understand the word “community”—schools and their ability

to help to make and create a positive, a positive environment for children and for families and for parents, and for parents to engage with their kids and with one another and to be able to create that overall positive relationship there.

And I am going to—Congressman Harris, Congresswoman Lee is here. I am going to give her—I am going to recognize Congresswoman Lee. I tried to get her in the first round. But then we will move forward, Dr. Harris.

So, Congresswoman Barbara Lee? You are on mute. Barbara, you are on mute.

Ms. LEE. Yes, I apologize for being late, but I was chairing my own subcommittee. So I am so glad to be able to just be with you for a few minutes.

And I want to thank all of our witnesses. This is such an important, important meeting, hearing to really secure the future for our young people in the country. And I wanted to just—forgive me if this is a redundant question on trauma.

Just wanted to find out how the schools, how you see the trauma that many of our young people now are experiencing as a result of, say, gun violence in many of our communities, as a result of being unsheltered, as a result of COVID. All of the trauma of just living—and many communities living poor, living as a black person, as a black-brown person, black and brown children.

And also how can—my background is psychiatric social work, and so I have always wanted more social workers and psychologists in our schools and defining their roles so that they are servicing schools and school districts, and with teacher turnover so high and staff changing, we wanted to find out how the Federal Government, what you think the Federal Government should do to intervene to make sure that we sustain levels of training that we need in our schools, as well as what we can do to address trauma-related factors that children now are experiencing?

Dr. CANTOR. Trauma is my specialty. This is—this is the work that I have dedicated my life to as a mental health professional. But we have—we have a lot, a lot of kids that have been impacted by the pandemic. So we can't say to ourselves that the solution is every child will have a therapist because that is unlikely to be something that we can provide.

But one of the things that we can provide is for all of the environments, whether they are schools or community-based organizations, after school programs, the whole principle of whole child design is that every single environment in which children grow and learn can be set up to address the things that trauma does to kids.

Trauma is about stress and stress' affect on the brain and on learning and on kids' emotional development. You have kids walking into environments every day that are going to be healing places, places that reduce stress, places that provide relationships, and places that connect kids to sources of support. That is the response that is required today because of the impact, the traumatic impact of the pandemic on development and learning.

Ms. LEE. And let me ask you—I have a couple minutes left—anyone who could answer this question, in terms of any Federal guidelines that provide guidelines for expulsions and disciplinary action. I, for many years, when I was in the legislature, tried to tighten

up the California code to have some criteria for expulsions, especially of black and brown young kids like in kindergarten, and never could get that done for a lot of reasons.

And so I am wondering do we have new guidelines? Because we want alternatives to suspension and disciplinary actions that would allow—that would force kids out of school. So what are the Federal guidelines, or are there any Federal initiatives that would make sure that kids have alternatives and that expulsions have some kind of criteria? If a kid is going to be expelled, it is going to be for the right reason, which I can't, for the life of me, determine what the right reason would be to expel a child.

Ms. DARLING-HAMMOND. Yes, I would love to speak to that from both the California and Federal perspectives. The Department of Education is right now revising and getting ready to issue guidelines on disciplinary actions and disparities and how they will be involved in investigating disparities as well as guidelines for the sort of practices that involve kids in community circles and in supports that teach them conflict resolution and a variety of things.

In California, the zero-tolerance policies that were in place have been eliminated. The use of suspension and expulsion for things like sort of discretionary behaviors like willful defiance and—

Ms. LEE. Right. Or wear hair like I wear my hair.

Ms. DARLING-HAMMOND. Yes. Have been eliminated. The State now looks at exclusionary discipline in its accountability system. We have got licensing standards that require teachers and principals to learn strategies that work to support children in learning behavior and staying in school.

So there is a lot that both the Federal guidance can do in this regard and that States can be picking up and can be encouraged to pick up as ways to keep kids in school. We see higher graduation rates. We see stronger achievement as a result of those kinds of actions.

Ms. LEE. Thank you very much. Thank you, Madam Chair.

The CHAIR. Got it. Okay, Dr. Harris.

Mr. HARRIS. Thank you very, very much.

And Mr. Eden, I want to follow up with you because if you read—if you go to CASEL's website and you read about things, and I am going to read from it, it says, "CASEL is refining a specific form of SEL implementation that concentrates SEL practice on transforming inequitable settings and systems and promoting justice-oriented civic engagement, which we are calling transformative SEL."

So SEL is being changed. So is there any academic evidence that transformative SEL, this new kind of SEL actually improves academic performance? Because I mean that is, hopefully, what the school system is all about. Because families can do a lot of social-emotional learning and teaching. Schools have to concentrate on academic performance.

Is there any evidence that transformative SEL improves academic performance in a highly rated study?

Mr. EDEN. Well, yes. Well, before answering that question, I kind of would like to pose a question, which is that if we know that SEL works from all these studies that we say that prove that it works, well, why transform it?

As for what we know about the outcomes of transformative SEL, given that it is based on a paper that was written in 2019 or 2018, I believe, and then adopted within about a year by the organization, and it takes a totally different moral, political, ideological spin to the enterprise, I would be shocked to find that there are studies, short term or long term, about SEL as it is now defined.

Mr. HARRIS. Sure, and that is totally—totally understandable because it is brand new, and I imagine your question was rhetorical because I think we know why. It is because we want to change this into a—because CRT is no longer very popular to use, people shy away from it.

By the way, Mr. Shriver, I am glad to hear that you don't want a top-down involvement because what we learned from COVID—and there are very few silver linings—is that parents finally figured out what is being taught in their schools, and they didn't like it. Parental involvement is absolutely essential, but they didn't like what they were seeing in schools.

Then when they tried to get information, they had to sign, as the gentleman from Virginia said, nondisclosure agreements to look at curriculum, something that should never, ever occur in our public school system, but it is going on.

Anyway, so, Mr. Eden, let me talk a little bit because I want to follow up on what my colleague from Washington State asked about, which is this idea that you kind of are turning teachers into therapists a little bit? Yes, with their mental health issues, I get it. You know, I am a physician.

To actually deal with mental health issues, we have complete residencies that take years and years. Teachers are not equipped to do this, and yet they may be asked to do it, and you suggest that things could go horribly wrong in a variety of ways.

How, why do you say that? I mean, I believe that is probably true. When you have undertrained individuals delving into very, very serious issues, why do you say that things could go horribly wrong?

Mr. EDEN. Yes, I will go straight to the scariest thing that scares me, which is the implementation of suicide awareness and prevention programs, right? Now, to my knowledge, I haven't looked at it deeply, I believe that it is possible to implement these programs well. It would stand to reason that it would be. But also there is a risk that that could terribly wrong because you might normalize the thought of suicide if you ask students repeatedly, year after year, possibly semester after semester, in surveys or interventions, are you thinking about hurting yourself? Are you thinking about killing yourself? You risk normalizing those thoughts.

You risk potentially increasing the overall number of suicides in an effort to address it. The scariest thing for me is if that happens, will the system double down on the intervention that might be engendering it? Will it say, oh, wow, we have this increase in student tragedies, let us double down in suicide prevention awareness?

I mean, that is the worst thing that can happen. But other things is when students are kind of asking questions about who they are, those are questions maybe best left to a therapist or to a psychiatrist. When it reaches levels of kind of gender dysphoria, reaches levels of extreme stress, those are things that teachers just

aren't trained and really can't be effectively trained with anything except for pop psychology, which frequently carries an ideological valence to it, even if it is not intended to.

You can feed all sorts of counterproductive not—not good thoughts into students while you are trying to help them.

Mr. HARRIS. Yes, it is the cart before the horse. I mean, we can agree that that might be important, but then we have to educate our educators to actually be therapists.

Finally, just one last thing is the privacy issue, a huge again. This was in the State of Maryland, where they were passing around these surveys and specifically not releasing the surveys to parents, the questions on the surveys. Very disturbing when it is dealing with early elementary school children.

Anyway, I yield back, Madam Chair.

The CHAIR. Thank you. If I might, since CASEL was referenced, and Dr. Shriver, you are on the board, chairman of the board of CASEL, I wanted to give you an opportunity to respond to the issue of transformative SEL.

Mr. SHRIVER. Thanks, Congresswoman. Thank you, Congressman Harris. Yes, thank you.

So I appreciate the concern about transformative SEL. It was a paper written, and as you pointed out, Mr. Eden, it suggests that there are forms of SEL for certain districts where local communities are particularly interested in the issues that you describe. It is not a reform of the basic science. It is a paper that describes ways to integrate certain strategies when communities are interested in that form of SEL.

It has become very popular in many districts. It is not inflammatory. Maybe some of the language sounds to some people that it is triggering or in some ways of concern. But it has been very well received as a form. Again, I just want to point out all of these decisions are made at the local level. CASEL is not impose—CASEL doesn't have a curriculum.

CASEL reviews and evaluates and creates knowledge of learning systems for teachers and superintendents and parents and others who want to look at curriculum and want to decide on what works in their community, but CASEL is not telling people what to teach. It is getting people guidelines about where the evidence is, as good as the evidence is, and where the evidence isn't.

So we are trying to create an open forum here that inspires people to experiment and challenge and try things. The studies that you referred to as not being about transformative SEL are not about transformative SEL. They are about other forms of SEL where you can look at the curricula that were in the meta-analyses, and those are the ones that are being evaluated. There is no secrets here. It is really—I mean, at some level, I think, Dr. Harris, you know, your point about the comparison to medicine I think is really important.

My mentor, Dr. James Comer, always used to say that in medicine every doctor has a basic science. It is the human anatomy. In education, we need a basic science, which is child development. It is not to say that you know on all moments how to apply the science. It is just to say we need the basic understanding of human

development as educators in order to be able to teach math and science and reading and so on better.

So what we are trying to do is underpin the field, if you will, the profession. Teachers should not be therapists. Absolutely, lesson one. I mean, I learned this, again, 30 years. When problems arise—and they are in the classroom already. I mean, we can hope that these problems aren't in the classroom, but they are there.

What we have tried to enforce and emphasize to teachers is when problems surface, make sure you have the capacity to recognize them and refer the children out. Help the children to recognize what we call help-seeking skills.

When I was a kid, when I was in trouble, I had no skills to look for help. I didn't know how. I was embarrassed. I was ashamed—if I was lonely, if I was angry, if I was confused, if my peers were using drugs. What we try to do in these programs is help children recognize when they need help. We call it help-seeking skills.

And we try to help teachers realize when children need help how to refer them out. We call it multi-tier systems of support. Classrooms are not therapeutic settings, but they can be very powerful settings for supporting development across an array of local environments.

The CHAIR. Congresswoman Frankel.

Ms. FRANKEL. Thank you. Thank you again, everyone.

Okay. So I have with me a calculator. Now if I ask this calculator, I don't ask it, but if I put in what is 2 plus 2, it tells me 4. It is uneventful. If I ask my grandchild that, depending upon his mood, I might get an answer.

So I just said a lot of this is just common sense. Of course, a child's emotional development is important to his education, his well-being, and to everybody else. That is not to say, and look, I believe that parents are the most important part of children's life or can be or should be. Unfortunately, some children are not blessed with the love and nurturing of parents.

But the fact of the matter is I just looked this up. The average child spends between 3 to 6 hours a day in school, depending upon the age. So by the time they are done with school, it is over 14,000 hours. Hello? These children are not robots. We better be paying attention to all aspects of their life.

And so I don't want rant and rave all day about my horrifying and embarrassing law in Florida, the "Don't Say Gay." Okay, I am going to go past that because we are mourning, we are still mourning in Florida the carnage of Parkland. The trial is going on this week. Seventeen children and teachers killed, 17 more injured.

And not to make an excuse for the killer, but it appears from his background that he was very—that he was bullied, that he had a lot of what I would say emotional problems. That is not an excuse. But it would have been nice if there had been some intervention because it may have saved so many lives.

And that is what I really wanted to ask—I am going to start with Dr. Cantor. If you could, just explain how this type of by recognizing the child's emotional development, how can this help at least point out to the powers that be that there may be a child in trouble?

Dr. CANTOR. So one of the things that Tim Shriver said a minute ago around this idea of what is knowledge that we have, and what is basic science? So one really crucial element of basic science is the impact of stress on development and learning. All of us, when we experience stress, have a biologic reaction to it that is mediated by a hormone, a hormone that travels to the brain and can create that fight-flight feeling.

When kids are bullied, when kids are othered, when they don't feel safe in the environment in which they go to school, these stress mechanisms are set off. And they will impact how a child behaves, whether they can concentrate and learn, and whether they are going to be able to thrive in a setting.

Now this is knowledge. This is not theory. I learned it in the 1980s in med school. Okay? So there is nothing about this that is new.

I also learned that the most powerful force that can mitigate, okay, that can address this feeling of stress is another hormone that is released because of positive relationships that kids have. That hormone is oxytocin. So in our bodies, we have one that raises stress and one that takes it away.

So what do we know that releases that helpful hormone that helps kids learn and helps them feel safe? Okay, it is an environment in which they feel safe, have positive relationships, know that they belong. You are actually impacting the biology of a child and making that child able to learn and thrive.

Okay, this is not theory. This is knowledge.

Mr. EDEN. Ms. Frankel, if you don't mind?

Ms. FRANKEL. Thank you very much. And I yield back.

Oh, I am sorry. Did you—

Mr. EDEN. Just a quick comment because I—

Ms. FRANKEL. Sir, no comment. I am out of time. I yield back. Sorry.

Mr. EDEN. Yes, ma'am.

The CHAIR. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. I thank you, Dr. Cantor. That was a very interesting discussion.

So we know that we had all these problems in the schools anyway—the bullying, the racism, the homophobic behavior even at a very young age. Now we have kids coming back to school from the pandemic, from the isolation, from the insecurities that they experience at home. I even have concern about children who have lost their caretakers, their providers during this pandemic, and now we are bringing them back into what we consider to be their normal routine of going to school.

What are some of the things that we need to be looking at and doing and are we doing to address the kind of sort of emotional condition that a child is coming back to school?

Dr. CANTOR. I think that the work on whole child learning, this was a collaboration where we sought, Linda Darling-Hammond and I and a team of scientists, to answer the question, what do we know from the science of learning and development that says how should a learning environment be designed so that children walking in the door are going to experience the conditions that optimally support their ability to engage and perform in school?

So those five factors in whole child design—relationships, belonging, rich instruction, supports, and building 21st century skills—all of that came directly out of the science of learning and development and pointed the way toward the design of these comprehensive environments.

We now have a playbook that can help districts implement toward that kind of comprehensive design. We have to stop binary solutions. We have to stop siloed solutions. You can't do whole child design with your left hand and have harsh, exclusionary discipline with your right hand. Okay?

These things are antithetical to each other. And we need to build holistic design in which we solve many problems at the same time for kids.

Mrs. WATSON COLEMAN. Thank you. Ms. Darling-Hammond, could you just quickly address where are we in our—in schools having access to this sort of learning paradigm and their readiness and willingness to engage in this approach to educating and addressing the needs of our children?

Ms. DARLING-HAMMOND. Yes. I think that where we started in the beginning of the hearing around the social-emotional learning programs that have been developed and vetted and are accessible to schools is a part of that. About a third of the districts that have used the American Rescue Plan Act money and the ESSA funding have used it to put in place these kinds of supports that enable teachers to help students process their emotions, talk about their experiences, learn coping strategies that allow them to work through some of what they have experienced.

The community schools component of it, which, again, many districts are using those funds for, are also accessing the mental health professionals and supports that then can help students deal with the trauma that they have experienced. But there is a lot of effort going in, and the Federal funding has been extremely valuable for this to help schools create this kind of a whole child design in the curriculum and in the support systems around them.

There is more to be done, to be sure, but we do see much better outcomes in the places that are putting those supports in place for students so that they can recalibrate and feel that the school is a welcoming place where they can get the necessary supports that they can't get otherwise.

Mrs. WATSON COLEMAN. Thank you. Can I say that I am so supportive of the community school design? I believe that we could co-locate services not only for students, but for even families.

Ms. DARLING-HAMMOND. Yes.

Mrs. WATSON COLEMAN. I mean, I had a visionary Governor who believed decades ago that we could have healthcare there. We could have job seeking there. We could have housing seeking there.

I also believe very much that we could keep children in school doing both academic and athletic and social involvement after the traditional school hours, keep them off the streets. I mean, there is just so much that we are not doing that we should be doing in public education.

So I love hearing this. Thank you, Madam Chair, for this opportunity, and I just look forward—

The CHAIR. Okay. Let me just—there is a couple points, and then I am assuming, Dr. Harris, that in the absence of Mr. Cole, I will yield to you for closing remarks. But I wanted to make a couple points.

And Mr. Eden, I appreciate really—very, very much appreciate your concerns about low-quality SEL investment. Which is why with the committee, with the grants that we have dealt with, they are included in what is a rigorous tiered evidence program, the Education Innovation and Research. So to do whatever we can to make sure that the quality of the program is as intended, you know, and not—I would just say about mental health issues, I would overall love to have an overwhelming support on both sides of the aisle. I believe we ought to have a mental health professional in every one of our schools.

That would be a goal to have a trained mental health professional, and one of the things we do most recently in the Labor-Hill bill is to include funding for mental health professionals. But I think particularly given what has happened with the pandemic and the aftermath of that, I think it would be a real investment in—a serious investment in how we would like to see our children be able to get past the absolutely tragedy of the last couple of years and to put mental health professionals in every single school.

And yes, and that is something that we ought to fund to be able to do. It would serve us well.

A last point before I recognize Mr. Harris is that this is the issue of the local effort, and I think we are looking at the creation of social and emotional learning that is in a nonpartisan way. It is in a safe—it is in rural, urban, suburban settings. And I just would mention to you the various States that are engaged and involved. There is Georgia, Kansas, Kentucky, Missouri, Oklahoma, Tennessee, North Carolina, North Dakota. And these are efforts that are being made that are grounded in what the need is on a local basis.

That is the genesis of this. At its core, it is about what—and I think about this issue of parents and school boards. As far as I know, and I have started to look into this, local school boards are parents. The local school boards all over the country include parents, and who have a vested interest, obviously, in what happens to their kids and have input into what is happening to their kids.

Now let me recognize Dr. Harris for closing remarks.

Mr. HARRIS. Thank you very much, Madam Chair.

And look, I want to thank all the panelists for your interest in making sure that our children get educated. That is the bottom line. That is incredibly important because, I think, as someone pointed out that is the future. I mean, our children are the future.

I am a grandfather of 10, father of 6. Clearly, I am very concerned with our ability to educate the next generation.

Look, I am going to concur with the chair. We are probably not going to agree on how to fund the mental health professional in every school because I think that is a State and local responsibility, but we should urge that to occur. Because unfortunately, over the past several decades, the schools have come to replace the families as places where social, emotional, moral learning and teaching goes on.

Now, look, that is the hand of cards we are dealt. We could try to put the family back in charge of some of that. But again, that may or may not be able to occur, and until that happens, we have to recognize that this now—and it is different from 50 years ago and 60 years ago—that schools are going to have to take up some of this.

I would urge us don't put the cart before the horse. We should do some rigorous research, see what works, what doesn't, and then train the next generation of educators for that. Because I am afraid a lot of the educators, you know, it is hard to teach an old dog new tricks. And a lot of educators I think look at some of this and say this is not what I was trained to do, and they are probably right.

So it is important to look at it, as long as we keep our eye on the same goal, which is to make sure that our children get educated, that their academic performance, their social, their ability to fit in socially is achievable within our society. That is our goal.

So I appreciate, Madam Chair, I appreciate bringing together the panel. I always appreciate when you bring together panels of people who are interested in just improving the lives of our children and how our children turn out.

So, with that, I want to thank you all, and I yield back.

The CHAIR. Thank you.

And just in closing, I want to end where I began with the Neil Postman quote. "Children are the living messages we send to a time we will not see." They are literally the legacy we leave behind us, and we know that everything we do needs to be making sure that—whether it is parents or educators, we need to make sure that our kids can meet the challenges of the future.

So it is incumbent on all of us, especially legislators, to ensure that they are prepared. And that is not only intellectually. That is emotionally and socially as well.

And I just might add I hear a lot about research and more evidence, well, there is substantial, substantial evidence behind, it is scientific. We are standing on very solid scientific ground here that the interventions and the science behind the interventions is overwhelming and that high-quality SEL programs that support these efforts result in absolutely positive and academic life outcomes.

And it is about the future of our children and, particularly now, of the stress and the hardship of our most vulnerable kids that they have faced in this pandemic.

And I was interested in, Congresswoman Watson Coleman, and I don't have the number at my fingertips, but the number of children who have lost their parents to COVID. What is happening to these children, and what are we doing to address this issue? So we are looking at the strategies that are effective strategies, as we know, that are needed now more than ever.

And which is why what we try to do is to engage through the Labor, Health and Human Services, and Education Subcommittee in addressing these issues and based on the science because we can look at study after study after study, and we know—and we have study after study telling us about how children learn, at what age they are learning, et cetera. It is now for us to put into practice the information that we know and to act on it. That is the moral obligation that we have in this effort.

I just want to say a thank you to our witnesses today.

I wanted to thank you for not only for your testimony today, but I want to say thanks for the years and years in your professional lives of devoting just to looking at the science, developing—helping to develop the science, taking the interest to understand how we need to—the most significant impact we can make on children is their education and where those educational opportunities will lead them.

And it is just so critically important. It is probably the most where we should have the greatest Federal involvement in supporting what local government is doing and what the research tells us are the ways in which we can transform the lives of our kids through education and making them feel that they have the environment, the cognitive ability, and have the social skills to be able to succeed. And thank you for devoting your lives to making that happen.

And with that, I am going to adjourn this hearing. Thank you very, very, very much for your testimony this morning. It is very appreciated. Thank you.



THURSDAY, APRIL 28, 2022.

**DEPARTMENT OF EDUCATION**

**WITNESS**

**HON. MIGUEL CARDONA, SECRETARY, DEPARTMENT OF EDUCATION**

The CHAIR. I now call to order the hearing on the fiscal year 2023 President's budget for the Department of Education.

This is a hybrid hearing, so we need to address a few house-keeping matters.

For members joining virtually, once you start speaking, there is a slight delay before you are displayed on the main screen. Speaking into the microphone activates the camera, displaying the speaker on the main screen. Do not start your remarks if you do not immediately see the screen switch. If the screen does not change after several seconds, please make sure that you are not muted.

To minimize background noise and ensure the correct speaker is being displayed, we ask that you remain on mute unless you have sought recognition. The chair or an individual designated by the chair may mute participants' microphones when they are not under recognition to eliminate inadvertent background noise. Members who are virtual are responsible for muting and unmuting themselves.

Finally, House rules require me to remind you that we have set up an email address to which members can send anything they wish to submit in writing at any of our hearings. That email address has been provided in advance to your staff.

Before I move into my remarks, I just want to acknowledge that today is the birthday of our ranking member, Congressman Cole. So we want to wish you all a very, very happy birthday, Congressman Cole. We are not going to ask you anything about age or any of those things, but we wish you a wonderful, wonderful day.

Mr. COLE. [Inaudible.]

The CHAIR. And I hope there is bourbon and cigars somewhere in the day.

Mr. COLE. Multiple times.

The CHAIR. Okay. This is great.

I also want to say—and I think Josh Harder may be, you know, virtual—we want to welcome Josh back, who has been, as he explained to me yesterday, changing diapers and staying up late and taking on his responsibilities as a dad. So welcome back, Josh.

So let me acknowledge the ranking member of the subcommittee, Tom Cole, and all of the members who are joining today's hearing both virtually and in person.

And I would very much like to welcome Secretary Miguel Cardona to his first in-person hearing in the subcommittee as Secretary of the Department of Education. You were with us virtually

last year, but there is nothing like being in person, so a very, very warm welcome.

Secretary CARDONA. Thank you.

The CHAIR. There is little more critical to our growth and progress as a Nation than support for the educational success of our students. If the last 2 years have proven anything, it is that as we struggle to overcome moments of so much change, we have a moral responsibility to ensure that our students and the families and teachers that support them every day have the resources to succeed and to flourish.

Schools and learning provide consistency. As educator Horace Mann said, and I quote, "Education, beyond all other divides of human origin, is a great equalizer." And, I would add, is a great constant in the constantly changing world.

Secretary Cardona, you have proven over the last year and throughout your career as a Connecticut educator to be a fighter for the programs and policies that give our students and our teachers the certainty that they need for success.

Next week is Teacher Appreciation Week, a moment to celebrate and to recognize you, Mr. Secretary, and the millions of teachers around the country who dedicate their lives to educating our students. And you and I both know the incredible sacrifice that being an educator entails, which is why the work that you do to support our teachers as they transform students' lives is so crucial.

I also want to acknowledge our parents, who have struggled to get their kids educated throughout the pandemic. And we agree they should have a big role and a big say in their children's education. There are some today who are trying to divide parents and teachers, but by design, our public school systems require significant input from local communities and parents.

Nationwide there are 13,500 school districts with about 90,000 school board members. Around 90 percent of these school board members are directly elected by their communities. One-third of school board members are parents of students in schools or preschools, with over 90 percent of those students attending schools in the districts that their parents represent.

I also get troubled by broader efforts to ban content. That is divisive. The banning of books from public schools and libraries, restricting free speech and access to books is divisive, and it impedes the development of our children. That also must hold at universities and in university libraries where freedom of expression is under attack. This too limits the growth and development of the next generation.

And we should not ally critical race theory with students learning about our history. America has a complicated history, but America is exceptional. American freedoms grew out of our history dealing with Native Americans, immigration, and slavery, and somehow we keep bending the arc toward progress and greater equality.

Strengthening our educational system and our students' learning begins with a strong Department of Education. So I thank you, Mr. Secretary, for joining us to discuss the Department's fiscal year 2023 budget. It builds on the transformative investments we have made over the past year. Under your and President Biden's leader-

ship, historic progress has already begun to improve the lives of our Nation's students, educators, and their families.

This work began with \$170,000,000,000 in the American Rescue Plan fund that were secured by congressional Democrats and President Biden, who moved quickly to reopen public schools, provide emergency grants directly to students, and assist colleges and universities in giving support to students in need.

The Biden administration has also taken swift action to ensure student borrowers are not denied the benefits that they are entitled to. With improvements to the Public Service Loan Forgiveness Program, \$6,800,000,000 in loan debt has been canceled for more than 113,000 public servants, and the administration's new waiver for borrowers and income-driven repayment will bring another 3.6 million Americans closer to loan forgiveness.

And the days of the fox guarding the henhouse at the Department are over. You have advanced strong proposed regulations that will protect students and taxpayers from predatory for-profit colleges, providing relief to the student borrowers that they have defrauded. And despite bad-faith arguments by some, you have proposed reasonable measures that will increase accountability and transparency in the Charter School Program.

Mr. Secretary, I applaud you and the President for your unprecedented support of our students, public schools, colleges, and universities. We have so much more to do as we continue reversing decades of underinvestment in our Federal education system, which is why I am so proud that Congress, led by this committee, passed in a bipartisan way the 2022 government funding Omnibus bill last month, which included historic funding, including an increase of \$2,900,000,000 for programs under the Department of Education.

I am especially proud of the \$1,000,000,000 increase included for Title I to support low-income students in our Nation's public schools, the largest increase in over a decade and, again, on a bipartisan basis. No child in this country should be denied a quality of education because of where they were born, their family's income, or their race or ethnicity.

And with an increase of \$448,000,000 for special education programs, we are also recommitting ourselves to improving the lives of babies, children, and young adults with disabilities.

As chair of this subcommittee, I was excited as we created an initiative on Social and Emotional Learning and whole child approaches, which we funded now for the third year in a row. We have included \$82,000,000 for evidence-based SEL grants; \$85,000,000 for teacher and school leader development that prioritizes SEL training; \$111,000,000 for school-based mental health professional grants; and an increase of \$90,000,000 and \$75,000,000 for full-service community schools, an increase of \$45,000,000.

These programs support students' social, emotional, and cognitive development and positively impact their academic performance and well-being.

Earlier this year, we held a hearing on these strategies where we examined the overwhelming evidence, the evidence based behind these interventions, and we heard how these effective strategies are needed now more than ever, considering the extreme stress and

hardship our country's most vulnerable students have faced during the COVID-19 pandemic.

And to make higher education accessible to even more students, we were proud to fight for and deliver the largest increase in over a decade to the maximum Pell grant, a \$400 increase. We delivered \$96,000,000 to historically Black colleges and universities and minority-serving institutions. We are proud of these critical investments which will make college more affordable for historically underserved students and their families.

Alongside the Department of Education programs, for the first time in 12 years, we included member funding for projects to directly support students and educators in our home districts. We were able to meet the needs of communities all across our Nation through district-specific funding for programs that support students with intellectual and developmental disabilities, mentorship, tutoring initiatives, college success, and learning loss programs for underserved students.

In my own district, \$2,000,000 will help the New Haven public schools as they expand job development opportunities for high school students interested in a career in the manufacturing sector with a new manufacturing education and pathways program.

As we begin the 2023 budget process, we need to build on these critical investments to help even more students and families to achieve that American dream, and I am pleased to see such a strong budget request to do just that.

The President's 2023 request includes \$88,300,000,000 for the Department of Education. It is an increase of \$11,900,000,000, 16 percent above the 2022 level. It would continue to build on the historic investments we have made in Title I, the cornerstone of our Federal support for public education. It provides an additional \$3,000,000,000 discretionary increase to support our students and those schools that are most in need.

The request also prioritizes support for our students with disabilities with a \$2,900,000,000 increase to IDEA Part B grants to States for special education services, and a critical \$436,000,000 increase for IDEA grants for infants and families, for early intervention services available to children with disabilities age birth through two and their families. And it supports English learners and immigrant students with a \$244,000,000 increase for English language acquisition program. A transformative \$393,000,000 increase for community schools will provide critical comprehensive services and expand evidence-based models that meet the holistic needs of children, families, and communities.

Your budget recognizes the immense value of higher education by providing key investments to make college more affordable and accessible for low-income and minority students. I am pleased to see a \$500 increase to the discretionary Pell grant maximum award, an additional \$249,000,000 for HBCUs, MSIs, and other underresourced institutions. We will continue to meet the needs of low-income, first-generation students and narrow our Nation's racial wealth gap and expand access to employment.

Mr. Secretary, the work that you do and the rest of the administration do day in and day out touches the lives of every single student and educator. The investments in this budget request and our

support for our students and our teachers ensure that our government will get one step closer to leveling the playing field so that every child and every student has a fair shot that allows for their God-given talent to help the opportunities that are created where they can flourish in our society today.

I look forward to working with you over the next year, looking forward to our discussion this morning. And thank you for being here today.

And, with that, let me recognize our ranking member, Congressman Cole, who has a very strong commitment to public education and the opportunities that it opens up and provides for our children. And I would like to yield to the ranking member for his opening remarks.

Mr. COLE. Well, thank you very much, Madam Chair. And you have been so kind to wish me a happy birthday, but this is a much more important day than my birthday. It is the first meeting of the big four.

The CHAIR. That is right. That is later today.

Mr. COLE. So I wish you well later today as you sit down—

The CHAIR. Thank you.

Mr. COLE [continuing]. And I want to take—

The CHAIR. What do we think about bourbon and cigars for that meeting?

Mr. COLE. I tell you what, it would go a lot better. I would be happy to send you in with all you need if you think that would loosen them up.

But I want to, again, take a minute before I get to my prepared remarks and just thank you, again, for getting us through the last process. You and Ranking Member Granger working together I think were critical to that. I think this committee took the leadership role, quite frankly, in pushing the process forward, and nobody did that more than you. And I am glad to see it is starting a little bit earlier this year and everybody has worked together.

So I will make a commitment to, once again, try to work with you and make sure that we get this budget done hopefully within the fiscal year but, if not, certainly within the calendar year. I think it would be a huge mistake for this budget to go into next year. And that is something we should all want to avoid.

That is not fair to the administration. It slows them up in terms of making important decisions. It is not fair to the next Congress. They shouldn't have to vote on appropriations bills that they were not here to be part of.

So I take considerable pride in the fact that for 7 years in a row you and I have managed to get this bill across the line. It didn't matter who was chairman, didn't matter who was ranking member, didn't matter which party controlled Congress. It didn't matter what the administration was. We've gotten it done under every conceivable scenario, and I would certainly like to make it eight in a row.

And I want to thank you for being such a good negotiating partner and such a good leader for this full committee in terms of us forcing our sometimes slower-moving Senate colleagues to actually do the work that they were elected to do.

Mr. Secretary, it is very good to see you this morning. And we don't always agree, but I always find you agreeable and professional and particularly accessible to this committee, and I appreciate that very much. You know, COVID has been a difficult time, but you have always made time anytime we have had questions or comments or whatever, and I appreciate the spirit in which you approach your job.

And, again, welcome. As the chairwoman said, it is great to get to deal with you in person and as many of our members as can be here in person.

I will start by, once again, expressing concern regarding the total level of spending proposed by the administration. I have been a longtime supporter of helping achieve better outcomes for our students, but I fear the proposed 15 percent increase for the Department of Education will leave the next generation saddled with the highest national debt our Nation has ever seen.

The fiscal year 2022 budget was just completed last month. We know it will take some time to get those funds out the door. A more moderate approach, in my view, is called for, especially in this time of runaway inflation.

I would like to turn next to the topic of which I believe is one of the greatest failures of the Federal response to the COVID pandemic, and that is the closing of many of our Nation's public schools for almost 2 years, and the subsequent lost student learning and mental health issues that are flowing from these bad decisions.

Your budget proposes increases in mental health and counseling to help with these issues, and I appreciate that. But the sad truth is we can never give those children back those years of their lives, and some of these wounds may never heal. In many cases, a growing level of learning in an adolescent, progress a student with a disability was making, or basic skills that were beginning to be solidified by a young student may have been lost forever.

A recent survey conducted by the Government Accountability Office highlighted just how widespread and profound these losses are. Their survey discovered that nearly half of public school teachers had students who were registered for class but literally never showed up online. Even more disturbing, students who never showed up came mostly from majority non-White urban schools. These are the very students that our Federal programs are in place to support, and I think our country will be seeing the negative consequences from school closures for years and years to come.

So, I certainly hope it is an experience—I know we all share this hope—that we don't have to go through again.

I will also ask some questions this morning on what I believe to be executive overreach on the charter schools policy. One of the greatest benefits of the charter school movement has been the fact that these schools are locally developed, authorized, and operated. The Federal role in charter schools has been one of providing limited financial support to secure physical infrastructure and some startup grant funding, but the Department of Education is not a national school board or a national chartering authority.

I agree with the 18 Republican Governors who have recently called for your department to pull back proposed regulations that

would, as they say, quote, impose a top-down, one-size-fits-all approach and undermine the authority of parents to choose the educational options best suited for their child, unquote.

I would like to ask unanimous consent to submit for the record a letter from our former colleague, now Governor Jared Polis, which outlines very well his objections and concerns to administration actions.

Is that all right?

The CHAIR. Yes, so ordered.

Mr. COLE. Thank you very much, Madam Chair.

My own State of Oklahoma has a long history in the charter school movement, and I believe that States, not the U.S. Department of Education, should continue to be responsible for what charters they do or do not authorize to operate within their jurisdiction.

I would also like to touch today on another area of executive overreach, and that is the President's recent decision to extend the student loan repayment pause to August 31. Not only is this inflationary, but there are also people making literally hundreds of thousands of dollars a year who aren't being asked to repay their student loans. I think that is unfair. And I have introduced legislation called the, quote, "can't Cancel Your Own Debt Act," to prohibit Members of Congress from voting to forgive their own student loans. These folks are making \$174,000 a year. Even if a Member favored debt cancellation for most people, we should not support this policy for people making this type of salary at the expense of our taxpayers and constituents.

Finally, I hope to discuss today another area which greatly concerns me, and that is the politicization of programs like civics education with controversial priorities and grant announcements. Programs like civics education should be used to bring our country together and focus on our own commonalities while teaching respect for our differences. Sadly, I fear that recent announcements put out by the administration have only fanned the flames of controversy and division rather than heal them. That is a disappointment.

In closing, I would like to say that as a longtime member of this subcommittee, I understand the important role played by domestic programs, and I certainly support increases for these critical programs.

I was pleased to see support for special education in your budget. We know the Federal Government has not upheld its fair share of responsibility for ensuring education is provided for students with a disability, and I hope we can see achieving support for sustained increases for special education as a bipartisan goal.

I also believe in strong support for Pell grant recipients and the TRIO and GEAR UP Programs. Pell grants and participation in TRIO and GEAR UP help first-generation college students chart a course to a better future into the middle class.

We need to continue to help these students not only enroll, but also graduate and find good-paying jobs. Unfortunately, our double-digit inflation is eating away at the salaries of these recent graduates and making it more difficult for them to establish themselves in their careers.

I also believe that we should do more to help underserved populations and underperforming schools. I support programs to

strengthen our teachers and school leaders, and I support the Title I program. But I also question whether simply dumping billions of dollars into the program without careful planning is the best way to help undo the damage caused by 2 years of school closure.

I want to again thank you, Mr. Secretary. Again, as I said, while we don't always agree, I do enjoy working with you, and I do appreciate the manner in which you approach your job and which you represent the Department.

I yield back the balance of my time, Madam Chair.

The CHAIR. I thank the ranking member.

And, Mr. Secretary, let me recognize you, and your full written testimony will be entered into the record. You are recognized for 5 minutes for your opening statement.

Thank you.

Secretary CARDONA. Thank you.

Thank you, Chairwoman DeLauro, Ranking Member Cole, members of this distinguished subcommittee. Good morning and thank you.

And, Mr. Cole, I would sing happy birthday, but the clock is running and I have 5 minutes.

Today's hearing is about more than the President's budget and proposed investments for the fiscal year 2023. It is about the needs of our students and how we can meet them if we work together.

The priorities in the budget reflect what I have learned in my visits to 32 States across America this past year. I visited schools in small towns, in affluent suburbs, urban and rural communities, including Tribal communities. And I know that addressing opportunity and achievement gaps is more important now than ever. I met with parents in Nevada worried about their kids catching up in the classroom. The gaps in underserved communities are so much greater now.

Let's close those opportunity gaps by boldly investing in our Title I schools. This is our best tool for reducing inequities between underfunded schools and their wealthier counterparts.

Let's also invest in full-service community schools, which provide high-poverty communities with easier access to services, like health and nutrition, enrichment, adult education, and more.

Last week in New Mexico, I met with students struggling with anxiety. They had depression, trauma from losing parents amid the pandemic. Our children are hurting. Anxiety and depression have doubled among youth. Teen suicide rates are up. It is heart-breaking.

Let's do something about it. Let's invest a billion dollars in hiring staff and building their skill set to support students' mental health needs so they can be their best in the classroom.

I met with superintendents and principals in red States and in blue States trying to fill vacancies so that teachers could spend more time providing that individualized attention that our students need now. The teaching profession is in crisis, and we have a solution.

Let's support and grow our educator workforce. We are proposing a half billion dollars for education, innovation, and research grants, including \$350,000,000 for recruiting and retaining teachers. Re-

member what it was like when we couldn't open our schools because of teachers and sub shortages. Let's not go back to that.

Let's invest in teacher quality partnership grants so more States can stand up innovative teacher residencies and Grow Your Own programs that prepare new and diverse candidates, like the programs I saw in Tennessee.

What I haven't heard is an appetite from parents for sowing division in our schools, or using our schools for culture wars, or telling students what they can or can't read or can't learn, or telling teachers what they can't teach, or telling any person what they can or can't be.

I know there are some that would rather distract and divide and spread misinformation to undermine our public schools and gain attention, but that is not what the parents that I have spoken to told me they want. That is not what I want.

Based on a recent survey, the overwhelming majority of parents, teachers, principals are on the same page about what children need in our schools. Our parents need their children to learn.

The American Rescue Plan got us this far. Today our schools are open for in-person learning, and our teachers are deep in the work of recovery. Now is our opportunity to reimagine what education can be. With your investments, let's build more inclusive, affordable pathways to higher education and rewarding careers for all of our students.

College enrollment has fallen by nearly a million students. We can't afford this. Let's invest in community colleges, historically Black colleges and universities, Hispanic-serving institutions, Tribal colleges, and other inclusive institutions, and let's build on the \$400 Pell grant increase you included in fiscal year 2022. We could double the Pell grant by 2029 if we start with another bold increase of \$1,775 for this upcoming year.

We know that these days a high school diploma is no longer a ticket to the middle class. We shouldn't let any student walk off the graduation stage without an onramp to a good-paying job.

Therefore, we are proposing \$200,000,000 for career-connected learning so more underserved students graduate high school with industry credentials and college credits. This is good not only for the students but for the economy.

Look, education gave me the tools to achieve the American dream. I grew up in a low-income community. I only had what the public schools offered me at that time. I attended a Title I school, and I graduated from a technical high school. I became a first-generation college student. I am a bilingual certified educator who benefited from quality teacher preparation and professional development. I am a product of the investments in this budget. Education brought the promise of the American dream alive for me. We must renew that promise for today's students and those to come.

This last year we fought hard against COVID. Together, this upcoming year, let's fight complacency. Let's not accept the culture of low expectations. Let's not return to the systems that weren't working for all students. Who here in this room hasn't wished for a reset button in education, a chance to take stock of our system and reimagine what it can be?

Well, our country is at a point of inflexion. Let's use it to re-imagine education, to show the American people we can come together, red and blue. We can come together to fight for what is right for our students. This budget is a chance to do that. So together, let's seize the opportunity.

Thank you.

The CHAIR. Thank you very much, Mr. Secretary.

And I know you have been a proponent of keeping our schools open, and I am happy to say that it was the American Rescue Plan that accelerated the opening of our schools nationwide.

Mr. Secretary, I strongly support the Department's modest—what I believe are modest, good government proposals for the 2022 Charter School Program competitions. However, the National Alliance for Public Charter Schools has been spreading wild exaggerations and misrepresentations in opposition. This kind of information campaign is a familiar tactic for the trade organization. It does represent charter schools that are run by risky, low-quality, for-profit education management organizations.

And I would just cite a couple of the examples of the recent expansion grants awards that were made to something like—you know, the Torchlight Academy Charter School in North Carolina now being shut down. Capital Collegiate Preparatory Academy in Ohio has been passed from one for-profit operator to another. A New York school, they have oversized fees for its services.

So as I point out, the modest—what I believe are modest, good government proposals for your charter school reform, what I would like to do is to ask you, what are the new proposed requirements in the Charter School Program and why are they necessary?

Secretary CARDONA. Thank you for the question. I appreciate an opportunity to speak to this, because there have been some misunderstandings and, quite frankly, some myths being spread.

I support all high-quality schools, including public charter schools. The budget continues the Charter School Program investment of \$440,000,000. I think the proposals are reasonable. And what they ask for is greater accountability, transparency, and fiscal responsibility. Again, they are proposals at this point.

And it is absolutely accurate that we do not authorize charter schools. If anything, when using Federal dollars, we do want there to be reasonable expectations around accountability, transparency, and fiscal responsibility.

The CHAIR. Let me just—I also, to move in a similar direction, am concerned by the proliferation of contracts between universities and online program management companies, OPMs. We had a Wall Street Journal investigation expose how the University of Southern California, in a for-profit OPM known as 2U, recruited thousands of students to an expensive online graduate program, which left student borrowers with a median debt of \$112,000 and median earnings of \$52,000 2 years later. And by the way, they received 60 percent of the program's total revenue, because they shoulder the cost of setting up the program by an exchange for getting a cut of the tuition. And calculated, USC could have been generating about \$142,000,000 for their for-profit company in 2021.

What will the Department do to protect students from the OPM cost escalation and recruiting abuses? And The Wall Street Journal did a very fine piece on this issue.

Secretary CARDONA. Thank you for raising that issue. It is really important that we maintain positive support for students, and that we, in all the decisions we make, are protecting our students, protecting our borrowers. We worked really hard this last year to move forward with policies and practices that keep our borrowers first, including borrower defense.

But one specific thing that I want to talk to regarding that is we reinstated our Office of Enforcement and the FSA Office. This office was disbanded, and we brought it back to make sure that things like that are not happening and making sure that we are protecting our students.

We are also in communication with college presidents to monitor situations like this because students aren't benefiting. We are going to continue with our borrower defense, but we are also going to make sure we are having communication with universities so these things are not happening.

Thank you.

The CHAIR. I would just say with regard to that, this is about harming student borrowers, but it is also about ripping off Federal taxpayers.

Secretary CARDONA. Right.

The CHAIR. Because the issue is with the—what is being proposed are—the Federal grad plus program that exists there. It lets students borrow as much as colleges charge, has provided a valuable revenue stream for universities, and that leaves students in debt and a greater proportion of revenue for the university.

So, again, I would just like to say to you and ask the Department to take that lead in protecting students from these agreements, and protecting the integrity of the student loan program for Federal taxpayers. It is about students and the Federal dollars that we are expending, and happy to do if they are going to good causes in that effort. So, I thank you.

Secretary CARDONA. Thank you.

The CHAIR. And, with that, I am going to yield to my colleague, the ranking member. And also ask my colleague, I have to dash to the Ag subcommittee for a few minutes and I'll be back, so I am going to ask Congresswoman Roybal-Allard to continue to chair the meeting.

Thank you.

Ms. ROYBAL-ALLARD [presiding]. Mr. Cole.

Mr. COLE. Thank you very much, Madam Chair.

Mr. Secretary, 18 Governors sent you a letter this month outlining their concerns with new regulations altering the Charter School Program. Quite frankly, the regulations, in our view, would dismantle, you know, frankly, a successful Federal, State, and local partnership that really has enabled millions of children to have a public education but in a setting that, in their view and their parents' view, best fits their needs.

Will you extend the comment period for these regulations to reflect the magnitude of the changes and to allow more time for public input?

Secretary CARDONA. Thank you, Ranking Member Cole. As I said before, I do support high-quality public charter schools, and I have seen examples of their effectiveness. We have had the public comment period, and we are reviewing the comments now. We have received the letters. So, we do have a process for reviewing comments that have been submitted.

Mr. COLE. And I recognize that, but I would hope you would extend that. I think, again, when you are hearing from nearly 20 Governors—and, frankly, not all Republicans. Obviously, our friend, Mr. Polis, is not a Republican Governor, but he certainly was a very able member of this body, very respected Governor. So, I would ask you to at least consider that.

And, you know, I would like to know what your attitudes are in terms of regulations that limit local control, including the new requirement for community impact analysis, which would mandate school districts be overenrolled, if I understand it correctly. And, you know, why would we do that? Why wouldn't we just let local people make their own decisions as to what is best for their kids?

Secretary CARDONA. We do agree. And I can tell you personally I do agree, as a former district person, that local decisions should be the ones that are driving, and I certainly continue to support that.

What I do think we have are reasonable expectations around getting an understanding of what the needs are in the community as a proposal to make sure that there is interest and make sure that the schools stay open. We want to make sure that these schools stay open.

Mr. COLE. And I would like you to at least consider delaying changes to the program—these are pretty major changes—until next fiscal year, so that we can continue to operate this year under a system everybody understands. I know there is never a convenient time to make a change, if that is the decision that is ultimately made, but I think it takes a lot of time to adjust to that. And whether or not we could implement—and, frankly, I hope we don't because, obviously, I don't agree with a lot of these proposals—in a timely way and give administrators and students, local school officials, an opportunity to adjust, I think, in the time-frame is something worth considering.

Is that something you have concerns about?

Secretary CARDONA. Thank you, Mr. Cole. We will take that into consideration and make sure that we are providing adequate technical assistance to all of the folks we serve.

Mr. COLE. Let me ask you something that caught my eye, because this is a very robust budget, but in two areas you actually reduce spending, I think, by about \$3,000,000 in Indian education, about \$16,000,000 in Impact Aid.

I will tell you, I have district concerns in both those areas. We have, as you know, a large Native population in Oklahoma; and, second, my district has two huge military facilities that, frankly, draw a lot of kids into local schools, but, obviously those facilities don't pay any State or local taxes. We get that. We are very proud to have them, but we certainly appreciate impact aid to help us offset the cost of those students that come with the service families that are located there or even the civilian workforce.

Secretary CARDONA. Thank you for that, and I couldn't agree with you more. I was able to visit Knob Noster High School recently. A hundred percent of the students were military-connected families, and let me tell you, I heard from students directly. We need to increase Impact Aid. And that was a community that did a great job—it was in Missouri—did a great job using Impact Aid.

And I last week was in New Mexico in the Pueblo of Jemez Tribal Nation, and I know the importance of funding there.

I think—well, I know the reason why it looks like a cut—it is an artificial cut—is because the submission was done after the 2022 allotment. So it looks like it is a cut, but it is not. We were using 2021 numbers because the Omnibus hadn't been passed.

Mr. COLE. Well, I certainly recognize that, because we weren't quite as speedy as I know we all would like to be in getting you numbers, and I just want to flag that for you because I will be trying to work with you to get a more appropriate number. Those are areas that have been underfunded.

Secretary CARDONA. Thank you.

Mr. COLE. And, again, I appreciate the technical difficulties that you had to face putting together your budget before, frankly, we had finished our deliberation. So that is a fair point.

I am close to the end of my time, Madam Chair, so let me yield back.

Ms. ROYBAL-ALLARD. Mr. Secretary, welcome.

Secretary CARDONA. Hi.

Ms. ROYBAL-ALLARD. As you know, many of our students in higher education are facing the burden of college tuition and rising costs of living, including food, housing, and child care. This is especially true for the 4 million parenting students who are pursuing a college degree or credential while taking care of a dependent child.

According to research from The Hope Center at Temple University, parenting students are much more likely to struggle to find and afford enough to eat for themselves or their families and maintain stable housing. Without proper support, these students are at risk of dropping out of college.

And I am happy that the administration is requesting an increase in the CCAMPIS program. Can you speak to how the CCAMPIS program helps parenting students and how it can be used also to help connect struggling students to more resources of financial support, as well as programs such as SNAP, WIC, and TANF?

Secretary CARDONA. Right. Thank you for that question. The Child Care Access Means Parents in School, or CCAMPIS, is something that I was able to see firsthand. And I think we have an opportunity, when I talk about reimagining education. We must look at this as an opportunity to attract students who may not be traditional students. There are many people during the pandemic that had an epiphany and wanted to change their trajectory in life, and they want to go back to school. And the CCAMPIS program is one of those programs that I saw firsthand allows parents to go back to college, pursue their degree, chase that dream.

I will speak to a situation that I was able to witness firsthand in Bergen County Community College where CCAMPIS was being

used to allow parents to attend while their children had childcare on campus. I spoke to a young lady, Kezia, who attended that college, and she and her husband were there, and their twins were down the hall in a childcare center being cared for while she was studying. And she said: This CCAMPIS, these funds are not only allowing me to change the trajectory of my life but that of my children, her two twins.

So I—for Kezia, she wouldn't be able to go to school if it weren't for CCAMPIS.

I remember visiting Nevada and talking to students there in a community college who were homeless, and the community college was trying to help them find housing, so they were making connections.

We have an opportunity to embrace students who traditionally didn't think of themselves as college students in this new wave now, and I really want to take advantage of it. Programs like CCAMPIS make that possible.

Ms. ROYBAL-ALLARD. Now, the fiscal year 2022 Omnibus actually lifted the cap on CCAMPIS grants, which limited an institution to receiving only 1 percent of its Pell grant receipts. By removing the cap, the Department of Education can now set a higher limit of support for CCAMPIS.

How much of an increase can schools expect to receive, and will there be any changes to the eligibility criteria?

Secretary CARDONA. We are requesting \$95,000,000 and we want to make that available for as many schools as possible. I can share more information about the criteria for that, but the goal really is to make sure it is available to more students across the country so more can have access to higher education.

Ms. ROYBAL-ALLARD. This year, we—you know what, I am also very close to ending, so I won't take the prerogative of the chair to go over my time, and I will now call on Mr. Fleischmann.

Mr. FLEISCHMANN. Thank you, Madam Chair, Ranking Member Cole.

Mr. Secretary, good morning, sir.

Secretary CARDONA. Good morning.

Mr. FLEISCHMANN. Thank you for being with us in person today. Really appreciate this.

I think we can all agree that we are glad to be back in person, and especially to have our students back, sir, in the classroom for in-person learning.

Secretary Cardona, the most recent data shows that 3.5 million STEM-related jobs will need to be filled by 2025 in order to maintain a stable workforce. It is imperative that we continue to support public-private partnerships to close the skills gap and cultivate a diverse workforce.

Last week, I was privileged to visit the Middle Valley Elementary School located in Hixson, Tennessee, in my district, to observe their public-private partnership with Amazon, a program that supports almost 175 schools with computer science curriculum, robotics clubs, and other learning opportunities. Actually, it was quite inspirational, very uplifting.

What is the administration doing to encourage more public-private partnerships in STEM and computer science literacy?

Thank you, sir.

Secretary CARDONA. Thank you for that question, Mr. Fleischmann. I couldn't agree more with you that we need to do much more. We are not doing enough currently. We need to make sure that our students are connected to great STEM programming within our schools, that are connected to the regional workforce needs, connected to the 2-year programs, the 4-year programs. I am really excited about the priority of redesigning high schools and providing better career pathways.

We have asked in the budget for \$200,000,000 for career-connected high schools, new competitive awards that reinforce districts like the one you visited and give them funding to make those programs consistent and grow those programs.

We have an opportunity now to reimagine what career pathways look like. Those are one of my priorities at the Department of Education. Not only do we want to address achievement disparities, we want to make sure we are connecting our high schoolers, our college students to careers that exist today in the STEM fields.

Mr. FLEISCHMANN. Thank you sir.

A followup. How can we provide continued professional development in STEM and computer science literacy for our teachers specifically, sir?

Secretary CARDONA. Right. Thank you for that. We have to make sure that, as we are doing these public-private partnerships, they include providing support for our educators, giving them real-life experiences to see what the jobs look like today, right? So I can envision having one of our teachers partnering with one of these regional workforce partners and having trips for the teacher to see what the site looks like and gain skills there, or something where it is co-taught or an after-school program for professional development for our teachers.

Mr. FLEISCHMANN. Thank you, sir.

And the final question for this first one here is, how important is early exposure to STEM and computer science curriculum to get students exposed to that early, sir?

Secretary CARDONA. Yeah. It is really important that we start early. We have to start in elementary school, and we have to make sure that we are connecting it to real world experiences, real world jobs. And by the time they get to middle and high school, students should be exposed to the different careers that there are in STEM, and there are many and they are growing.

Mr. FLEISCHMANN. And, Mr. Secretary, I would like to put something on your radar, if I may, and for our other members. I would like to encourage members on this subcommittee to consider co-sponsoring H.R. 3602, the Computer Science for All Act. This is something that actually our distinguished colleague, Ms. Barbara Lee, from the majority, is working with me on. She is the lead Democrat; I am the lead Republican. The Computer Science for All Act, which provides new grant opportunities that would make computer science education more accessible for all students, pre-K through 12th grade.

So, Mr. Secretary, thank you. I would like you to take a look at that legislation, and I would appreciate members of our subcommittee to take a look at that as well.

Thank you.

Secretary CARDONA. Thank you.

Ms. ROYBAL-ALLARD. Ms. Clark.

Ms. CLARK. Thank you, Madam Chair.

And welcome, Mr. Secretary. We are delighted to have you here.

I can't thank you enough for prioritizing the mental health and well-being of our students. In a recent survey out of Massachusetts, 60 percent of the parents and caregivers responded, reported at least one death in their family, 60 percent, and we know what a crisis this is. It is a compounding crisis to one we were already facing, and I appreciate the resources that you are putting into this.

Secretary CARDONA. Thank you.

Ms. CLARK. I want to specifically ask, as we are facing a dual crisis of retaining and recruiting educators, how is your budget also addressing the mental health needs of those educators as you are doing so well with our students?

Secretary CARDONA. Yeah. I appreciate your acknowledgment of the crisis that we are having in mental health.

I had a lunch with Dr. Xia yesterday. We were talking about how the crisis went from counting cases to thinking about the impact of mental health on our students, on our staff, on our community in general, and how we must continue to put energy toward addressing them.

I am really proud that with ESSER—thank you for the support of ESSER—there is a 65 percent increase already in social workers in our schools, 17 percent increase in counselors, but we have got a ways to go.

What we want to do is make sure that we are not just adding one or two more counselors; that we are giving students an opportunity to have mental health support not only during the school day but outside of the school, parents having access to mental health support or being able to access support through connections with the school.

We are proposing funds in the fiscal year 2023 to really make it more foundational in our schools. I will tell you, Representative Clark, we had mental health issues in our schools that were unaddressed before the pandemic. They were just made worse. But we have a moment now to really make sure it is a foundational support that we provide our students, and I look forward to leading that.

Ms. CLARK. Are we also going to be able to provide that to our educators? Is that part of the plan you are working on?

Secretary CARDONA. Without question. You know, we cannot act as if only our students suffered during the pandemic. I have spoken to teachers in all of my visits, who are doing everything they can for their students, but are also struggling with changes in their family or loss in their family. So making it more accessible to our staff is going to be critical if we expect them to be there for our students.

Ms. CLARK. And speaking of staff, we know we have lost almost 117,000 early education jobs, and I know that we have spoken about this privately before.

Secretary CARDONA. Yes.

Ms. CLARK. But what strategies have you considered, are you working on, to build a pipeline of students who are pursuing early childhood credentials and training that are going to be so necessary for our childcare needs of the future?

Secretary CARDONA. This is an area of opportunity. Much like Mr. Fleischmann's questions with STEM, we must really reinvent Grow Your Own programs in our schools. I speak to Tennessee's program. They have a program in their high schools where students are going toward teaching, and there is a relationship between the high school and the college.

In the budget, the request is \$514,000,000, a \$288,000,000 increase over the 2022 enacted level, to develop Grow Your Own programs, to invest in these teacher preparation programs.

The shortages are real. They are going to get worse if we don't invest in them. And as I said in my opening remarks, in January, we dealt with school closures not because of Omicron, but because we didn't have the staff, and we can't afford that in this country.

Ms. CLARK. In my brief 1 minute, we know how much LGBTQ students are facing attacks that are compounding this mental health crisis that we have been talking about. Can you tell me about how the increased funding for your Office for Civil Rights, what that funding will go to, and what is the level of need and cases being reported to the OCR that you are seeing?

Secretary CARDONA. A recent study by GLSEN found that LGBTQ students are bullied 42 percent compared to 15 percent of non-LGBTQ students. It is an issue that we are taking very seriously. Supporting the Office for Civil Rights will help us be more expedient in the investigations, and ensure that all students are going to school in an inclusive environment that sees them, respects them, and welcomes them.

Ms. CLARK. Thank you.

I yield back, Madam Chair.

Ms. ROYBAL-ALLARD. Ms. Herrera Beutler.

[Audio malfunction.]

Ms. HERRERA BEUTLER. Thank you so much, Mr. Secretary. So I have just been—there is so many different things I wanted to talk with you about. I am going to start—I think I am going to start with this—let's see, I am going to start, actually, with the proprietary schools issue because, you know, I am a huge fan of Pell. I am a big supporter of Pell. I think it helps nontraditional students. And I am—you know, a year-around Pell increasing it, I think it just gives a lot of flexibility.

And one of the things that has been brought to my attention is that there seems to be a real anti-proprietary school ideology within the administration. And I know that there have been bad actors, but I also know there have been really bad actors in public, you know, school systems on the secondary level too. So I think apples to apples, there are similar challenges.

But when I think about the population that do take advantage of proprietary schools, it is primarily women. It is a lot of 40-year-old women. Maybe I am looking for a job. Oftentimes, it can mean people of color or people who are looking for a second career or who maybe only have a high school degree but want to earn something more than minimum wage. And to tell that whole block of people,

Well, you don't fit the 4-year liberal arts academics, when the 4-year schools right now, especially the top—you know, not even the top schools. You know, middle schools—you know, middle range schools are not accepting—I mean, they are 50 percent acceptance rates, and that is a good acceptance rate. It seems to me you are cutting out a whole class of trade workers by refusing to support their desire to attend a proprietary school.

Could you speak to that?

Secretary CARDONA. Sure. Thank you. Thank you for that.

And I agree with you. We have to create stronger career pathways. I am really looking forward to making sure that all schools, high schools and 2-year schools, do more there.

There are many great short-term programs that deliver great value to students. Last week, I was at D.C. Central Kitchen—

Ms. HERRERA BEUTLER. I am going to—I am so sorry. I am going to cut into that really quickly just because I am going to be cognizant of my time.

Secretary CARDONA. Okay.

Ms. HERRERA BEUTLER. Specifically, I am aware of current rule-making at the Department of Education, surrounding eligibility requirements for programs authorized by Title IV, and I have heard that cosmetology schools in my district feel like their opinions haven't been considered in this process and it could threaten their ability to provide financial aid to their students.

So I guess more specifically, as that rulemaking process moves forward, can you commit to actively at least engage with these schools and hear from them as you are making the rules about it?

Secretary CARDONA. Certainly. We definitely will, and I appreciate your advocacy, and we can provide a more detailed written response also.

Ms. HERRERA BEUTLER. I would love that.

Secretary CARDONA. Happy to work with you on this.

Ms. HERRERA BEUTLER. Thank you.

Secretary CARDONA. Thank you.

Ms. HERRERA BEUTLER. Thank you so much.

I just think the nontraditional route needs to be just as valued. I have brothers in the trade that didn't go to a 4-year school, and I just think it is the way we need to look at higher education.

Another piece along that line—and I guess I am going to switch over to the K–12 system. I received an email from some of my—from parents in my district who said that, due to a Federal law, they needed to submit their child's demographic information to the school. This was a public high school. It was my public high school district that I went to.

I know that the Office for Civil Rights has taken steps to increase data collection on students and update definitions, but as you can understand—I mean, this basically says, We are getting this message—this is from the school to the parent—because you haven't updated ethnicity information for your student. Due to new Federal laws, yada yada, we need to keep all this information. Of course, we are going to forward it on to the State, but we won't put your kid's name in there, which every parent has concerns about that privacy issue.

Could these updated data collection requirements create an additional administrative burden for schools, and how do you plan to keep that information private?

Secretary CARDONA. Thank you. Thank you for that question.

You know, student privacy, as a father of two high schoolers myself, I certainly want to make sure that they are protected and their information is private and it is not everywhere else. I believe you are referring to the CRDC report, Civil Rights—

Ms. HERRERA BEUTLER. I don't know. The parent didn't know.

Secretary CARDONA. And I would be happy to have a followup with you and even the school, if necessary, to make sure that it is clear for that parent what they are asking for.

For us, ensuring that schools are providing students with opportunities to succeed, all students, regardless of race, gender, is critically important. So I believe it is referring to the CRDC report. Happy to follow up with you to get more on that.

Ms. HERRERA BEUTLER. Okay. And I have more questions. Some of them have to do with mental health, which I know we are going to talk about. Hopefully, we will get a second round of questions maybe?

Ms. ROYBAL-ALLARD. Yes.

Ms. HERRERA BEUTLER. Okay. With that then, I will yield back. Thank you.

Ms. ROYBAL-ALLARD. Ms. Frankel [inaudible]

Ms. Frankel.

Ms. FRANKEL. Oh, yeah. Hello. Yeah. Thank you.

Thank you to Mr. Secretary. I want to ask you just a question on title IX. I know that you are working on some new rules. Can you give us a progress report on that?

Secretary CARDONA. Sure. We are working on the new rules, and we are expecting next month that they are released in May. So I can't really get into specifics now, but at the end of the day, the goal is to make sure we have equal access, protect students against discrimination, and protect students against sexual violence.

Ms. FRANKEL. Okay. Thank you very much.

Just another title IX question. According to the research for the Women's Sports Foundation and the National Women's Law Center, girls of color have not benefited from title IX the same way as White girls. And so Black girls face disadvantages both based on race and gender and have lacked access to participation in schools, sports, and other activities that are available to boys. Any comment on that? Any efforts that your department is going to make to remedy that?

Secretary CARDONA. Thank you for the question. You know, it is put in—title IX was put in to ensure equal access, and we still have a ways to go. The question that I had before you—you asked the question was about the reporting that was done, the CRDC report. That helps us get information to ensure that, regardless of race or place, students are getting a high-quality education with equal access to extracurricular activities to high-level courses. And that is why we collect those data, to ensure that we are supporting districts, supporting States that are maybe inadvertently creating gaps in opportunities for students.

This is our responsibility to make sure all students in the country have access. And looking at those data really makes us—reinforces the important work that we are doing to collect those data but, more importantly, to provide support to our States and districts and make sure all students, regardless of race, socioeconomic status, have access to high-quality learning and high-quality after-school activities.

Ms. FRANKEL. So let me just do a follow-up, because I am a big advocate for sports and children playing sports. It is not just fun, but they learn so much—

Secretary CARDONA. Right.

Ms. FRANKEL [continuing]. About themselves, about being part of a team. So this year marks the 50th anniversary of Title IX. Wow, that is unbelievable. And I know we have made a lot of progress. Still, I think there is—research shows that the majority of high school administrators still don't know who their title IX coordinator is, and that 83 percent of college coaches say they have never received formal title IX training.

So it is hard—when people are ignorant of the law, sometimes it makes it harder to enforce it and may be partially the reason why we still have this discrimination or lack of activities for—especially for girls of color.

Does your department have designated funding for training title IX coordinators, and do you have any kind of plan of action on this effort?

Secretary CARDONA. Yes. Thank you for that question. I agree with you wholeheartedly. Cocurricular activities—and I don't like to call them extracurricular, because they are not extra, they are cocurricular activities—must be a part of the experience for our students. In fact, due to the American Rescue Plan, I put a challenge out there for every high school student to be connected in at least one cocurricular activity, whether it is theater, athletics, clubs. We should make sure that every student feels connected.

And, yes, the Department of Education, as we celebrate the 50th anniversary, have several events planned. We have had webinars. It is unfortunate those data that you shared with me regarding the lack of understanding. We will be amplifying the importance of it, making sure that we can reverse those data that you shared. All athletic directors, all school leaders, all district leaders should make it very clear who the Title IX coordinator is but, more importantly, the purpose of Title IX and the importance of having access for all students.

Ms. FRANKEL. So I—yes, I agree with you on that latter point. So—but do you have plans to follow up to make sure that that happens?

Secretary CARDONA. Yes, we do.

Ms. FRANKEL. You do, okay.

Secretary CARDONA. Yeah.

Ms. FRANKEL. I don't know—I lost you off the screen. I don't know what happened to you.

But I will yield back. I do have another, I think, important question, but I will yield back, if we have another round.

Thank you so much, Mr. Secretary.

Secretary CARDONA. Thank you.

The CHAIR [presiding]. Mr. Moolenaar, and we are following each other at the various hearings, so—and my apologies again to the committee. There wound up being two subcommittees that I had to be at.

So Mr. Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair. Appreciate it.

And, Mr. Secretary, good to see you again. I want to follow up with you on some of the questions Mr. Cole had raised regarding the charter school. And, I guess, you know, when I read some of the comments from previous Presidents, President Obama once said that charter schools serve as incubators of innovation and give educators the freedom to cultivate new teaching models and develop creative methods to meet students' needs.

And then when you think of President Clinton when he celebrated the passage in the Senate, the first charter school's legislation, he said that it puts the Federal Government squarely on the side of public school choice and innovative charter schools.

And, you know, when I heard you speaking earlier about transparency, accountability, fiscal responsibility, I think everybody would be in agreement that that is important in public education.

What I am concerned about is the proposed rule really seems like kind of a radical departure from this idea of allowing innovation, encouraging innovation, and specifically this community impact analysis at the expense of people trying to start a charter school.

My experience with charter schools is they form in a variety of ways, but often it is parents, teachers coming together, seeing a need that is not being met, an opportunity, a tremendous amount of work and cost to start something up. And by putting sort of a one-size-fits-all Federal rule that discourages that and creates more burdens, more costs, you are actually—whereas you may be, you know, an advocate for high-quality charter schools, and I don't—you know, I take you at your word on that, but what you are doing is, by this new rule, discouraging new innovation, discouraging people to take the risk to jump in and be part of this.

Like Mr. Cole, you know, I think that the comment period is pretty tight. And I would just encourage you to consider extending that, really look through to see what can be done to encourage some of the things that you are talking about in terms of transparency, but at the same time, not put a burden on people who are trying to do something innovative in a community because there is a need that is not being met. So I would just ask you if you would consider that, think through that, and any feedback you have on that.

Secretary CARDONA. I appreciate that, Mr. Moolenaar. And, you know, I agree that they—and I have seen great examples of that, where people in the community come together. And we certainly don't want to discourage innovation or interest in this, and we do believe it is reasonable.

What we are trying to protect is against closures, premature closures, because, you know, the need or maybe there wasn't enough analysis done around the community need. But without question, we do know that charter schools can serve unique needs, and they are often incubators of innovation and we want to continue to encourage that.

Mr. MOOLENAAR. But when you say premature closures, are you talking about traditional schools or charter schools that would open and then close?

Secretary CARDONA. Correct.

Mr. MOOLENAAR. Okay.

Secretary CARDONA. Underenrollment or it seemed like there was an interest and then a year or 2 later they are closing because there wasn't enough interest.

Mr. MOOLENAAR. Okay. Well, my experience would be, you know, I think the flexibility that is there between authorizers and, you know they certainly have the ability to start up. And if there is not a market there or there is not a need, then you kind of learn about that and you close. I understand that is disruptive. But at the same time, in the cases where it could be tremendously impactful, innovative, and really a good thing in the long term for a community, you just don't want those barriers to getting started.

Secretary CARDONA. I understand. Thank you.

Mr. MOOLENAAR. Thank you. I yield back.

The CHAIR. If I could just take one second because I think you asked an interesting question, Mr. Moolenaar. And I would recommend an article, and I will get it to you. There was an interesting statistic in it that more than one in four parents who walked their kindergartner into a new charter school have to find another school for their children by the time they reach the fifth grade. That is about the alarming closure rate of those schools. Over one in four closes during the first 5 years; by year 10, 40 percent are gone. Between 1999 and 2017, nearly 1 million children were displaced due to the closure of their schools.

So an interesting thing to follow up on to see what the issue is, but I will share that with you.

Congresswoman Lawrence.

Mrs. LAWRENCE. Thank you, Madam Chair.

And thank you, Secretary for being here.

I have a question. It is a follow-up on a response you gave on—I am very excited about the career connected learning. We all know we have a staffing crisis, but the issue is the crisis is present. The connected learning, what is the expectation we can have for when we will have a trained workforce that will be able to let us get parity with our need and with our workforce?

Secretary CARDONA. Thank you for the question, Mrs. Lawrence. I have to go back to my visit. I went to Henry Ford Community College—

Mrs. LAWRENCE. Yes.

Secretary CARDONA [continuing]. In Michigan, and let me tell you, like, if there was a model I could lift up, they get it. They understand that high schools can feed into 2-year schools, and then the workforce partner is waiting.

I visited Groton with Congressman Courtney, and the Groton submarine base was waiting for the graduates of those schools who were learning how to weld with the same machines they use on the sub base, because the partnership was there. Unfortunately, across the country, we have pockets of excellence. It hasn't been systematized.

So what we are trying to do is make it so that every school—and not just technical high schools, which I am a proud graduate of—not just technical high schools but all comprehensive high schools have career options that are responsive to the community needs, to the regional needs.

And I want to go a step further to say, we would expect that districts and States have models of workforce partnership boards with our 2-year college representatives, our 4-year college representatives, our workforce partner representatives, and our K–12 system so that the program feeds.

Now, students should graduate with options. Unfortunately, in our country today, they don't. We have to do better. So the funding for the career-connected high schools is \$200 million in new competitive awards to systematize it, so that when a superintendent leaves, she doesn't leave with those great ideas and the system stays there. We really have to lift—raise the bar there across the country.

That is how we are going to become competitive. That is how our students are going to be able to get high-paying, high-skilled jobs earlier. They can continue with their college. In many cases, these workforce partners are paying for the college. So we have an opportunity here and I really want to seize it.

Mrs. LAWRENCE. So my next question goes to the mental health of our schools and our teachers, as has been mentioned. I just visited with my governor a school that has partnered with a community-based healthcare system that supports the school's mental health needs.

Now, I saw that program being very, very effective, because when we talk about putting enough staffing for mental health, and you talk about a pocket of excellence, I really want to encourage you to have a systematic plan to support these mental health providers in the community, because the mental health provider didn't have the restrictions or the normal part. They were just there, and those—and it was referrals that were able to be made by the school staff, nurse and social worker, and they were in the schools and it was seamless. We—our needs for our teachers and our parents.

And the one thing that was brought to my attention during this meeting is that when you see the connection between mental health of our children, the crisis there, and the crisis of the parent, if we don't recognize that and do what we can to support the resources as needed, it is going to become generational.

So do you have any planning for that?

Secretary CARDONA. Three things I want to accomplish as Secretary of Education: close achievement gaps, improve career-connected pathways, and address the mental health needs of our students.

In Santa Fe High School, last week or 2 weeks ago in New Mexico, I saw a program that really could be replicated where our community partners, mental health partners were in the school. They had space in the school, and they were connected to a university a research university, so that is taking it to that next level.

But what we can do, kind of going to your first question, is not only connect our health centers to our schools and give them space there where even parents can come in and access it but also create

a throughway for our high school students to learn about fields in the healthcare industry and maybe even take some courses there or learn from the health experts that are in the building. That is another example where, as you mentioned, pockets of excellence are not going to get us where we need to go.

We have to systematize it. The funding request that we have here will move that along much quicker.

Mrs. LAWRENCE. Okay. Thank you.

Secretary CARDONA. Thank you.

Mrs. LAWRENCE. And I will yield back.

The CHAIR. Congressman Cline.

Mr. CLINE. Thank you, Madam Chair.

Thank you Mr. Secretary, for joining us today. I don't know if you saw the news this morning that the U.S. economy saw a 1.4 percent decline in Q1 GDP growth of this year. Definitely supply chain issues and inflation are the primary drivers of the decline that we have seen, but the pandemic policies of this administration that include massive trillion dollar spending packages and economic restrictions, like the ones we saw in my home State of Virginia under Democratic-led administrations, started this ball rolling.

\$190,000,000,000 in COVID relief funds has been distributed by your department to be spent on preparedness and learning loss. We have all seen the stories of how some of these funds have been spent. For example, in a Whitewater, Wisconsin school district, the board voted to allocate almost 80 percent of their \$2,000,000 to build synthetic turf fields for the football team.

An Iowa school district spent \$100,000 of COVID relief money to renovate the weight room and add new floors, and now the district has recently reported more students interested in football. That is great. But the East Lyme, Connecticut school district spent \$175,000 to address drainage problems on the baseball field. A Pulaski County, Kentucky, school district spent \$1,000,000 in COVID relief dollars on resurfacing two outdoor tracks.

In March 2021, the Government Accountability Office reported that the U.S. Department of Education system for tracking data was inadequate. Can you report on how you provide oversight for these Federal investments to avoid this type of waste? And how many school districts are truly prepared for the future? What percent of funding was spent on learning loss of students, because we saw that across the Nation? And how is your agency using data to help understand the impact of these harmful school closures that we saw?

Secretary CARDONA. Thank you, Mr. Cline, for the question. And I agree wholeheartedly with you that we must ensure that these dollars are being used to address learning loss and mental health needs, and it is something that we take very seriously at the Department.

As a matter of fact, the GAO report that you referenced, we instituted new protocols for oversight because we felt that the data collection was poor, and we have to fix that mess. There were several messes we had to fix.

With regard to ARP accountability, I have visited more than 100 sites, and the first question that I ask is, how is the ARP money

being used. We are trying to lift best practices. We have had dozens of webinars with State chiefs, superintendents. I have spoken to hundreds of superintendents, visited their sites to make sure that we are very clear, learning—addressing learning loss or missed instruction is critical, mental health needs of our students is critical, and making sure that our schools could be safely reopened. We are doing that. We are going to continue to do that.

And a recent report from FutureEd reported that the projections of spending will go \$30,000,000,000 toward academic recovery, which is exactly what you were asking for; \$26,000,000,000 of the \$130,000,000,000 in the K–12 space would go towards staffing, which include mental health support; \$26,000,000,000 for infrastructure.

And I have to say, some of the examples of what I have seen in my visits include deferred maintenance in buildings where air quality was really poor or the—so infrastructure is being fixed during—with the use of the American Rescue Plan.

Schools are open today. We went from 46 percent of the schools open when President Biden took office, 99 percent open today because of the American Rescue Plan and their ability to get their schools open safely.

Mr. CLINE. I think that one of the things that the American Rescue Plan also resulted in was the inflation that we are seeing today. The Department just announced steps to further exacerbate this problem by dealing with student loan forgiveness.

The Federal Student Aid estimates that the changes you are proposing will result in an immediate debt cancellation for at least 40,000 borrowers under the Public Service Loan Forgiveness program. More than 3.6 million borrowers will also receive at least 3 years of additional credit toward income-driven repayment forgiveness.

Can you tell me how the Department plans to pay for the planning, implementation, and execution of these proposed forgiveness programs?

Secretary CARDONA. Thank you. We recognize that one of the things we had to fix when we came in was the Public Service Loan Forgiveness program. It was enacted in 2007, was to take effect in 2017, and there was a 98 percent denial rate for those who qualified for it. So only 16,000 borrowers received forgiveness in the program.

What we ended up doing was revisiting that program, fixing it. And as you mentioned, at least 40,000 borrowers were added to the list of borrowers who received loan forgiveness with the income-driven repayment changes.

We are working really hard at FSA to build up systems of support for our students to make sure that they have the information, and we are processing their applications as quickly as possible.

Mr. CLINE. Thank you. I yield back.

The CHAIR. Congresswoman Bustos.

Mrs. BUSTOS. All right. Thank you, Madam Chair.

Mr. Secretary, it is good to see you. You were kind enough to come with the First Lady to Sauk Valley Community College, which serves the congressional district that I represent in the northern part of the State of Illinois, so thank you for that.

You know, I know you are on the road a lot and you have a lot of conversations. I had brought up to you at the time, we had a short discussion about teacher shortages, and that is what I would like to talk with you about this morning.

In the budget request, I was really, really happy to see that President Biden requested an increase in 400 TEACH grants awarded. So these students will receive \$4,000 if they commit to teaching a high-need subject in a high-poverty school for 4 years. So really happy to see that.

And we talked about this in your visit about teacher shortages continuing to be a major problem. I know this is affecting a lot of States all over our country. It is a big problem in the State of Illinois. And the Illinois State Board of Education says that Illinois school districts have about 4,100—4,100—unfilled positions right now, and that includes teachers, paraprofessionals, and other licensed staff.

So, Secretary Cardona, what I would like to ask you is, what impact will the President's budget request have on teacher shortages, such as programs like the TEACH Grant and through investments like the Teacher Quality Partnership Grant Program? I would love for you to address that if you could, please.

Secretary CARDONA. Thank you very much. Great to see you again.

There is \$350,000,000 in the budget to propose—to support recruitment and retention efforts. Just yesterday, I was with the 50 State Teachers of the Year and the National Teacher of the Year, Kurt Russell, talking about the importance of the profession. And while it seems that the profession is under attack at times and, you know, during the pandemic there was a great support for teachers, now it seems like teachers are being asked to do more and sometimes not given the respect that they deserve for what they have done during the pandemic.

So it is a difficult time to recruit teachers, but in this budget, there is a clear commitment to making sure that we have enough teachers. And as mentioned with the question from Mrs. Lawrence, we have to create Grow Your Own programs in our districts. We have to create programs that get students thinking about teacher—becoming a teacher earlier on. I think of Tennessee's program where there is an apprenticeship available for students who want to become teachers.

The funding in the budget would allow us to create systems that help us ensure that we are not going to have teacher shortages. I made reference earlier to January when, because of quarantining, we didn't have enough teachers. We didn't have enough substitutes. That is unacceptable. Our students deserve better.

This funding will allow us to create systems to make sure that we have pipeline programs for our teachers and programs that are embedded in our high schools that connect to our colleges, to ensure that we have enough teachers moving forward, especially in those hard-to-fill areas like special education, bilingual education. We have to be proactive about this because it is unacceptable for students not to have highly qualified, prepared teachers in front of their classrooms.

Mrs. BUSTOS. And this plays into it, kind of part two of this in a sense, teacher salaries. Obviously, that is part of retaining teachers. It is part of attracting people to the profession. And as you know, the salaries are too low across the country in many—especially in low-income districts. And in my home State of Illinois, we are working really hard to address this. But obviously, I think there is more that we can do even at the Federal level to retain and to attract people to the profession.

Last year, I introduced something that we call the Retaining Educators Takes Added Investments Now Act. You know, we always like to come up with these acronyms. It is called the RETAIN Act. And along with other professions that the legislation, the RETAIN Act, it provides fully refundable tax credits for teachers in title I schools. So the credit starts at \$5,800 and then ramps up to \$11,600 over the years to help retain staff.

So, Mr. Secretary, how could increased title I funding help school districts increase teacher pay and promote retention? And then part two of that is, what investments do you think we could put into programs that fight teacher shortages for this fiscal year?

Secretary CARDONA. Thank you for that, and I appreciate the efforts that you are taking to help address this issue.

Imagine the headlines if we didn't have the American Rescue Plan funds to help incentivize teachers staying in the profession. We would be talking about schools being closed much more, so thank you for the support of the American Rescue Plan.

I was talking to a principal yesterday who was telling me that, in her State, the starting salary for teachers is in the \$20,000s. That is unacceptable. That is unacceptable. So we need to do more. Pay does matter, working conditions matter, and teacher voice matters.

And to answer your question about title I, title I gives us the opportunity to ensure that there are enough reading specialists, that professional development is available to help these teachers become highly skilled in addressing achievement disparities that exist, and ensure that teachers have a competitive salary in urban districts or high-poverty districts compared to their suburban counterparts. That is what title I does.

Mrs. BUSTOS. All right. Thank you so much, Mr. Secretary.

My time is out, and I will yield back to our chairwoman.

Secretary CARDONA. Thank you.

The CHAIR. Congressman Harder.

Mr. HARDER. Thank you so much, Chair DeLauro, for hosting today's hearing.

And thank you, Secretary Cardona, for being here.

I wanted to talk about doctors in the PSLF program. At the height of COVID, the ICUs in my community were over 100 percent capacity, not because we didn't have the bed space, but because we didn't have the doctors to take care of people. And one of the major contributors to that is that since the implementation of the Public Service Loan Forgiveness program, doctors in California and Texas have been excluded from partaking in this program due to State laws prohibiting direct employment of doctors by hospitals.

This disproportionately affects rural and underserved communities like mine. We have about half of our physician residents after they graduate who move away from our communities to go and work in another of the 48 States that are covered by this program.

I have sent you two letters on this. And in the fiscal year 2022 LHHS report, it urged the Department of Education to address this regulatory exclusion through negotiated rulemaking this year. One of the letters that I sent you was signed by 67 Members of Congress, almost the entirety of the California and Texas delegations, telling you how important this issue is.

But I am very concerned that public documents released by the Department of Education throughout this rulemaking process indicate that the Department either still does not understand how to fix this issue or is not prioritizing fixing it.

Specifically, the proposed language that has been suggested still requires a W-2 form for their employers, which would continue to exclude 100 percent of California and Texas doctors, because they don't get W-2 forms even if they work at a nonprofit hospital because they are banned from working directly for hospitals in California and Texas.

So, Secretary Cardona, will you commit to having the Department fix this exclusion of otherwise qualifying doctors in California and Texas from the PSLF program this year?

Secretary CARDONA. Thank you for the question, Representative, and for your advocacy for these heroes who during the pandemic have bent over backwards to protect lives.

As you are aware, the rule related to PSLF is under OMB review, and we hope to publish a notice of proposed rulemaking in the spring. And I know you have been in communication, and my staff will continue to be in communication with you about this issue, and I appreciate your advocacy here as we try to work toward a solution.

Mr. HARDER. Thank you. I just really want to emphasize to you and to your team that the proposed fix does not fix this issue, and every single physician in California and Texas will still be excluded. And it is, frankly, a little confusing to me that after all the whole volute that has happened because of this problem, that the negotiated and proposed language still falls short of our goal here.

Can I at least get your commitment that you will do everything that you can to make sure the California and Texas doctors who meet all other PSLF requirements receive PSLF support?

Secretary CARDONA. I understand the problem. I commit to, number one, having a conversation with you specifically about this to hear your perspective, although I have read the letters and have had conversations. I want to make sure that you feel that I am giving you my best here to support the doctors in Texas and in California.

Mr. HARDER. Well, thank you. And I just want to underscore that this is bipartisan, bicameral. We have enormous support around this, because it will lead to 10,000 physicians working in underserved communities in California over the next 10 years. It is a major game changer. And especially after what we have seen in COVID, I think now is the time to make sure that we are getting

this addressed. And I want to make sure that the Department understands how their current proposed language falls short.

I would like to also enter, Madam Chair, two records into—two documents into the record: The first is my bill language for H.R. 1133, the Stopping Doctor Shortages Act; the second document contains three language proposals that also fix the exclusion of qualifying California and Texas doctors from the PSLF program without impacting other healthcare professionals or allowing nonqualifying doctors to receive PSLF support.

We know there is good language out there. These are three suggestions that do address this problem, and I would really encourage the Department and the Secretary to take a good, strong look at this. And I appreciate your effort to have a conversation on that. I am more than willing to do that anytime.

So thank you again, Secretary Cardona, for testifying.

And I yield back the remainder of my time.

Secretary CARDONA. Thank you.

The CHAIR. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Madam Chair, and thank you for holding this hearing, and it is good to see you.

Mr. Secretary, thank you very much for being here.

I am always interested in equity of opportunity, providing the opportunities for our children to be globally educationally competitive irrespective of where they live. I am also very concerned about all of the sort of research that we found lately that demonstrates that children of color, particularly Black girls, are disciplined more than their White counterparts for the same infractions. I am concerned that there have been issues of discrimination because of their hair, because of their dress codes, and things of that nature.

I am impressed that you all have actually noted the challenge and the desire to ensure that educational opportunity is more evenly distributed and available. New Jersey is one of the most segregated States in the Nation when it comes to K-12 schools.

So my question to you is, while you have this commitment, what is it that you are actually going to do or be able to do that will positively impact the minority child's experience in the school? What will you do to prepare teachers? What will you do to prepare the administration? What kind of training, bias training, et cetera, is going to be made available? And how will you hold those institutions accountable who are not doing the things that you expect them to do, and what measures can be used to ensure their accountability and responsiveness?

Secretary CARDONA. Thank you for the question. As I said earlier, the focus during my time as Secretary will be to address disparities in this country, provide better access to college and career, and to support students' mental health needs. As we know, they are greater now.

To your question, you know, there are several things in the budget proposal that will support our efforts, our specific efforts to diversify the staff in our schools, to make sure that the professional staff in our schools represent the beautiful diversity of this country; ensuring that title I schools have the support that they need so that they can have that intervention, that small group instruction, that evidence-based—those evidence-based strategies that we know

close reading gaps and address the needs that our students have academically.

We want to make sure that we are continuing to disaggregate data to ensure that all students are accessing public education adequately and equally and that they have the same opportunities for cocurricular activities, access to AP courses, access to higher education.

So we are monitoring these things. We are more accessible. I said in the beginning I want our agency to be a service agency. I want us out in the field. I want us talking to educators, teachers, principals. And we are working with them to make sure that we are building capacity, we are providing greater oversight. And we are being very clear about, if you are using Federal dollars or even if you are not using Federal dollars, the expectation is that all students have an opportunity to succeed.

I opened with I am a beneficiary of public schools and everything that this budget asks for, and I expect that for all students across the country. The budget will help us get there.

Mrs. WATSON COLEMAN. So do the school districts and the States understand what you expect of them? And what will happen if they are not even achieving or attempting to achieve those things that you think are very important and achievable that the Federal Government supports in terms of funding?

And what is it that you actually think the Federal Government can do tangibly to desegregate these schools? Do you really believe that desegregated schools, particularly in the lower-income communities, can provide all of these educational opportunities and the innovations that are available? What can you actually tangibly do to help desegregate?

Secretary CARDONA. Thank you. First of all, I do believe the State chiefs, the superintendents, principal groups, teacher groups, they are aware of what we are doing, because we are at the table with them and they are at the table with us. And I believe we have a shared purpose. It is just a matter of drilling down and looking at those places where it is not working, building capacity through technical assistance, and ensuring that the funding is being used for the right things, but also holding them accountable and withholding funding if the actions go against equitable outcomes. That is what we are working on.

Mrs. WATSON COLEMAN. Okay. Yeah. I want you to know that, in closing, I am very supportive of community schools. And I think the community schools that have diversity of services to both the child and the parent and that even finds educational/recreational opportunities and after-school hours is vitally important to our communities, and I strongly support it. And anything I can do to that end with you, please count on me.

Secretary CARDONA. Thank you.

Mrs. WATSON COLEMAN. Thank you. And, with that, I yield back.

Secretary CARDONA. Thank you.

The CHAIR. Congressman Harris.

Mr. HARRIS. Thank you very much. And I apologize, but we have the Ag—as you know, because you appeared before us, we have the Ag Subcommittee.

And, well, thank you, Mr. Secretary, for being here. I want to follow up first on something that the gentlelady from Washington brought up. You know, Elon Musk famously tweeted back in December of 2021, the fact that an 18-year-old can't take out a \$10,000 business loan but can take out a \$100,000 student loan tells you everything you need to know.

So I have a question for you, because, you know, the gentlelady brought up the issue of the importance of trade skills. And so, for instance, I met with new car dealers. They can't find mechanics, like, literally they can't find them.

You know, when a mechanic finishes their vo-tech training, for instance, a set of tools cost them \$15,000 or \$20,000. Without that set of tools, they have got to go work for somebody else. They can't work for themselves. Nobody is going to lend them \$15,000 or \$20,000 out of school, but they have a marketable skill, a valuable marketable skill.

Why don't we lend them money? Why do we lend the money to go to a 4-year college to study something in the humanities that may or may not bear any fruit and not lend the person who just learned a skill to get started in being a vibrant part of our economy?

Secretary CARDONA. Yeah. Thank you, Dr. Harris. As a former automotive technician student myself in high school, I had to buy those tools—

Mr. HARRIS. Yep.

Secretary CARDONA [continuing]. And I know what you are talking about. And I fully support making sure we have better access to careers. I fully support creative pathways there and those that give students opportunities to try different pathways that maybe don't exist now. I am fully supportive of that.

Mr. HARRIS. Great. Thank you very much.

So I am going to spend the last few minutes just on the—my concern about the charter proposed rules. And I know you have addressed it. Again, I am sorry I couldn't listen to everything that was said. But, you know, in Maryland, I was there on the Education Committee in the State senate when we passed the charter school bill. It was to help Black students in Baltimore City. There were successful charter schools which were almost entirely minority.

Secretary CARDONA. Right.

Mr. HARRIS. So when you come out with, you know, a proposal that a charter must serve a diverse population, these were actually designed to serve a nondiverse population in Baltimore City, a population that was underserved, that didn't have educational choice.

When you say that, you know, the community impact analysis has to have evidence of over enrollment of existing public schools, that is not the issue. It is not that there aren't public school spaces available; it is that those public schools are failing and parents get the choice of charter schools.

So are you aware of these concerns?

Secretary CARDONA. I am. And I do believe proposals are reasonable. I said at the beginning, before you were here, you know, I remember when I was in Connecticut, one of the last presentations before COVID shut everything down was Stamford Excellence

Charter School. The achievement in that school was amazing, and we lifted it up as a great example. I know in Rhode Island there is a great learning community charter school, involves parents in ways that we want to see across the country. So we know there are great examples.

And my department's technical support assistance is going to be available to help any school that wants to open to be successful. So I think these are reasonable, but I do understand that there is a lot of concerns. There is a lot of misinformation and there is a lot of myths that maybe we are not in support. I am in support of high-quality public charter schools.

Mr. HARRIS. Thank you very much. So I did tune into a little part of your commentary.

Secretary CARDONA. Okay, good.

Mr. HARRIS. You said you support quality schools.

Secretary CARDONA. I do.

Mr. HARRIS. And you are right, look, some charter schools weren't quality schools, but some really are. And please don't throw out the baby with the bathwater.

Finally, you know I am a strong advocate for the D.C. Opportunity Scholarship Program. I am very glad that the administration in this year's budget did not include the phase-out language. That was very disappointing to me. This is—again, this is a program that serves overwhelmingly minority students where the parents have, you know, waiting lists, they do the lotteries for this. I mean, these parents really want this to exist, and I am glad that the administration realized that and then took out the phase-out language.

I am also glad they didn't include the poison pill language, the language that would, again, look at the timeline religious exemptions through a lens that basically would disallow a lot of the schools.

This project, this is just a great—giving parents choice in a failing school system is a good idea, not a bad idea. I get it, it is controversial. I get it, union opposition. Again, I lived through it all in Maryland when I was in the State senate. I urge you, again, to support programs like this that are broadly supported by parents where we can demonstrate that they are qual—that there is a quality aspect to the education. And, again, I thank you for being here. I apologize for being so late.

I thank the chair for her indulgence, and I yield back.

Secretary CARDONA. Thank you.

The CHAIR. Congressman Pocan.

Mr. POCAN. Thank you, Madam Chair and Ranking Member Cole. I also was one of those folks late because of the Agricultural hearing. So I want to say happy birthday to Ranking Member Cole. Hopefully there is a quality cigar in your day at some point.

Mr. COLE. Several.

Mr. POCAN. Several. Good, good. I want to make sure.

Since a lot of the questions were asked, let me just hit a couple points and then I will ask a few questions. One, I have great concern on the teacher shortage issue as well. In fact, Madam Chair, it might be good to have a special hearing on this sometime, because I think it is such a big issue. I think the way you broke it

down on pay and conditions and teacher voice is very accurate, and there is challenges in all three.

You know, we saw the conditions with COVID and what has happened to teachers. We have seen places like Wisconsin where they have attacked public employee unions. And we have watched the devastating numbers of people not applying to go to become teachers.

In my main school district, it used to be almost impossible to get in as a teacher. Now, they have positions where they only get two or three applicants for a teaching position. So this is a real issue, and I think whatever we can do to—I appreciate what you have in the budget, but I think there is probably more we are also going to need to do.

Second, perhaps a little different than the ranking member on this, on the charter programs. I really appreciate the direction you are doing with the extra scrutiny and efforts. Wisconsin was one of the first States to have those, back now almost 30 years ago. Yes, there was some rough periods that we have corrected where, you know, we gave money to people who opened schools who said they could read a book by putting their hand on it and all sorts of interesting ways, but we still don't have the performance out of them. And I think when you look at the statistics that were given by the chairwoman, you know, I am glad we have that extra scrutiny.

Completely agree with Representative Herrera Beutler on Pell. I went to school because I had Pell grants, and I am not lifting the ladder up. I am trying to make sure we are going to continue to try to double those Pell grants. Thank you for those efforts.

And I guess where I will get to a question now is I agree with what Representative Clark and others said about the Office for Civil Rights budget. I am especially concerned that there is a trend among some States to have these so-called "Don't Say Gay" laws, and they are going to have some really big impacts, again, on teachers but also on students.

And, you know, specifically in that area, are there some strategies that you are looking at? Because I have got the feeling you are going to have a lot of potential firings and expulsions and others because of those laws.

Secretary CARDONA. We are asking for an increase of almost \$26,000,000. Really, it is our—one of our primary responsibilities to ensure all students have access to a school that is inclusive, where they feel welcomed, and that is what we heard from students, and that is what we heard from parents. We have been listening to parents. They want their children to feel welcomed and embraced.

And what we are finding now across the country is that we have to be proactive to ensure that we are out there and communicating with these educators and these policymakers that are introducing policies that go against that. Our Office for Civil Rights is prepared. But what we want to do is build a culture of inclusivity. We really need to be proactive about this. OCR alone is not going to take care of this. We need to create a culture of acceptance and inclusion for all of our students.

I recently visited students in Florida and parents who told me, all I want is for my kid to come back—just like every other parent—go back into school, make up for some lost time during the pandemic, and feel welcome, feel accepted, and that is under attack. And we are not going to tolerate it. We need to support every student, including our transgender students who are under attack in many places.

As Secretary of Education, I need them to know I have got their back. And the Office for Civil Rights is here to support and take investigations if we have requests for them, because we take this very seriously. That is something that we are not going to compromise on.

Mr. POCAN. Thank you. And then two questions around financial aid that have been brought up from my district. One around FAFSA. You know, there has been repeated verification points for the issue of requiring students to apply for that annually. I believe there might have been some relief around that through COVID in the requirement to reapply.

Is there a way to start looking at those multiple-year applications that you don't have to every single year apply for it when people are looking for a 4-year degree so that you could have less disruption?

And secondly, there was, again, some relief during COVID around Pell grants, and to the same end, if it was possible to have some of the relief that we had during that time period continue. We know there is going to be negligible effects, but there is a lot of paperwork involved, and also it holds back some families from being able to apply on the income verification side.

Could you address those two points?

Secretary CARDONA. Sure. And, you know, they are connected in some ways. And I have to first acknowledge the dedicated people, career staffers in FSA, who have been working tirelessly to, you know, work on the systems that we are trying to improve.

What we are trying to do is work closely with our services also to make sure that they are supported throughout this process, while also simplifying and making sure we have the data that we need without over—creating more paperwork or more challenges, more obstacles to this process. We will continue to do that, and I look forward to hearing more from you and your team to see what we can do to continue to improve that process.

Mr. POCAN. Great. Thank you very much, Mr. Secretary.

Secretary CARDONA. Thank you.

Mr. POCAN. I yield back. Thank you, Chair.

Secretary CARDONA. Thank you.

The CHAIR. That concludes the first round of questions here, and it appears that we have some time and that we can allow for a 3-minute round of questions. So really for the quality of the discussion, et cetera, is really—it is rich and it is so critically important.

I will just say to Mr. Pocan, I love the idea of a hearing with regard to teacher shortage, and we are going to take you up on that and pursue it. So thank you. I think it is a very, very big issue.

Mr. Secretary, I would like to, one, say thanks with regard to the great work of you and your staff on borrower defense. More than 100,000 defrauded borrowers have received loan discharges under

the borrower defense repayment provision. But we have got another, you know, tens of thousands of additional borrowers who are waiting for their claims to be adjudicated.

I just read the article that was handed to me coming out today: Education Department approves \$238,000,000 group discharge for 28,000 Marinello Schools of Beauty borrowers based on borrower defense findings.

I think it is interesting, I know my colleague, Ms. Herrera Beutler, talked about for-profit cosmetology schools being worried about regulation. But if you take a look at the article and what was found here is that this was—the Department found schools failed to train students in key elements of cosmetology program, how to cut hair, I mean, some very basic things, so that cracking down on these schools that do—are predators is really critically important.

Tell me what you are—I know we are waiting for a borrower defense rule. In the meantime, what are you trying to do to adjudicate these outstanding defense claims for groups?

Secretary CARDONA. Thank you. You mentioned today's announcement. Prior to that, over \$2,000,000,000 in relief through borrower defense for 105,000 borrowers who were taken advantage of, misled. We really need to send a message that we are not going to let that slide, that these practices of taking advantage of students trying to chase that American Dream is something that we are going to be monitoring more closely.

I am proud of the enforcement team being brought back up under Richard Cordray's very capable leadership. It is really creating a new culture to make sure that the return on investment for our students is there so that they are not saddled with debt for the rest of their life earning low-income.

So I mentioned borrower defense. We are feeling similarly with income-driven repayment. We are feeling the same way with Public Service Loan Forgiveness. A lot of attention is on broad loan forgiveness. We are working really hard, especially this first year, to fix systems that are broken, that were not working for students, and borrower defense is one of those.

The CHAIR. Okay. And I just would mention, I mean, the students and the taxpayers are the ones who should be worried about what is happening here, and there is overwhelming data that talks about what attorneys general have found—

Secretary CARDONA. Yep.

The CHAIR [continuing]. About misleading students, harassing students, worthless degrees, major student debt. That has to be drummed out of the system.

Secretary CARDONA. Right. Right.

The CHAIR. That is what we have to do. No one is saying let's not give people technical education. It is critically important to do that. And we can work with that, work with businesses, we can work with community colleges and getting the people what they need and the technical credentials to move. But we cannot allow corruption to take advantage of our kids or of the Federal tax dollars. Thank you, Mr. Secretary.

I now yield to the Ranking Member, Mr. Cole.

Mr. COLE. Thank you very much, Madam Chair.

I have got two quick questions, one you might want to take for the record, but you may know off the top of your head. What percentage of the \$76,000,000,000 in Higher Education Emergency Relief Funds remain unspent, and how does the Department plan to make sure that that money is actually used for COVID-related purposes?

My friend, Mr. Cline, pointed out, we certainly have some egregious examples where people I think misused the money for things that none of us envisioned they would spend it on.

Secretary CARDONA. Thank you, Ranking Member Cole. I will get you specific numbers. I don't have it off the top of my head. But I will tell you, in my visits to higher education institutions, I have seen a shift. These institutions understand they have to meet the students where they are, in many cases, food insecurity, housing insecurity, dealing with some basic needs, books, not only tuition support. But I think if it weren't for the money in the higher education space, we would be talking about colleges closing. We would be talking about a dropout rate that is much higher.

What I have seen anecdotally and in stories of students who have told me, I am only here because of the funds that the school is providing, that they wouldn't have had if it weren't for that. So I can get more information to you, but I can tell you firsthand—

Mr. COLE. I would appreciate it, because I agree very much with your basic point. Look, this money was necessary and—so I won't quibble with that. I do worry, potentially it was an unprecedented new program.

Secretary CARDONA. Right.

Mr. COLE. It is pretty easy. You don't have controls set up. So I just want to make sure, because I have seen some pretty egregious examples of money spent on things that I know nobody on this committee, on either side of the dais, would have approved of.

Second question quickly, and this may call for a longer discussion another time, is title I, where, again, I think the purpose of the money is a really worthy purpose. I am concerned that over—you know, we spend a lot of title I money, and a lot of times we don't see much difference in performance over time in the places where—I am not disagreeing where it is targeted. I am wondering whether or not we are doing the things we need to actually use the money to get a better result for students.

So can you just quickly give me some of your thoughts on that and how we can improve the performance to follow the dollars?

Secretary CARDONA. Thank you, Mr. Cole. And I agree with you wholeheartedly. Money doesn't always mean success if it is not being used well. That is why I am proud to be an educator and be able to say, if these funds are being used, they better be used for evidence-based practices.

Deputy Secretary Cindy Martin has been working really closely with our Office of Elementary and Secondary Education to ensure that good teaching principles, good leadership principles are being used with these funds. We both served as educators at different levels, and we are really interested in making sure that there is a good return on investment not only for the students, but for the taxpayers who are funding this.

Mr. COLE. Yeah. If you could—and my time is about up, so you don't have to respond, but if you could get us some information on that that shows where the dollars have actually markedly improved performance and, you know, what are the reasons why that worked.

Secretary CARDONA. Gotcha.

Mr. COLE. In other words, what are the things we did with the dollars that actually helped kids get a better outcome.

Secretary CARDONA. Happy to do that. Thank you.

Mr. COLE. Thank you very much, Madam Chair.

The CHAIR. Congresswoman Roybal-Allard.

Ms. ROYBAL-ALLARD. Mr. Secretary, this year we celebrate the 50th anniversary of the Federal TRIO Veterans Upward Bound program, which helps military veterans prepare to reenter the academic pipelines. A Department of Education study found low-income and first-generation veterans who participate in the TRIO Veterans Upward Bound program were 42 percent more likely to complete a degree than those who did not participate in the program.

Can you address what steps the Department is taking to improve college access and completion for our veterans through this program or any other program that you may have?

Secretary CARDONA. Yeah. I can tell you, in some of my visits, some of the best stories are of our veterans who had access to higher education and their family had access to resources for all of them to find success.

We have worked closely with veterans groups, and we have had them in the Department telling us how we can improve programming, how we can work together with DOD and Department of Veterans Affairs to make sure that the communication to them is streamlined.

We will continue to work with them and to make sure that they have access to the programs and the benefits that are due to them. They have served our country, and it is important for us at the Department that they feel that we are supporting them in their process of accessing higher education.

Ms. ROYBAL-ALLARD. I have several questions that I won't have the time for, but I will submit them for the record.

Secretary CARDONA. Please do.

Ms. ROYBAL-ALLARD. But I just do want to make one point and that has to do with the issue that has been brought up by my colleagues with regards to trade schools.

Secretary CARDONA. Sure.

Ms. ROYBAL-ALLARD. And I just want to point out that, in addition to the financial support and other things that have been talked about, I think it is also important for the Department of Education to change public attitude about going to a 4-year college versus going to a trade school. And then just quickly, let me just give you one example of what I am talking about.

I was talking with some parents in my district and they were bragging about their—of their oldest child who was going to a 4-year college and, you know, how proud they were of them. And when I asked about, well, what about, you know, your other son,

they were almost apologetic in telling me that that son was going to a trade school.

And I think that there is various reasons, historical reasons, you know, for that being the way it is, but I think it is important that we find a way to give the same kind of status to those who go to a 4-year college and those who get a degree in some kind of trade school, for all the obvious reasons that have been mentioned. And I think the Department of Education can be helpful in helping the public and parents understand that both have tremendous value.

Secretary CARDONA. Absolutely. As a graduate of a technical high school, I couldn't agree more. We do have more work to do to change the culture, the stigma that is, unfortunately, associated with it. There are high-paying, high-skilled jobs out there.

I remember visiting a place in Michigan—I can't think of the name of the school now, but it was a graduate program. The students that were studying plumbing were going into jobs making six figures when they left, with very little debt. They are doing pretty well. We have to change the stigma, and I am excited to do that work.

Thank you.

The CHAIR. Well said, both of you.

We have another member of the committee that has joined us. Can you introduce her, Mommy?

Ms. HERRERA BEUTLER. Say, Hi, I am Isana Mae.

ISANA MAE. I am Isana Mae.

Ms. HERRERA BEUTLER. Isana Mae.

The CHAIR. Okay. Well, welcome.

Ms. HERRERA BEUTLER. Thank you.

VOICE. Give her questions.

Ms. HERRERA BEUTLER. I don't know if anybody could handle—that would be a tough question.

I wanted to ask, kind of following up along this, you know, I agree with the chairwoman that corruption and defrauding students and the American taxpayer should never be tolerated. I am in no way afraid of any kind of investigation into someone who is a bad actor, like full stop. I do think, though, my challenge is, is there are not similar applications of I feel like justice being applied.

You know, one of the things that madam chair—and I agree with this—she said, we cannot allow corruption with Federal tax dollars, worthless degrees, and thousands of dollars in debt.

Well, any average person watching this might think we are talking about, you know, one of the many students who went to a 4-year liberal arts degree and has thousands of—hundreds, in some cases, of thousand dollars in debt, and they are working as baristas. You know, right now, we have over a million workers that just disappeared from the economy, and your administration that you work with is talking about forgiving their debt, and I am thinking and we are trying to get rid of trade schools?

One way we can make this whole thing work is if we change the stigma, root out the bad, and apply that same level of justice. And it was frustrating to me as this rulemaking process is happening that I have good acting trade schools that provide good jobs in my district who are saying, Department of Ed won't respond to us. It

is not even that they are giving us bad information or they don't like us; it is that they won't respond to us. That is not appropriate.

And I would like to see that same measure being applied to our 4-year schools. Is it still true that financial aid counselors cannot counsel a student, Yeah, you know, you are taking out all this debt, yet your degree isn't going to help you pay that off? Like, it has been the rule that financial aid counselors can't actually point that out to students. I think we need to—I agree that the system needs to be cleaned up.

Secretary CARDONA. Yes.

Ms. HERRERA BEUTLER. And let me add to that nursing. Nursing is another area. If you are talking about forgiving loans, I know that you are talking about the Public Health Service Corps and the Public Service Loan Forgiveness programs. Those are great. But if you are going to talk about widespread forgiving of, you know, everybody's loans, there needs to—Federal taxpayers need to have some benefit there.

So why can't we consider asking those people to serve in high critical need areas? They are going for a psychology or psychiatry degree, maybe help serve in a childcare desert. You know, maybe you should put in the same 5 years of service that a health service corps person would do to get that loan forgiveness. I think that needs to be considered.

So that is a lot.

Secretary CARDONA. I appreciate it. Thank you for sharing that. I welcome an opportunity to have more conversation about how you are perceiving it, what you are hearing, and how we can at the Department of Education be more service-oriented to those who might feel like they are not hearing from us.

Thank you.

Ms. HERRERA BEUTLER. Thank you.

The CHAIR. Congresswoman Clark.

Ms. CLARK. Thank you, Madam Chairman.

I was delighted to see in your budget another \$616,000,000 to help simplify the FAFSA process. I think few forms for students looking to further their education and families that support them create more of a daunting process than that particular form. So I would love a brief update on where you are with that.

And, in particular, we have been looking at the issue for homeless, foster, and justice-involved youth that even a simplified process is still very difficult. So I would love to hear about your strategies for helping those students enroll and complete their postsecondary education.

Secretary CARDONA. Thank you. I couldn't agree with FAFSA simplification any more after having gone through the process with my own son several months ago. And as you know, the deadline was extended, but I am glad to say that homeless and foster provisions won't have to wait another year. That will be ready for the following year.

We can't have a program that is intending to help students that need additional help make it so hard for them to understand it or their parents to understand it. I can tell you, one of my son's friends called me—called my son and said, "Could your father help my mother with the FAFSA because she doesn't understand it?"

And that told me—and she knew that I am in education, so he said, “Well, I will call him.”

The process has to be much easier. It has to be accessible to those who need it most. There can’t be barriers there that make someone think it is easier just to forget and ignore that. That is unacceptable. And I am glad we are moving forward toward simplification. I wish it could be ready now, but I am happy that for the homeless and those in foster care, they don’t have to wait another year, that theirs will be ready in 2023, 2024.

Ms. CLARK. And I know this is primarily a State issue, but one of the other factors that has come up, especially for foster youth, but it really applies across the board for some of our more vulnerable populations, is aging out of foster care.

And 21 States still have not extended the age limit. But in a recent visit to a community college, talking to the administration and students, even with the extended age of 23, with all the interruptions of the pandemic, the high costs of housing, food insecurity, you know, I think we have to think about a different way that we address these needs and help these students finish without an arbitrary age cutoff. It just doesn’t reflect the reality of many, many students, but also especially of homeless and former foster youth.

We need to make sure that we are—we are looking at that. And it is often a State issue, but I am hoping we can collaborate and think about solutions.

Secretary CARDONA. Yeah, I appreciate that. And especially now after the pandemic where so many have faced disruption that might have taken them off course for a little bit.

I am very eager to learn more about this and maybe work with you to hear specific examples of things we can do to help that process along.

Thank you.

Ms. CLARK. Thank you. We will follow up. Thanks, Mr. Secretary.

I yield back.

The CHAIR. Ms. Frankel.

Ms. FRANKEL. Thank you, Mr. Secretary.

Well, the Governor of Florida has decided to be the leader in the cultural war of extremism in our country. And I know Mr. Pocan talked to you about the situation with what he calls the Don’t Say Gay bill, but I want to talk to you about the WOKE bill.

The WOKE bill is aimed at limiting how schools and colleges and businesses discuss race. It blocks any instruction that could hint at one race feeling guilt for past actions or that their race necessarily determines a person’s status as privileged or oppressed.

Now, I wanted to say I was at the Museum of African American History the other day. And if anyone hasn’t been there, I just urge you to go there. And, you know, the first exhibit that I saw had all of these slave ships and showed how human beings were packed in these horrible, awful conditions. And I have to say, I had very strong emotions, all kinds of emotions, whether it was sadness, or guilt, or whatever.

And I just do not understand how—I mean, it seems to me that, under Florida law now, children are not going to be able to be

taught about slavery. One district recently canceled a workshop on the civil rights movement out of fear of violating the new law.

And so, you know, what my constituents are asking me is can the Federal Government do anything to intervene against this craziness, this horrible effort by the State of Florida to basically block teachers from telling the truth or have students having any emotional feeling when they hear the facts?

Secretary CARDONA. You know, we—as a lifelong educator myself, I know the importance of making sure students feel engaged in learning. And while the Federal Department of Education doesn't have a role in curriculum, to me it is really important as an educator and as a father that our students are engaged and proactively introduced to the beautiful diversity that has made this country the most amazing experiment in the world. But that includes, you know, our history. That includes parts that we are not proud of.

I trust that—

Ms. FRANKEL. I understand. I agree with you, but is there anything that the Office for Civil Rights can do about this effort in Florida?

Secretary CARDONA. What the Office for Civil Rights can do is thoroughly investigate any request for investigations around lack of rights of students. And, you know, I can't speak prematurely to that, but I will tell you, we do believe that students should have quality programming, and we are concerned with some of the policies that are less curriculum, more about division, more about bringing politics into the schools. I said at the onset, our schools should not be the place for cultural wars.

Our parents want our children to recover from what was missed during the pandemic, for the missed instruction. They want the mental health needs of their students cared for. They want all students to feel welcome. That is what our parents are asking for. We are not going to get distracted going into the cultural wars, but I also encourage our State leaders and our local leaders to make sure that they are also in the conversations around what our students need.

And I know that our educators and parents want the same thing for their kids. They want their children to learn in an environment that is inclusive, that is welcoming, and that teaches the truth.

Ms. FRANKEL. Thank you. I yield back.

Thank you, Mr. Secretary.

The CHAIR. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Madam Chair.

Secretary, the whole notion of community schools is something that we explored about three or four governors ago when the Governor of Florida believed that schools should be a community outreach. Parents can come there and get services they need. Children get services they need. School doesn't end at 3:00. I am so excited about those. I really believe that they are an answer to a lot of our issues in our particularly underserved communities.

So I thank you for the work that you all are doing. I look forward to that expanding.

I wanted to just draw your attention to the HBCUs and the TCCUs and the MSIs. I know that you all recognize the signifi-

cance of them, the importance of them, and that is recognized in the budget because of the investments that you have increased in those areas.

Could you please speak to the importance and impact of better funding these universities that primarily care for students of color?

Secretary CARDONA. They care for students of color, but they punch above their weight. HBCUs, for example—only 3 percent of our colleges and universities are HBCUs, yet they are producing tenfold the percentage of Black doctors, judges, attorneys.

So, for us, this is really about making sure that we are supporting institutions that have historically been underfunded and don't have the endowments in many cases that other universities have but are producing high-quality graduates and are contributing in positive ways to our economy.

So, for me, you know, my visits to not only HBCUs but MSIs and HSIs and TCCUs underscore the importance of supporting these institutions that are helping next generation of many times first-generation college students find success and achieve that American dream.

So it is a great investment, not only for these institutions, but for our economy and for our country.

Mrs. WATSON COLEMAN. I think that your budget proposal, the President's budget proposal definitely moves in the right direction in so many areas that are important to us, and I look forward to working with you. And I thank you for all the work that you have done and for the places you shared based upon your lived experiences, which are very important and very relevant.

Secretary CARDONA. Thank you, ma'am.

Mrs. WATSON COLEMAN. I yield back.

Secretary CARDONA. Thank you.

The CHAIR. Thank you.

With that, I will ask the ranking member if he has any closing statements.

Mr. COLE. Yeah, just a few. And thank you, Madam Chair, and it is wonderful to be back here and maybe next time in our own room, but this is still good.

And, Mr. Secretary, it is always a pleasure to have you.

I come away from our hearing with four conclusions. One, I would ask you to really look carefully, Mr. Secretary, at this charter school issue. We had four different members on our side raise concerns about that, and I think they reflect what their governors are thinking in many cases or certainly what their constituents are. So we have a lot of concerns in that area, and we are going to continue probably to push pretty hard on that.

Second, I would ask you—and you acknowledged this—to look at Impact Aid and Indian education. Again, I understand why the numbers are a little bit lower, but I think we could probably all agree those are areas that we want to continue to work on, certainly Native American education. I know a lot of that is actually in the Interior budget. That is a whole other discussion for another time as to where that would be appropriately funded, but we would certainly like to see some increases there.

Third, on a very hopeful note, you know, as I draw away, and I listened to all the comments and your testimony, I see some ter-

rific areas of cooperation, and they are pretty traditional for us here. Special education is something I think we all feel strongly about with IDEA in particular. Early childhood has been a favorite of this committee on both sides of the aisle for quite a few years. First-generation college students, I think we all think that is an investment that is not only a good investment, but helps us deal with inequities that we know exist over time.

And finally—and your background would probably make you especially sensitive here—career and technical education where, again, as you pointed out in your testimony, there are some terrific job opportunities for kids, and we need to make sure that we don't disparage the 70 percent that choose to do another route than the traditional 4 years, and that can often lead to a very, very good outcome, and we don't want to miss those opportunities.

Finally, the last thing I will say is just renew my commitment. Probably the best gift we can get you—of course, you want everything that you would ask for, and that is fair enough, but the best thing we could do for you is get you something on time and, you know, make sure that you have got the time to implement. So I want to reiterate, I want to work very closely with my chairwoman, whom I admire a great deal, and try to make sure that we get this done closer to the time so that you have got, you know, the full amount of time to implement these things.

And we got you a budget I am pleased to have voted for, but we got it to you awfully late, and I know that has made things very difficult for your department. We are going to try and do a better job. And if we don't do a better job, I can assure you it won't be the fault of the House of Representatives or our chair. It will be the fault of the United States Senate. So we are going to push them pretty hard too.

So thank you.

And thank you for the hearing, Madam Chair. I yield back.

Secretary CARDONA. Thank you, Ranking Member.

The CHAIR. Thank you very much.

And I too am committed to seeing that we can get these bills done in time for people to be able to utilize the resources that they need and not wait several months before they can do that. And I want to thank the ranking member for his assistance in getting the bill, the omnibus over the finish line. And he knows that I welcome his support, and I will ask for his support and help and guidance as we try to make it through the next go-around.

And this afternoon, we will have a meeting with the four corners. And, you know, I am optimistic about having, you know, a good direction and one where everyone understands the need to, you know, move quickly.

Just a couple of points. We talked about, you know, the issue of technical schools and having youngsters be able to really realize their dreams and their aspirations. The fact is that 70 percent of people in the United States do not have a 4-year college degree, nor—if you can, fine, and if you can't, that is fine. But that means that is all the more reason why we have to address what is important to 70 percent of the people in this Nation.

And, you know, that is critical in making sure that those institutions are the very best and are providing the kind of instruction that allows them to realize those dreams and aspirations.

I would say I understand Ms. Herrera Beutler's need, you know. She has that little urchin there that, you know, needed to run off with. But I would just say, because I—at the outset in my questioning, I talked about a private institution, the University of Southern California, and what it costs for their master's degree program and what they are doing. So we need to root out that kind of—you know, I call it corruption, I really do, you know, out of wherever it is, to provide youngsters with what they need.

And you started out—and I did as well—Mr. Secretary, that talked about—you know, I talked about Horace Mann: "Education, beyond all other devices of human origin, is the great equalizer." Education is the great equalizer.

There isn't a person on this panel here or even out there whose parents have said to them, "Get yourself an education because it is the root to success." You know, your family said that to you. You know, that is what my parents told me, you know, over and over again. And the parents sacrificed to make sure that that happened so that we could realize our own dreams and aspirations.

But no child should be denied a quality education because of their parents' economic circumstances, or where they are born, or if they have a disability, you know, or their ethnicity, or their race, their gender. That is not who we, you know, strive to be. And I know that that is the heart and soul of where you are.

And so that—and as I said that education is the great equalizer, and it is our teachers, it is our public schools, our universities, they are more essential now than ever to be fulfilling that effort.

Our job is—and you talked about it at the outset. You know, the numbers are important, because we have to take a look at what the funding is, et cetera, but what is the underlying mission? What needs to propel us to get those opportunities out to youngsters, whether it is K-12 or postsecondary? You know, how do we do that?

We now have a new set of challenges as well. We have serious mental health issues with our kids. We have people who are struggling with hunger, housing costs with college, you know, students. There are disparities which are there. We have outside forces today that you don't want to create a new dynamic around education and use teachers in many respects and scapegoat teachers, you know. I mean, this is—it is tough. It really is. So we have to kind of navigate our way through.

And I want to commend to you, because I think that your background, your experience is what we critically need at this juncture to navigate education. And, absolutely, people are not always going to agree on everything. We will disagree. But as the ranking member said, we do it with civility. We do it with the goal in mind. That is where we need to go in the course of our Nation's history. What is the goal? And on both sides of the aisle, like they did in the past when we created a social safety net in this country, it was Democrats and Republicans coming together and saying, "This is the challenge. How do we get there?" We want to help you get there, and that is what our goal will be here.

And, with that, I thank you. I thank your team for all that you do and your commitment to our youngsters' education. So thank you.

And, with that, this hearing is adjourned.

[Answers to submitted questions for the record follow:]

**Committee on Appropriations**  
**Labor, Health & Human Services, and Education Subcommittee**  
*FY 2023 Budget Request for the Department of Education*  
*April 28, 2022*

Questions for the Record for Secretary Miguel Cardona

**Submitted by Rep. DeLauro**

***Graduate Student Debt***

I appreciate your responses to my questions and concerns over the proliferation of for-profit Online Program Management (OPM) companies in higher education. I am deeply troubled by how tuition-sharing agreements between universities and for-profit companies can create perverse incentives that drive up costs, waste taxpayer dollars, and rip off students. I look forward to following up with you and your staff so we can take swift action to establish commonsense guardrails for these relationships to protect students and taxpayers.

The *Wall Street Journal*'s piece on the University of Southern California and 2U also highlighted the role OPMs can play in saddling students with unsustainable student debt by taking advantage of the graduate student loan programs. According to *The Wall Street Journal*, "the Grad Plus program, which lets students borrow as much as colleges charge, has provided a valuable revenue stream for universities." According to the President's budget, excluding consolidations, graduate student loans are expected to make up over 47 percent of new federal student loan originations in fiscal year 2023. This is way up from the 34 percent of new loan originations graduate student debt represented in fiscal year 2014. While OPMs play a concerning role in this trend, I am also concerned about the broader landscape of graduate student debt.

**Question: Is the Department concerned by the disproportionate share of new student loan originations represented by graduate student programs? If so, what steps is the Department taking to address high levels of debt at graduate student programs? In addition, what efforts is the Department taking to ensure that graduate program outcomes are commensurate with the debt levels of their students?**

*The Department is focused on providing affordable and high-quality educational opportunities to all students, including graduate students. The Department is considering policies that would ensure more affordable options for students enrolling in graduate school programs. This includes increasing transparency into the relationships between institutions of higher education and OPMs, and reviewing those relationships, to ensure compliance with federal laws and regulations and to evaluate how such contracts may*

*lead to increased costs for students. The Department is also focused on ensuring career training programs provide positive outcomes for students, which is why we are currently working to develop regulations ensuring that “gainful employment” programs lead to well-paying jobs for their graduates and providing for better and clearer information for students before they enroll. Protecting students is a top priority for the Administration and that includes making sure that graduate program outcomes are commensurate with the debt levels their students are forced to take on.*

### ***Strengthening School Diversity***

Four decades of research show that all students benefit from attending integrated schools, both academically and socially. Moreover, the benefits of diversity continue to adulthood, leading to higher levels of social cohesion and civic engagement; reduced racial prejudice; and less segregation in neighborhoods, colleges, and workplaces. Research also demonstrates the democratic value of meaningful, sustained cross-racial contact among youth. In short, these benefits to individual students also benefit our society in important ways.

**Question:** In the 2022 Omnibus, I secured language directing the Department to prioritize its technical assistance and capacity building support under the Student Support and Academic Enrichment Grant program to State and Local education agencies seeking to foster school diversity across and within school districts. How do you anticipate carrying out this directive?

*The Department shares your commitment to supporting state and local efforts to increase district and school diversity. This is why our FY 2023 proposal maintains the FY 2022 request for \$100 million for the Fostering Diverse Schools grant program – a program aligned with the bipartisan Strength in Diversity Act that passed in the House last Congress. The Department is in the process of considering options for carrying out this important directive using FY 2022 funds, which will be carried over into FY 2023 and will be able to provide additional information most likely in the coming months. This process includes determining the actual amount of funds available for this purpose. And while the use of these funds will be leveraged to the maximum extent possible by the Department, these funds are only a fraction of what the Department is requesting for this purpose. Options for these funds could include, among other things, a center for technical assistance to local educational agencies (LEAs) engaged in school integration activities and small capacity-building grants to support LEAs in developing comprehensive plans for increasing racial and socioeconomic diversity in schools, including through inter-district partnerships.*

### ***Early Intervention for Students with Disabilities***

The FY23 budget proposes a \$436 million increase for Part C of the Individuals with Disabilities Education Act, which provides services and supports to children with disabilities birth through age two and their families. The budget request also includes proposals to improve Part C and modernize the program. In the FY22 Omnibus, I was proud to secure language to allow States to

close gaps in services for young children with disabilities from their third birthday until the beginning of the next school year. But with the COVID-19 pandemic and challenging economic crisis the last several years, we have had more families needing early intervention support – causing even more demand on states for these important services.

**Question:** Can you explain how the budget’s proposals for Part C will expand and improve existing services, increase eligibility to services, and provide more equitable access to services?

*The Biden-Harris Administration is committed to ensuring that every child receives the services and supports they need to grow and thrive. To that end, the President’s FY 2023 Budget Request proposes historic increases and important reforms for the Grants for Infants and Families program that would support a significant expansion of early intervention services for infants and toddlers with disabilities and infants and toddlers at-risk of experiencing a substantial developmental delay, particularly for historically underserved children such as children of color, children from rural areas and children from low-income families. The COVID-19 pandemic resulted in a substantial decline in the number of children receiving services under the Part C program, likely due in significant part to difficulties in effectively identifying and evaluating children who were less likely to be regularly accessing services and supports that typically serve as vehicles for State child find systems (e.g., daycare centers, pediatricians).*

*As a result, the Administration believes States are likely to see a significant increase in the number of new children into the program over the coming years and that these children are likely to have more intensive needs associated with the delay in identification, evaluation, and service provision. The requested funding increase for this program would provide critical support to meet State needs for adequate staffing to ensure that they have enough high-quality and well-trained service providers to meet the increased demand.*

*Recognizing that increased funding alone cannot ensure access to services for underserved children, such as children of color, children from rural areas and children from low-income backgrounds, the request proposes to increase equity and access to Part C services through several proposals, including:*

- 1. **Expanding access to children at-risk of developing delays and disabilities** by providing financial incentives under the Part C State Incentive Grants (SIG) program for States to serve at-risk infants and toddlers. Providing at-risk children with Part C services can expedite the provision of services so that a child highly likely to develop a delay does not have to wait for the delay to clinically manifest before receiving services. Furthermore, serving at-risk children can particularly increase access to the program for underserved children, as children of color and children from low-income backgrounds are disproportionately likely to qualify through these risk factors.*
- 2. **Promoting more equitable distribution of funding** through proposed appropriations language that would incorporate a measure of poverty into the Part C State*

*allocation formula, similar to formula allocations under the IDEA Grants to States and Preschool Grants programs. An equitable allocation of Part C funding should factor in poverty, which is strongly correlated with many risk factors for developmental delay or disability, such as low birth weight, poor nutrition, and lead exposure.*

3. ***Easing entry into the Part C program for new parents*** by giving States the flexibility to use Part C funds to design and implement systems that make initial entry into the Part C system as transparent and seamless as possible for new parents and families. The request includes proposed appropriations language to provide flexibility to States to use their Part C funds to conduct child find, public awareness, and referral activities for individuals who are expected to become parents of an infant or toddler with a disability.
4. ***Promoting equitable access to Part C services*** by ensuring that States engage in a comprehensive planning process to strategically deploy resources to increase enrollment of underserved children. The request includes appropriations language that would require all States receiving funds under Part C to develop and implement a plan approved by the Secretary that would be updated annually and include (1) identified subgroups and regions the State determines have limited access to Part C services, based on service rate data; (2) a comprehensive set of evidence-based practices the State intends to implement to engage underserved subgroups and meet the needs of those populations; and (3) a proposed budget for executing its plan.
5. ***Reducing fiscal barriers to services*** by ensuring families are not charged fees for services. The Department also recognizes that a State's system of payments under Part C can itself be a barrier to equitable access to program services. Therefore, the Department is proposing appropriations language that would prohibit States from charging family fees or out-of-pocket expenses. The proposed increase in program funding would more than offset revenue lost by ceasing collection of family fees.
6. ***Ensuring continuity of services*** by addressing uncertainties and disparities in the provision of services through proposed appropriations language that would require States to provide families at least 24 months' advance notice of any changes to eligibility requirements under the Part C program that would limit participation. Requiring such advance notice would remove short-term incentives to cut costs by restricting eligibility and ensures that infants and families will be able to receive their full range of services without interruption. This proposal also aims to amplify the voices and concerns of families, providers, and other stakeholders by requiring States to conduct public participation procedures prior to a State narrowing criteria. The Department has also started an interagency working group including representatives from multiple Federal agencies to develop resources on strategies to improve the identification of infants and toddlers for the IDEA Part C program, improve the

*eligibility determination process, and increase access to services. The working group plans to release a series of implementation guides beginning in summer 2022.*

- 7. Ensuring that every child has access to higher quality service providers by leveraging the resources provided under Part D of the IDEA, including the proposed \$159.8 million increase to the Personnel Preparation program, to both increase the number of early childhood training grants it supports each year under Part D and make new grants to States to support State-driven reforms to increase the effective recruitment, preparation, induction, professional development, support, and retention of highly effective early intervention service providers, with a particular emphasis on increasing the diversity of providers, including providers from underrepresented backgrounds. With the requested increase to the FY 2023 appropriation, the Department could begin development of a discretionary grant competition to award funds for this purpose upon enactment of FY 2023 appropriations.**

**Submitted by Rep. Barbara Lee**

***Oakland Unified School Closures and Disproportionate Impact on Communities of Color***

Secretary Cardona, as you may be aware several K-12 public schools in the Oakland Unified School District (OUSD) in my district of Oakland, CA are slated for closures or mergers. Black students make up 22% of OUSD's enrollment but account for 45% of schools impacted by school closures. The ones that are likely to close have majority Black student populations. Since 2004, OUSD has closed 16 schools with primarily Black student populations.

I am very concerned about this through an equity perspective especially with the disruptions to students' learning because of the COVID-19 pandemic. Furthermore, closing schools in low-income, predominantly Black and Brown neighborhoods will lead to more educational segregation and financial drain and our students deserve to have high quality education without unnecessary disruptions and dislocation.

**Question:** Can the Department of Education assist with facilitating an investigation as to why several K-12 schools in my district are slated for closure and whether Title I funds or previous ARP funds were used to support these schools?

*Thank you for your important question, equity is at the center of the Department's work. Unfortunately, the Department does not collect information on Title I or ARP allocations to individual schools. However, the California Department of Education (CDE) monitors the amount of ARP ESSER funds allocated to schools on a quarterly basis. We recommend that you contact the CDE for more information regarding these schools. If there is concern about a potential civil rights violation, a complaint can be filed with the Department's Office for Civil Rights to initiate an investigation and determine whether any violation exists, and if so, the appropriate remedy.*

***HBCU's, PBI's and MSI's***

Mr. Secretary, as you know, Historically Black Colleges and Universities (HBCUs) provide enormous value for students and the nation, particularly for many first generation college students. HBCUs represent approximately 3 percent of all two-and four-year colleges and universities, but confer 18 percent of all bachelor's degrees awarded to African Americans and 25 percent of all STEM degrees awarded to African Americans. I'm glad to see that the President's FY 23 budget increases support for HBCU's PBIs and MSIs. We have heard that some HBCU's are looking to expand their campuses to develop satellite campuses on the West Coast.

**Question:** How can your Department support the development of expansion of HBCUs in California?

*We are grateful for the outstanding work our HBCUs do to provide high quality education to all of their students, and for the value and innovation they provide for our country. The Department supports the continued effort by HBCUs to meet the needs of their students, including efforts to expand as needed, as long as those efforts do not lose sight of their primary mission and do not exceed their own financial stability and institutional bandwidth to the deficit of the existing campus community.*

**Submitted by Rep. Cheri Bustos**

***TRIO and Pell Grants***

**Question:** In Fiscal Year 2022, the Federal TRIO program provided support for 1,800 projects nationwide, including 11 in my district that served 1,500 students, to provide individual support to help Pell grant students navigate the path to a college degree and beyond. For low-income students, getting into college and paying for it is one thing – but completing college is even harder. How will how the Administration’s investment in the TRIO Programs work hand-in-hand with the Pell Grant to ensure that students are able to take advantage of the opportunities provided by financial aid, and actually complete a college degree?

*The Department recognizes that the Federal TRIO programs and Federal Pell grants both play a critical role in ensuring that low-income students are able to enroll and persist in postsecondary education. With that in mind, the Biden-Harris Administration’s FY 2023 Budget request includes a \$160 million increase for TRIO programs, increases the maximum Pell Grant by \$1,775, and lays out a path to double the Pell Grant by 2029. We believe that TRIO programs must ensure that all TRIO participants have the information and capacity required to apply for and receive Pell grants and other forms of financial assistance. In fact, TRIO program projects are required under the Higher Education Act to provide information to participants on the full range of available Federal student financial aid programs and benefits, including Federal Pell Grant awards. The Department supports the provision of technical assistance to all TRIO program projects to ensure that these projects have the capacity to assist students in finding the financial aid necessary to achieve their higher education goals. For example, the TRIO Training grant program, which provides training directly to TRIO project staff, prioritized in the FY 2022 competition grant applications that assist students in receiving financial aid from financial aid programs such as Pell grants. In addition, in April the Department partnered with the Consumer Financial Protection Bureau to provide technical assistance on financial aid tools to TRIO grantees via a webinar entitled: Tools for Student, Student Loan Borrowers, and Educators.*

**Submitted by Rep. Bonnie Watson Coleman**

***Fostering Diverse Schools***

We are less than a month away from the 68<sup>th</sup> anniversary of the landmark unanimous decision of *Brown v. Board of Education* that held that state laws enshrining “separate but equal” public schools for Black and white students were unconstitutional. While much progress has been made, *Brown*’s promise had not yet been fulfilled. In too many places in our nation students of color have less access to educational opportunities than their white counterparts. For example, my home state of New Jersey has one of the most segregated school systems in the country. Though the majority of New Jersey’s school-age population is non-white, the state’s schools remain staggeringly segregated. A Center on Diversity and Equality in Education study found almost 25 percent of New Jersey schools are “desperately segregated”.

Moreover, despite the research that shows that all students benefit academically, socially, and through other life outcomes, our schools are increasingly segregated. For example, a 2016 report published by the Government Accountability Office found that a growing percentage of k–12 public schools in the nation are hyper segregated, with largely Black and Latino/a student populations and students from low-income families. Further, about half as many Black students are in integrated schools as was true in the 1980s.

**Question:** One policy to address how segregated our schools have become is found in the President’s budget request, which proposes to invest \$100 million in the Fostering Diverse Schools program. This program is modeled off of the Strength in Diversity Act, which passed the House on a bipartisan basis during the 116th Congress and was marked up in committee this past November, 2021. It would provide grants to help communities foster diverse learning environments. Secretary Cardona, can you speak to the importance of students learning in racially, socioeconomically, and linguistically diverse learning environments, and why it is important that Congress include the Fostering Diversity program in the FY2023 spending bill?

*The negative effects of racial isolation and concentrated poverty are well documented yet, in the dialogue on education, too often overlooked. The proposed Fostering Diverse Schools program would shine a national spotlight on this issue and, through planning and implementation grants and robust technical assistance, support an increasing number of communities in developing schools that are racially, socioeconomically, and linguistically diverse by design. This investment is critical to efforts to remove the barriers to success that children and youth living in racial isolation or concentrated poverty persistently face and to improve outcomes for all students. Research shows that diverse schools benefit all students and can improve not only academic outcomes but social and emotional, civic, and economic outcomes as well.*

**Submitted by Rep. Cole**

**Question:** Some states have not delivered any education services to any nonpublic school students under the Emergency Assistance to Nonpublic Schools program. What is the Department doing to hold those states accountable? How is the Department ensuring Federal dollars are being spent for this program?

*Under the Emergency Assistance to Non-Public Schools (EANS) program as authorized by both Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (CRRSA) and American Rescue Plan Act of 2021 (ARP), a State educational agency (SEA) must obligate funds within 6 months of its award date, but services or assistance may be provided to non-public schools throughout the program period. Through conversations and other correspondence with SEAs regarding allowable activities and program requirements, as well as other technical assistance, the Department has developed an understanding of some of the challenges that SEAs are facing in implementing the EANS program. In some instances, these challenges have resulted in delays in providing any allowable services and assistance to non-public schools. These challenges include lack of processes and procedures within SEAs for providing services to non-public schools (SEAs are typically administrative agencies, while local educational agencies are accustomed to providing services to students, including equitable services to students attending non-public schools under Federal formula grant programs, such as Title I, Part A of the Elementary and Secondary Education Act of 1965); often lengthy and complex State procurement requirements and timeframes; and supply chain issues. When these problems have delayed the obligation of EANS funds, the Department has worked closely with individual SEAs to resolve these issues. With respect to ARP EANS, the Department approved State applications between September 2021 to April 2022, and SEAs are in various stages of implementing the ARP EANS program.*

**As of July 13, 2022, under CRRSA EANS.**

- 52 SEAs have obligated funds.
- 13 SEAs are continuing their obligation activities due to various challenges such as State procurement or legislative regulations.
- 18 SEAs have fully obligated the funds for contracted or direct provision of services and resources.
- 21 SEAs obligated their funds but also reverted (or are in the process of reverting) a portion of funds to their Governor for allowable uses under GEER. The estimated amount of reverted CRRSA EANS funds is \$415,692,327.
- The estimated amount of obligations that have been made for contracts or services is \$1,726,572,089.
- All but 1 SEA have drawn down funds; the remaining SEA anticipates doing so in the next several weeks but has had contracting/procurement challenges.

As of July 13, 2022, under ARP EANS,

- 17 SEAs have not yet reached their 6-month obligation date for ARP EANS as these obligation dates continue to October 1, 2022.
- Of the 35 SEAs that have reached their obligation date,
  - 8 have fully obligated funds,
  - 13 have obligated funds and are in the process of reverting unobligated funds,
  - 7 are completing obligation activities, and
  - ED is waiting for 7 SEAs to respond to obligation inquiries.
- An estimated \$840,274,120 has been obligated for services or assistance and an estimated \$290,051,189 has or will be reverted to Governors for allowable uses under GEER.
- To date, 17 SEAs have drawn down funds.

Concerning your question about Departmental actions to hold SEAs accountable for proper implementation of the EANS program, the Department engages in multiple activities to provide technical assistance and ensure that SEAs are meeting program requirements. In early 2021, the Department established an internal, cross-office EANS working group to respond to specific questions, develop FAQs, and engage in ongoing technical assistance. The EANS workgroup continues to address implementation questions of the EANS program and respond to inquiries from the field to assist SEAs. The Department has produced multiple EANS documents, webinars, and other forms of technical assistance to address questions or concerns raised from individual SEAs. Under CRRSA EANS, as each State's 6-month obligation deadline neared, the Department met with every SEA to discuss the implementation of EANS and learn about the status of obligations. These meetings were also an opportunity for the Department to conduct informal monitoring of EANS implementation and in many cases work with SEAs on how to remedy implementation challenges. For both CRRSA EANS and ARP EANS, the Department has requested written verification of the obligation status in each State and is tracking that information. Finally, SEAs are required to provide data on EANS implementation through the Department's Annual Performance Report beginning May 2022. If you have additional questions about State implementation of the EANS program, please let us know.

### **Civics Education**

On April 19<sup>th</sup>, the Department of Education published in the *Federal Register* proposed priorities for the American History and Civics Education programs. The department proposed adding two new priorities to the programs, which included grantees proposing projects that focused on “systemic marginalization, biases, inequities, and discriminatory policy and practice in American history” and “promoting information literacy skills.”

Following critical congressional feedback, the department opted to classify these priorities as “invitational” in its final notice inviting applications, which it said would not give an application

priority. In discussions with my office, the department also said it reserved the right to reclassify the priorities in the future if desired.

**Question: Does the Department intend these priorities to remain invitational for Fiscal Years 2022 and 2023?**

*For fiscal year 2022, the Department plans to use funds available for new awards to fund down the 2021 National Activities slate. The Department is in the very early stages of planning for American History and Civics competitions in fiscal year 2023 and has not yet made decisions about any priorities that might be used for those competitions.*

**Submitted by Rep. Jaime Herrera Beutler**

***Student Mental Health***

In Washington state, a recent Healthy Youth Survey showed that 38% of 10<sup>th</sup> graders reported feeling sad or hopeless in 2021. Even more concerning – 20% of 10<sup>th</sup> graders said they have seriously considered suicide.

**Question:** How will the Department of Education ensure that resources are being used to support student mental health in an effective and efficient manner?

*With the help of the American Rescue Plan, public schools have seen a 53% increase in the number of social workers and an 18% increase in the number of counselors since the years before the pandemic. To continue and build on this progress, the Department has engaged in activities to provide technical assistance and guidance to help educators, schools, and districts meet the mental health needs of students and to support educators and mental health professionals serving students, including by using American Rescue Plan funds to support students' mental health, a priority of the program. As part of this effort, last Fall we released the "Supporting Child and Student Social, Emotional, Behavioral and Mental Health Toolkit" to provide information and resources to enhance the promotion of mental health and the social and emotional well-being among children and students. This resource highlights seven key challenges to providing school- or program-based mental health support across early childhood, K–12 schools, and higher education settings, and presents seven corresponding recommendations. Furthermore, the Department will continue to work with the Department of Health and Human Services to provide technical assistance to State Medicaid agencies, local educational agencies and school-based entities on using Medicaid to provide mental health services in schools to eligible students.*

*At the time of drafting a response to this inquiry, we are also drafting proposed priorities for our existing Mental Health Service Professional Demonstration Grants program and our School-Based Mental Health Services programs aimed at maximizing benefits of the additional funding provided through the Bipartisan Safer Communities Act for these programs in fiscal year 2022, particularly in ensuring equitable access to high-quality mental health supports in participating States and school districts. In addition, the Administration's fiscal year 2023 budget request maintains the FY 2022 proposal for a \$1 billion investment to increase the number of mental health providers in schools as a key step toward improving access to essential mental health services.*

***Civil Rights Data Collection***

Recently, the Office for Civil Rights has taken steps to increase data collection on students and update definitions.

**Question:** Why is updated demographic data being collected on students and how is the Department of Education using it?

*At this time, no updated data is being collected. However, the Department currently has a pending proposal to collect new demographic data, add a third sex category – nonbinary – limited to those States that now collect the data, in the 2021-22 CRDC Information Collection Review (ICR). See <https://www.federalregister.gov/documents/2021/12/13/2021-26873/agency-information-collection-activities-comment-request-mandatory-civil-rights-data-collection>. The 2021-22 CRDC ICR proposal has completed one round of a 60-day public comment period as required by the Paperwork Reduction Act of 1995. OCR will respond to all comments and submit the ICR for the second 30-day public comment period also required by the Paperwork Reduction Act of 1995. The U.S. Office of Management and Budget must approve the proposed data elements for the 2021-22 CRDC before OCR may collect and utilize the data. In sum, the Department of Education currently is not collecting updated demographic data on students because the ICR process is not yet complete.*

*The Department explained in the ICR's Supporting Statement A that the inclusion of a nonbinary sex category would allow OCR to capture data that would provide a greater understanding of the experiences of nonbinary students, where this data is already being collected, and would help to further OCR's mission to enforce Title IX's prohibition on discrimination on the basis of sex. Nonbinary would be defined as students who do not identify exclusively as male or female. See <https://www.regulations.gov/document/ED-2021-SCC-0158-0042>.*

**Question:** Could these updated data collection requirements create an additional administrative burden for schools?

*If approved by the U.S. Office of Management and Budget, only LEAs that indicate that they collect this information from students would be required to report student enrollment data for nonbinary students for the 2021-22 school year, and this data will be optional for all other LEAs..*

**Question:** How is the Department of Education protecting students' privacy and is there any risk that this data could be compromised?

*The Department is committed to ensuring that the CRDC does not compromise student privacy protections. All CRDC data released to the public must undergo a rigorous privacy protection methodology. The Department's Disclosure Review Board approves the procedures implemented to protect students' privacy. See <https://nces.ed.gov/statprog/confproc.asp>. Moreover, the CRDC does not collect student names, or contact information, including identification numbers. The CRDC's privacy protection methodology for the most recent collection, for the 2017-18 school year, is described through its Technical Documentation. See, pages 6-7, <https://ocrdata.ed.gov/assets/downloads/Data%20Notes%202017-18%20CRDC.pdf>.*

### ***Proprietary Institutions***

Rulemaking is underway at the Department of Education surrounding eligibility requirements for programs authorized by Title IV (4). I have heard from cosmetology schools in my district that their opinions have not been considered in this process, which could threaten their ability to provide financial aid to their students.

**Question:** As the rulemaking process continues, how will the Department of Education actively engage with and consider the opinions of cosmetology schools?

*The Department appreciates and shares your concern about ensuring that quality institutions in the cosmetology and related sectors are able to meet gainful employment standards and remain eligible for Federal financial aid. We are committed to ensuring that we engage with representatives of many types of institutions, including cosmetology schools, throughout the process. The Department held public hearings regarding the gainful employment rules on June 21, 23, and 24, 2021, during which the Department heard from numerous representatives of the cosmetology and cosmetology school industry. The concerns of cosmetology schools were discussed throughout the negotiated rulemaking process held between January and March, 2022, including inviting daily public comment for each session. As we continue to develop a proposed rule, we have heard from many institutions and associations about their interests and concerns to help inform our process, including the American Association of Cosmetology Schools. We look forward to issuing a Notice of Proposed Rulemaking (NPRM) in the coming months, and we will invite further feedback on that proposal through the public comment process. Through numerous opportunities for engagement over the last year, we have appreciated the insights of cosmetology school representatives, and look forward to continuing to hear and incorporate their feedback as appropriate.*

### ***Community and Technical Colleges Enrollment***

The pandemic has not only led to significant learning loss, but it has also impacted higher education. In Washington state, community and technical college enrollment has dropped by 24%. This is concerning as 70% of new jobs in Washington state will require a B.A. or a trade industry certificate.

**Question:** How will the Department of Education's FY23 budget assist students who have not enrolled in higher education due to the pandemic?

*We know that the pandemic either disrupted or put on hold the postsecondary education hopes and dreams of millions of Americans, and our FY 2023 request is aimed at helping students of all ages get back on track toward their college education and career training goals.*

*For example, we are proposing to increase the maximum Pell Grant by \$1,775 over the 2022-2023 award year, through a combination of discretionary and mandatory funding, a change that would help an estimated 6.7 million students from low- and middle-income backgrounds overcome financial barriers. The Administration also continues to support*

*expanding federal student aid, including Pell Grant eligibility, to Deferred Action for Childhood Arrivals (DACA) recipients, commonly known as DREAMers.*

*We also are asking for a nearly \$201 million increase for TRIO, which provides a wide range of supports and assistance to encourage individuals to enter and complete postsecondary education, including information on higher education opportunities in the community; academic advice, personal counseling, and career workshops; and help in completing applications for college admissions and securing financial aid.*

*The FY 2023 request also includes several proposals aimed at improving transitions to postsecondary education, including a College Bridge Initiative and new grants to support disconnected youth without a high school diploma. In addition, we are asking for \$200 million to launch a Career-Connected High Schools initiative that would improve the integration and alignment of the last two years of high school and the first two years of postsecondary education. Participating students would progress directly from high school to postsecondary education, largely eliminating current admissions and financial barriers that often pose as significant obstacles to students of color and students from low-income backgrounds.*

### ***Seclusion and Restraint***

**Question:** *What is the status of the Department of Education's updates to the definition of seclusion and restraint?*

*The Department proposed new definitions for restraint and seclusion in the Department's 2021-22 CRDC ICR, which must undergo two notice and comment periods, pursuant to the Paperwork Reduction Act of 1995: an initial 60-day period, followed by a 30-day period. The initial comment period closed on February 11, 2022. See <https://www.federalregister.gov/documents/2021/12/13/2021-26873/agency-information-collection-activities-comment-request-mandatory-civil-rights-data-collection>. The Department proposes the following definitions for restraint and seclusion:*

- *Mechanical restraint refers to the use of any device or equipment to restrict a student's freedom of movement. The term includes the use of handcuffs or similar devices by sworn law enforcement or other school security to prevent a student from moving the student's arms. The term does not include devices used by trained school personnel or a student that have been prescribed by an appropriate medical or related services professional and are used for the specific and approved purposes for which such devices were designed, such as:*
  - *Adaptive devices or mechanical supports used to achieve proper body position, balance, or alignment to allow greater freedom of mobility than would be possible without the use of such devices or mechanical supports;*
  - *Vehicle safety restraints when used as intended during the transport of a student in a moving vehicle;*
  - *Restraints for medical immobilization; or*
  - *Orthopedically prescribed devices that permit a student to participate in activities without risk of harm.*

- *Physical restraint refers to a personal restriction, imposed by a school staff member or other individual, that immobilizes or reduces the ability of a student to move his or her torso, arms, legs, or head freely. The term physical restraint does not include a physical escort. Physical escort includes a temporary touching or holding of the hand, wrist, arm, shoulder, or back of a student for the purpose of inducing a student to walk to a safe location, when the contact does not continue after arriving at the safe location. Physical escorting that involves methods utilized to maintain control of a student should be considered a physical restraint.*
- *Seclusion refers to the involuntary confinement of a student in a room or area, with or without adult supervision, from which the student is not permitted to leave. Students who believe or are told by a school staff member that they are not able to leave a room or area, should be considered secluded. The term does not include a behavior management technique that is part of an approved program, which involves the monitored separation of a student in an unlocked setting, from which the student is allowed to leave. Seclusion does not include placing a student in a separate location within a classroom with others or with an instructor where that student continues to receive instruction, is free to leave the location, and believes they can leave the location.*

*OCR will review and respond to comments received during the 60-day period on these definitions and other proposed changes, and once the review is complete, OCR's responses will be submitted to the U.S. Office of Management and Budget, for its review, and for the public's second and final opportunity to submit comments.*

**Question: If the Department identifies a school with high instances of seclusion and restraint, how will this be dealt with?**

*Each investigation is fact-specific; high instances of seclusion and restraint alone do not demonstrate a violation of federal civil rights laws. When investigating whether use of restraint or seclusion violates laws within OCR's jurisdiction, OCR collects and analyzes relevant information, in addition to data, to determine whether legal requirements are satisfied. If OCR's investigation identifies concerns or violations that indicate a failure to comply with the law, OCR will work with officials of the recipient school district to obtain a voluntary resolution agreement, that when fully implemented, will bring the recipient into compliance with the law. OCR will monitor the resolution agreement until such time as OCR determines that the recipient is in compliance with the terms of the agreement, as well as the statute(s) and regulation(s) at issue in the case.*

*A recent example of OCR enforcement related to restraint and seclusion, involved some 61 uses of restraint or seclusion on a Kindergartener in a single school year, as well as a school district admission that CRDC data it submitted for the 2017-18 school year regarding uses of restraint had been incorrect. In resolving that investigation, the school district committed, among other things, to update its policy and provide staff training related to restraint and seclusion, offer compensatory education for affected students,*

*and comply with accurate reporting regarding restraint and seclusion in future CRDC submissions.*

**Submitted by Rep. John R. Moolenaar**

***Charter School Program***

Mr. Secretary, I remain concerned about the recent proposed rules for the Charter School Program (CSP), and if finalized as drafted, its impact on limiting a family's and more specifically, a student's ability to choose another option, such as a high-quality charter school, when the public school is failing to meet their educational needs.

**Question:** What is the purpose of the first prong of the “community impact analysis” where there needs to be “unmet demand” to justify the establishment of a new charter school?

*Since 2001, almost 15% of the charter schools and proposed charter schools that received federal funding either never opened or closed prior to the end of the grant period – these schools received more than \$174 million in taxpayer dollars. It is critical that in planning for a new charter school, as with the establishment of any new school, there be reasonable evidence demonstrating the need in the community for that school. The Department recognizes there are multiple ways applicants can go about doing that and in the final rule, published on July 1<sup>st</sup>, a number of examples of evidence applicants may provide to indicate the need for the proposed charter school, such as current waitlists for existing charter schools, or interest in a specialized instructional approach, are described. The needs analysis (which has replaced the community impact analysis, in the proposed priorities) is aligned with other Department grant programs, such as the Magnet Schools Assistance Program and the Full-Service Community Schools program, which also require applicants to demonstrate a need in the community for the establishment of new schools.*

**Question:** What are the specific parameters on defining “unmet demand” and what percentage of over-enrollment triggers this clause?

*Over enrollment is only one of a number of factors that might provide insight into demand for new schools. The final rule makes is clear that multiple factors – including but not limited to wait lists at existing charter schools and specialized programs – may be used to demonstrate demand.*

*It is also important to note that there have been instances where expected demand has not materialized, contributing to a charter school either not opening or having to close prior to the end of the grant period. As previously stated, almost 15% of grantees that received funding through CSP either never opened or closed prior to the end of the grant period, costing at least \$174 million in taxpayer dollars. The Department is committed to fiscal responsibility with federal resources.*

**Question:** What are the checks and balances on local school districts/boards who, under the proposed rules, are required to certify that there is unmet demand and a need for a charter school?

*As previously stated, applicants would have options for describing their projected enrollment and the impact of their proposal on the community, as is the case across numerous grant programs. Applicants are not required to obtain certification from a local school district or board that there is unmet demand and a need for the proposed charter school(s).*

**Question:** I would submit that the proposed rules run contrary to existing law, the *Every Student Succeeds Act* (ESSA) – the main federal law governing K–12 education. ESSA authorizes the CSP under a section entitled “expanding opportunity through quality charter schools.” It explicitly states that the purpose of the section is to “provide financial assistance” to charters and to “increase the number of high-quality charter schools available to students across the United States.”

Could you explain whether or not collaboration requirement would have the opposite effect of “increas[ing] the number of high-quality charter schools available to students across the United States.”?

*The Department is not requiring applicants collaborate with school districts in FY2022 CSP competitions and will not do so in future competitions run by this Administration . Rather, in the FY2022 CSP Developer competition, the Department included an invitational priority to promote these collaborations without preferencing applicants who propose collaborations over other applicants. There is a growing body of research that the kinds of collaborations described in the notice can improve the quality of educational opportunities across charter and traditional public schools. This includes studies by WestEd and the Center for Reinventing Public Education among others. For example, an analysis of the collaboration between Washington, D.C. Public Schools and Washington, D.C. Public Charter Schools identified over 60 examples of where they were able to partner in mutually beneficial ways. These include shared professional development, scaling innovative practices, sharing grant application, and research development. A similar relationship exists in Boston, Massachusetts where a compact to coordinate across traditional public schools, charter schools, and Catholic schools was created to share best practices.*

*These partnerships can also support the needs of our students with disabilities enrolled in charter schools. According to a report by the Center for American Progress, developing the expertise to successfully serve students with disabilities can be particularly challenging for charters schools that may not enroll many students with low-incidence disabilities and who require highly specialized services and supports. Collaboration with the district can help charters to access expertise that would help improve student services and outcomes, and better understand their nondiscrimination obligations to charter*

*school students with disabilities. The Center for American Progress published a report with the National Center for Special Education in Charter Schools that profiled examples of districts and charter schools pursuing similar efforts.*

*The Center for American Progress report also identified that these partnerships can improve economies of scale for small charter operators as many charters are not able to access the same pricing for curricula, supplies, support services, or technology as larger districts and networks. This frees up resources for charters to invest elsewhere in their programs.*

*This final priority reflects the research on how these mutually beneficial partnerships can improve educational opportunities for students enrolled in charter schools as well as traditional public schools. It is not meant to be a barrier to establishing charter schools, rather to improve the educational opportunities for students enrolled across all public schools.*

**Question:** Why are charter schools being singled out in circumstances involving vendors, or entering contracts with vendors, when public schools are permitted to engage vendors to provide educational services, but the proposed rules would prohibit charter schools from such activities?

*The final rule does not prevent contracts with vendors, such as those that provide payroll or other services.*

I'd like to share the following with you once more for consideration: The Charter School Program, actually charter schools in general, have received strong support from both Republican and Democratic administrations in the past – even the Obama Administration. In fact, President Obama once said charter schools “*serve as incubators of innovation*” and “*give educators the freedom to cultivate new teaching models and develop creative methods to meet students’ needs.*” Let’s go back a bit further, when President Clinton celebrated the Senate passage of the first federal support of charter schools in 1994, saying the legislation “*puts the Federal government squarely on the side of public school choice*” and “*innovative charter schools.*”

For the Fiscal Year 2022 (FY22), there were good faith, bipartisan negotiations in constructing the Labor-HHS section of the omnibus that led to the exclusion of restrictive language on the Charter School Program – which had been included in the House’s FY22 Labor-HHS bill.

**Question:** Understanding that including such prohibitive requirements in legislative language would not pass Congress, could you help inform us whether your department’s intent is to circumvent Congress?

*No, the Department is neither intending to circumvent nor circumventing the intent of Congress. The final priorities are fully consistent with all statutory requirements. The Administration supports high-quality public charter schools. We will work to ensure that*

*charter schools funds support schools that are subject to strong accountability, transparency, and oversight, show demonstrated family and community support, provide equal access for students with disabilities and English learners, and serve students from diverse racial and socioeconomic backgrounds. This is not inconsistent with the purpose of the program and successful implementation. By taking these steps to ensure federal funds are used to support high-quality schools that open and remain open, and provide a high-quality education to students, these priorities advance the program's purpose to increase the number of high-quality charter schools*

### **Federal TRIO Programs**

The post-COVID economy will require new skills – particularly among older adults and nontraditional college students. Many Members in Congress and on this Committee are concerned with workforce readiness to help our businesses and economic growth.

In Michigan's 4<sup>th</sup> Congressional District, the Federal TRIO programs serve more than 2,200 low-income students across my district through projects at Delta College, Central Michigan University, and Mid-Michigan University. Included among them is an Educational Opportunity Center at Delta College which offers educational planning, career exploration, financial aid advising, help with scholarship searches, and college preparation workshops for adult learners trying to make their way back into the postsecondary pipeline.

**Question: As we celebrate the 50<sup>th</sup> Anniversary of the TRIO Educational Opportunity Centers program, can you share how the Department is employing Educational Opportunity Centers to address the growing challenges for older adults and nontraditional students who are transitioning careers?**

*We believe the EOC program serves a critical need for adult learners and nontraditional students who are transitioning careers. During the 2018-2019 program year, 37 percent of EOC program participants were 28 years of age or older and 26 percent of EOC participants were high school graduates without college experience while six percent were adults without a high school diploma. Approximately 61 percent of eligible EOC participants received a high school diploma or equivalent and 59 percent of eligible EOC participants enrolled in college or received notification of deferred enrollment.*

*The Department recognizes that additional work is needed to create opportunities for older adults and nontraditional students transitioning careers to succeed in postsecondary education. In fiscal year 2021 the Department prioritized applicants that proposed EOC projects designed to foster flexible and affordable paths to higher education. These projects will create or expand opportunities for students, including adult and non-traditional learners, to obtain recognized postsecondary credentials through the demonstration of prior knowledge and skills, such as competency-based learning.*



THURSDAY, MAY 26, 2022.

## **TESTIMONY OF INTERESTED INDIVIDUALS AND ORGANIZATIONS**

The CHAIR. Let me begin the hearing and bang the gavel, and let us get underway.

Again, some housekeeping issues to start with. The hearing is fully virtual so we have to address these issues.

For the meeting, the chair, or the staff designated by the chair, may mute participants' microphones when they are not under recognition for the purposes of eliminating inadvertent background noise. Members are responsible for muting and unmuting themselves.

If I notice when you are recognized that you have not unmuted yourself, I will ask the staff to send you a request to unmute yourself. Please then accept that request so you are no longer muted.

I remind all witnesses that the 5-minute clock applies during today's public witness day. If there is a technology issue, we will move to the next witness until the issue is resolved, and you will retain the balance of your time.

You will notice a clock on your screen that will show how much time is remaining. At 1 minute remaining, the clock will turn yellow. At 30 seconds, I will gently tap the gavel to remind witnesses that their time is almost expired. When your time has expired, the clock will turn red, and I will begin to recognize the next witness.

With that, I would like to acknowledge and thank our ranking member, Tom Cole, for being here this morning, other members of the committee.

And welcome to the Labor, HHS, Education Subcommittee's public witness day hearing. I think we all want to express our deep gratitude to the 24 witnesses testifying today and to all of those who sent written testimonies for the record.

It is about your experiences and your testimonies. They are so invaluable to us. The work that we do together to fund the programs in this subcommittee's bill impact the lives of Americans across our country.

At last year's public witness day hearing, I said that today's hearing is one of the most important things the committee does, and that has certainly rang true. With the help of public witnesses, we developed a fiscal year 2022 bill that has made transformative investments to tackle America's toughest challenges.

Our bill grows educational opportunities with more funding for high-poverty schools, for students with disabilities, and for programs that expand access to postsecondary education. It strengthens lifesaving biomedical research with increased funding for the NIH. We bolster our public health infrastructure with an increase of investment in the CDC and in State and local governments.

We tackle the urgent health crises—maternal health, mental health, gun violence, and substance misuse, while reducing unacceptable health disparities. We are supporting middle-class working families with more funding for childcare, for Head Start, for preschool development grants. The bill creates and sustains good-paying jobs with investments in job training, apprenticeship programs, and worker protection. All of these were made because of input from public witnesses.

As we draft the 2023 bill, using the President's budget request as a starting point and direct input from stakeholders, including all of you, we will continue to transform the lives of Americans all across the country.

Looking forward to your testimony this morning, and I thank you all for being here today.

And with that, please let me turn it over to our ranking member, Congressman Cole, for any opening remarks.

Mr. COLE. Well, thank you very much, Madam Chair.

Thank you for holding this hearing. It has been a while since we have been able to have it due the pandemic, and I, for one, miss it a great deal.

And I invite those of you that are testifying today to not just show up for your testimony, but if you have the time, listen for a while. And it is an education because it will give you a clear idea of the true range of this subcommittee, the diversity of the topics it deals with, the sheer quantity of requests that we get every year to address specific problems and to come and testify.

Frankly, I don't think there is any other subcommittee that has anything like the number of people that want to come and participate, and it actually underscores something our chair likes to say quite frequently, that this is the people's subcommittee. And in many ways, it is. Because these are usually urgent issues that affect people's daily lives that we try to direct appropriate money toward ameliorating their circumstances, improving their circumstances, and generally bettering our society.

So, again, I look forward to today's hearing. And for all of you who have come to testify, thank you very much for your interest in the work of the committee, and thank you very much for taking some of your time to educate us and our staff about the things that we need to focus on. It is enormously helpful, as the chair said, when we get down to actually putting together the bill.

So, with that, Madam Chair, thank you again for the hearing, and I yield back.

The CHAIR. Thank you.

So we will get underway with our first witness this morning. That is Bob Lanter, who is the executive director of the California Workforce Association.

Mr. Lanter, you are recognized.

**BOB LANTER, EXECUTIVE DIRECTOR, CALIFORNIA  
WORKFORCE ASSOCIATION**

Mr. LANTER. Good morning, thank you.

Good morning, Chairwoman DeLauro, Ranking Member Cole, and members of the Labor, HHS, Education Appropriations Sub-

committee. My name is Bob Lanter, and I serve as the executive director of the California Workforce Association.

CWA is a statewide nonprofit representing the 45 local boards, as well as a broad coalition of workforce stakeholders in California. My testimony today will focus on the Workforce Innovation and Opportunity Act Title I programs at the Department of Labor—Adult, Youth, and Dislocated Worker.

The fiscal year 2023 budget request would increase funding for the Adult, Youth, and Dislocated Worker Programs to the fiscal year 2020 WIOA authorized levels. WIOA Title I should be funded at least to the amounts following—Adult Employment and Training Activities, \$899,000,000; Youth Activities, \$963,000,000; Dislocated Worker Employment and Training Activities at \$1,600,000,000.

While we support this proposed increase, we know more is desperately needed to respond to the ongoing impacts of COVID-19 on our Nation's economy. The House recently passed a WIOA 2022 reauthorization package that includes historic investments for these programs, beginning in fiscal year 2023, and we strongly support those funding levels moving forward.

The Federal funding approved through this subcommittee is the primary source that supports a national network of local workforce development boards, led by the private sector, and American Jobs Centers throughout each of your respective districts. These centers and their staff serve as a critical resource for job seekers, businesses, training providers, and other agencies to address the economic needs of their communities.

We thank the leaders and members of this subcommittee for your efforts during the fiscal year 2022 appropriations process, which provided marginal increases—about 1 percent—for WIOA Title I programs when compared to fiscal year 2021 levels. Unfortunately, this level of Federal investment does not address our current or future national workforce needs.

In California, during the 2021 program year, our adult and youth formula allocations were cut by nearly 7 percent each. Twenty other States also experienced cuts to their adult activities during this time. This funding cut, during the height of COVID, reduced the capacity and services for individuals looking to re-enter the workforce, as well as businesses desperate to hire skilled workers.

The labor market remains very fluid with record job openings and separations, and innovative talent pipeline development strategies are needed if we are to support business and provide opportunities to job seekers, particularly those working to achieve economic self-sufficiency.

One of the advantages of the Federal workforce system, as funded by WIOA, is the ability to leverage and engage broad stakeholders, such as education and training, business, labor management partnerships, and economic development. Through these networks, Federal funds, invested locally through workforce boards, can be intentionally directed to communities where businesses and individuals need them most.

Unfortunately, the impacts of COVID-19 hit the most vulnerable populations earlier and longer. The effects continue to create significant barriers to employment for minorities, women, disabled individuals, out-of-school youth, ex-offenders, and others.

Affordable access to childcare, transportation, food, and housing often prevent individuals from enrolling in education and training programs or even getting or keeping a job. This type of support services and additional resources for them will expedite barrier removal.

Career pathways are also developed in partnership with business, labor, education to incorporate in-demand skills into program delivery. Collaborations like this lead to better outcomes in job placement, wage gain, and skill development. In California, the High Road Training Partnership Initiative is designed to model sector-based strategies, ranging from transportation to healthcare to hospitality.

Earlier in this Congress, the bipartisan Infrastructure Investment and Jobs Act was enacted as a landmark achievement to significantly increase spending on traditional projects like roads and bridges but also include broadband expansion and renewable energy sectors. Local boards in California and across the country are leading efforts to identify, train, re-train, and connect workers to these opportunities.

The WIOA Title I programs must be funded beyond current levels to help reach the potential needed in constructing and advancing infrastructure projects by connecting them to our communities' vulnerable neighborhoods.

In closing, increased Federal investments in WIOA Title I programs will facilitate thousands of successful workforce and economic development examples like those referenced earlier. Providing resources that are desperately needed by workforce stakeholders will lead individuals from unemployment and low-wage jobs to education and careers, allowing them to become economically self-sufficient and contribute to our Nation's economy and the future of America.

Thank you very much, and I would be happy to take questions.  
[The information follows:]

May 26, 2022

House Labor, HHS, Education Appropriations Subcommittee  
Fiscal Year 2023 Public Witness Day  
Testimony Provided by: Bob Lanter, Executive Director, California Workforce Association

Introduction

Good morning Chairwoman DeLauro, Ranking Member Cole, and members of the Labor, HHS, Education Appropriations Subcommittee. My name is Bob Lanter and I serve as the Executive Director of the California Workforce Association (CWA). CWA is a statewide, non-profit representing the 45 local workforce boards and other workforce development, education and community-based organization stakeholders. We also work closely with a network of other state associations committed to increasing federal workforce development investments to boost worker training, skill development, employee retention, and economic competitiveness.

My testimony today will focus on the Workforce Innovation and Opportunity Act (WIOA) Title I programs at the Department of Labor – Adult, Youth, and Dislocated Worker Employment and Training Activities. The FY2023 Budget Request would increase funding for the Adult, Youth, and Dislocated Worker programs to the FY2020 WIOA authorized levels. WIOA Title I should be funded **AT LEAST** to the amounts below:

**Adult Employment and Training Activities – \$899,987,000**

**Youth Activities - \$963,837,000**

**Dislocated Worker Employment and Training Activities - \$1,682,664,000** (includes \$527,386,000 in Dislocated Worker National Reserve)

While we support this proposed increase, we know more is desperately needed to respond to the ongoing impacts of COVID-19 on our economy. The House recently passed a WIOA 2022 Reauthorization package that includes historic investments for these programs, beginning in FY2023, and we strongly support those funding levels moving forward.

The federal funding approved through this subcommittee is the primary source that supports a national network of local workforce development boards, led by the private sector, and American Jobs Centers throughout each of your respective districts. These centers, and their staff, serve as a critical local resource for job seekers, businesses, training providers, and other agencies to address the economic needs of their communities.

### **Funding Needs**

We thank the leaders and members of this subcommittee for your efforts during the Fiscal Year (FY) 2022 Appropriations process which provided marginal increases – about 1% - for WIOA Title I programs when compared to FY2021 levels. Unfortunately, this level of federal investment does not address our current or future national workforce needs. In California during the 2021 Program Year, our Adult and Youth formula allocations were cut by nearly 7% each.<sup>1</sup> Twenty other states also experienced cuts to their Adult Activities program funding allocation. This funding cut, during the height of the COVID-19 pandemic, reduced capacity and services for individuals looking to re-enter the workforce as well as businesses desperate to hire skilled workers. The labor market remains very fluid with record job openings and separations.<sup>2</sup> In fact, regional labor markets in California and across the Country are unlike anything we have ever seen, and innovative talent pipeline development strategies are needed if we are to support business and provide opportunities to job seekers, particularly to those that are working to achieve economic self-sufficiency. WIOA Title I programs equip local stakeholders with the tools to navigate these challenges but the combination of these factors with COVID-19 and inflation require additional federal funding.

Since its overwhelmingly bipartisan passage in 2014, Congress has failed to fund WIOA to its authorized levels which has limited its potential in reaching historically underserved populations and our most vulnerable citizens.

### **Benefits to Increased Federal Funding**

One of the advantages of the federal workforce system, as funded and designed in WIOA, is the ability to leverage and engage broader stakeholders such as education and training providers, business, labor management partnerships, and economic development organizations. Through these networks, Federal funds, invested locally through workforce boards can be intentionally directed to communities where businesses and individuals need them most. Increased direct funding through WIOA Title I allows for these existing partnerships to expand and address the significant workforce challenges we face in key industries across the country like advanced manufacturing, health care, and child care, among others. Registered Apprenticeships are a valuable tool for the workforce system and there is a nationwide effort to expand into more non-traditional industries like health care, advanced manufacturing and hospitality.

Unfortunately, the impacts of COVID-19 hit the most vulnerable populations earlier and longer. These effects continue to create significant barriers to employment for minorities, women, disabled individuals, out-of-school youth, ex-offenders, and others.<sup>3</sup> Affordable access to childcare, transportation, food, and housing often prevent these individuals from enrolling in

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<sup>1</sup> <https://www.dol.gov/sites/dolgov/files/ETA/budget/pdfs/21adu%24.pdf>

<sup>2</sup> <https://www.bls.gov/news.release/jolts.nr0.htm>

<sup>3</sup> <https://crsreports.congress.gov/product/pdf/R/R46554>

education and training programs or even getting/keeping a job. Support or wraparound services are a critical component for completion in training programs and keeping people employed. Additional resources will expedite barrier removal.

Work experience is a key factor for employers as they consider candidates. A major impact of the COVID-19 pandemic was the reduction and absence of work opportunities, especially during the summer, for young people. The workforce system works with employers to provide year-round employment, with a focus on out-of-school and opportunity youth. Given the lack of openings in recent years, we are concerned about further disconnection within youth groups in the workforce. Additional federal funding is necessary to confront this challenge.

Career pathways are developed in partnership with business, labor organizations and education providers to incorporate in-demand skills into program delivery. Collaborations like this lead to better outcomes in job placement, wage gain and skill development. In California, the High Road Training Partnerships (HRTTP) initiative is designed to model sector-based strategies from around the state, ranging from transportation to health care to hospitality. The HRTTP model exemplifies a focus on industry partnerships that deliver equity, sustainability, and job quality. Essential elements include industry led problem solving, partnership with business as a priority, worker voice and training solutions.

Earlier this Congress, the bipartisan Infrastructure Investment and Jobs Act (IIJA) was enacted as a landmark achievement to significantly increase spending on traditional projects like roads and bridges but also include broadband expansion and renewable energy sectors. Local workforce boards in California and across the country are leading efforts to identify, train, re-train, and connect workers with these opportunities. The WIOA Title I programs must be funded beyond current levels to help reach the potential needed in constructing and advancing these infrastructure projects by connecting them to our communities' vulnerable neighborhoods.

### **Conclusion**

In closing, increased federal investments in WIOA Title I programs will facilitate thousands of successful workforce and economic development examples like those referenced earlier. Providing resources that are desperately needed by workforce stakeholders will lead individuals from unemployment and low wage jobs to education and careers, allowing them to become economically self-sufficient and contribute to the future of America.

The CHAIR. Let me start with the ranking member, if he has any questions? Or I saw Mr. Cline, if he is on?

Mr. Cole.

Mr. COLE. No, Madam Chair. I have no questions.

The CHAIR. Okay. I think I heard Mr. Fleischmann is on. Mr. Fleischmann.

Mr. FLEISCHMANN. Madam Chair, no questions. Thank you.

The CHAIR. And Mr. Cline.

Mr. CLINE. I have no questions, Madam Chair. Thank you.

The CHAIR. Thank you.

I want to say a thank you to you, Mr. Lanter. We all know the benefits of the WIOA programs and how beneficial they are for adults, for youth, and the disadvantaged.

One of our issues will be what we will be seeing as an allocation for the subcommittee. That has not yet been determined. But I think you can rest assured to say that if you have seen in the past, while it is not to the levels that you would like and that we would like, is that we understand the value of the programs, and our direction is to reinforce these efforts because we know that is where the security of the workforce and for the economic security of the people that these programs benefit.

So thank you so much for being with us today. We really appreciate your time and your testimony.

Mr. LANTER. Thank you, Chairwoman. Appreciate it.

The CHAIR. We now recognize for 5 minutes as our witness this morning, Jodi Grant, who is executive director of the Afterschool Alliance, Washington, DC.

Ms. Grant, it is wonderful to see you. Thank you for your outstanding work.

#### **JODI GRANT, EXECUTIVE DIRECTOR, AFTERSCHOOL ALLIANCE**

Ms. GRANT. Thank you.

Chairwoman DeLauro, Ranking Member Cole, members of the committee, it is truly an honor to be before you today.

And on behalf of the Afterschool Alliance, the afterschool field, families across America, thank you for increasing funding for the Nita M. Lowey 21st Century Community Learning Centers in fiscal year 2022. It provided vitally important support to afterschool programs serving 1.6 million kids. We ask you to build on that and help address the vast unmet need for afterschool programs by providing \$1,790,000,000 in fiscal year 2023.

The Afterschool Alliance is a nonprofit that supports more than 23,000 afterschool partners that are expanding learning opportunities for students nationwide. They keep kids safe and fed and offer them engaging, hands-on learning experiences that improve school attendance, academic achievement, and graduation rates.

During the past 2 years, COVID-19 presented afterschool programs—and the students, families, and communities that rely upon them—with enormous challenges. Programs faced skyrocketing unexpected costs, serious health concerns, limited access to school facilities during closures, staffing shortages, and more.

But I am so proud because the afterschool field rose to meet this challenge. Programs adjusted their schedules to address the urgent

needs of children and families by providing meals, caring for children of essential workers all day long, keeping students connected during remote learning, providing safe spaces for online learning and in-person enrichment, and so much more.

Afterschool programs are now helping young people emerge from the pandemic strong, resilient, and hopeful. None of that would have been possible without Federal support.

Programs operate before school, during school, during—I mean after school, during the summer months, and they provide a safe learning environment, enrichment, caring adults and mentors. And 21st Century Community Learning Centers are unique because of the collaborations that bring the best of a local community's resources to its students.

They offer holistic supports to students of all ages that can prepare them to be college and career ready. Community-based organizations, nationally affiliated non-profits, colleges, public libraries, parks and rec centers, faith-based institutions, traditional public schools, charter schools, museums, and others are all eligible for 21st Century Community Learning Center funding, but the “secret sauce” is that all of these entities join together to provide a quality learning experience for pre-K through 12th grade students.

21st Century programs are helping students reconnect, re-engage, and develop the skills they need to be successful not just in school, but in life. And after school, students discover their passions, be it robotics, gardening, coding, or music, or dance. And at this moment, when so many of our youth are struggling, afterschool programs provide so much more than just academic and career support. They are a safe place where kids can have healthy interactions with each other and caring adults and, most important, a place where they belong.

But there are not nearly enough funds. States are able to provide grants for just one in three requests for 21st Century funding. Across 10 years, \$4,000,000,000 in local grants were denied due to insufficient funding. Before the pandemic, almost 25 million students nationwide were on the afterschool waitlist.

Students who regularly participate in afterschool programs improve their school attendance, health-related behaviors, and math and reading achievement. The COVID-19 relief funds you provided are helping students get caught up while providing whole child supports. But too many school districts are using those Federal COVID dollars only for academics. Without increased funding for 21st Century, students will miss out on the holistic afterschool and summer opportunities that can help them navigate the challenges created and exacerbated by the pandemic.

Additional funding will also help ensure that programs have the resources to address staffing challenges, which is a major and growing concern. And afterschool and summer learning programs provide a lifeline for working parents and those trying to get back into the workforce.

Finally, I want to end by quoting Kyla Anderson, a high school student attending a 21st Century Community Learning Center in Illinois. “During the pandemic, I was social distancing and not doing certain activities. But at my 21st Century Community Learning Center program, I’ve been able to meet new friends, commu-

nicate, and be social with others. I wasn't a talker, but now I am. The mentors helped me stay on top of my work and encouraged me. Without my program, I wouldn't have the grades I do now, and I wouldn't be as social as I am."

I urge you to increasing funding for 21st Century Community Learning Centers by \$500,000,000 to give more young people like Kyla opportunities to learn and to thrive.

Thank you.

[The information follows:]

May 24, 2022

**Public Witness Testimony of Jodi Grant**

Executive Director  
Afterschool Alliance  
Washington, DC

**Submitted to:**

U.S. House Committee on Appropriations  
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

Dear Chairwoman DeLauro, Ranking Member Cole, and Members of the Subcommittee:

On behalf of the Afterschool Alliance, the entire afterschool field, and especially the 1.6 million students in Nita M. Lowey 21<sup>st</sup> Century Community Learning Centers, I extend our sincere gratitude for the remarkable funding and support received in fiscal year (FY) 2022. Those critical resources helped keep many young people and their families supported and connected in the midst of the COVID-19 pandemic. In FY 2023, we ask Congress to build on past success and tackle the challenges of tomorrow by providing the Nita M. Lowey 21<sup>st</sup> Century Community Learning Centers (CCLC) program within the U.S. Department of Education with \$1.789 billion, a \$500 million increase over FY 2022.

I'm Jodi Grant, the Executive Director of the Afterschool Alliance, a national non-profit organization that works to ensure that all children and youth have access to quality afterschool and summer learning opportunities. We support a network of more than 23,000 afterschool partners that are expanding learning opportunities for students nationwide and tapping community partners to keep children safe and well-nourished and provide engaging, hands-on activities that raise school attendance, academic achievement, and graduation rates.

During the past two years, the COVID-19 pandemic presented afterschool programs—and the staff, organizations, students, and families that rely on them—with challenges they never could have anticipated. Programs endured unexpected costs, serious staff and student health considerations, limited access to school facilities during closures, staffing shortages, and much more. The afterschool field rose to the challenge. With local partners, afterschool programs across the country adjusted their operations to address the urgent needs of the children and families in their communities: providing meals, offering care for children of essential workers, finding ways to keep students engaged and connected while learning remotely, providing in-person programs and safe spaces for online learning, and remaining a source of support to students and families as they confronted numerous challenges. Working with communities that often face particularly intense hardships caused by the pandemic, afterschool programs remain critical partners that are ensuring young people emerge from this crisis strong, resilient, and hopeful. Of course, none of this is possible without federal support.

For more than 20 years, 21<sup>st</sup> Century Community Learning Centers have played a vital role in communities across the nation by providing a range of services to students with academic challenges, especially those in low-income communities. These programs are unique collaborations between schools and local communities that provide a balance of academic, social, and emotional supports to students in need. Programs operate before school, during summer months, and in peak after-school hours when students can most benefit from a safe learning environment, enrichment activities, and caring adults and mentors. 21<sup>st</sup> CCLC programs provide:

- opportunities for new, hands-on, academically enriching learning experiences to meet challenging state academic standards;
- a broad array of additional services, programs, and activities, focusing on subjects like science, technology, engineering, and math (STEM), physical fitness and wellness, drug and violence prevention, nutrition and health education, service learning, youth development, and arts and music;
- activities that connect to in-demand industry sectors or occupations that are designed to reinforce and complement the academic program of participating students, including, but not limited to, financial and environmental literacy, career readiness, internships, and apprenticeships; and
- opportunities for families of students to actively and meaningfully engage in their children's education, including opportunities for literacy and related educational development.

Based on the most recently available data, 21<sup>st</sup> CCLC funding currently supports afterschool and summer programs in 10,496 school-based and community centers; 41 percent are in cities, 38 percent in suburban areas, and 21 percent in rural communities. 21<sup>st</sup> Century Community Learning Centers provide essential support to 1.564 million students, many of whom are from underserved communities, and offer creative, engaging learning opportunities to kids of all ages and backgrounds. Programs stay open on average 13.8 hours per week, 5 days per week, for 32 weeks per year. More than 127,000 individuals make up the staff of 21<sup>st</sup> CCLCs; 35 percent are certified teachers, 32 percent are community partner staff and youth workers, and 9 percent are college students.

What makes 21<sup>st</sup> Century Community Learning Centers work? They are individualized to each state and community, and providers examine the needs of the population and design programs to offer holistic supports to students of all ages that prepare them to become college- and career-ready. Community-based organizations, schools, nationally affiliated non-profits, colleges and universities, public libraries, park and recreation centers, faith-based organizations, charter schools, museums, and more are all eligible for 21<sup>st</sup> CCLC funding, but the "secret sauce" is that these entities come together as partners to provide a quality learning experience for pre-K-12<sup>th</sup> grade students. For students who attend programs, the opportunities provided through 21<sup>st</sup> CCLCs are a lifeline that helps them reconnect, re-engage, and develop the skills they need to be successful in school and in life. 21<sup>st</sup> Century Community Learning

Centers orchestrate opportunities that anchor students to peers and caring adults in their schools and communities, and often help them discover their passions, be it robotics, culinary arts, gardening, writing, flying drones, coding, music, creative dance, or calligraphy. Academic supports are paired with personal connections, community partnerships, and structured opportunities that allow students to explore and develop talents and interests that are often not addressed during the regular school day.

The greatest weakness of 21<sup>st</sup> CCLCs is that there is not enough funding to offer programs to students in many schools and communities. In fact, only 1 out of 3 requests for 21<sup>st</sup> CCLC funding is awarded nationally. Across a span of 10 years, \$4 billion in local grant requests were denied because of the lack of adequate federal funding and intense competition. And while the program serves nearly 1.6 million children, demand for quality afterschool and summer programs, like those offered through 21<sup>st</sup> CCLC, continues to grow. Before the pandemic, 24.6 million students nationwide were on the afterschool waitlist. For every child in afterschool, three were waiting for an available program. In 2020, 7.7 million school-age children were unsupervised and alone after school between the hours of 3 and 6 p.m. An October 2020 survey of parents found that 79 percent agreed that all children deserve access to quality afterschool and summer programs.

What are the students who are unable to attend programs missing out on? The research is clear that participation in afterschool programs, including 21<sup>st</sup> CCLC programs, yields a wide array of positive outcomes:

- Statewide evaluations of 21<sup>st</sup> CCLC programs have found a positive impact on student engagement and motivation in school, with gains seen across grade levels, from elementary to high school.
- Students who regularly participate in 21<sup>st</sup> CCLC programs improved their school attendance, school engagement, health-related behaviors, and math and reading achievement.
- Regular participation in afterschool programs helped narrow the achievement gap between high- and low-income students in math, improved academic and behavioral outcomes, and reduced school-day absences.
- Businesses want to hire problem solvers and team players. Students learn by doing in afterschool programs and develop the skills they need for the jobs of tomorrow.
- Students regularly participating in 21<sup>st</sup> CCLC programs see gains in skills and competencies valued by employers, such as the ability to communicate well, collaborate with others, and think critically.
- Jobs in science, technology, engineering, and math (STEM) are driving global economic growth. Nearly six million students are getting opportunities to develop an interest in and explore STEM in afterschool.
- More than 8 in 10 parents say afterschool helps give working parents peace of mind and helps parents keep their job.

During the pandemic, 21<sup>st</sup> CCLCs faced challenges but were able to rise to the moment and provide critical supports for students and families. Although many states reported disruptions

in data collection during the pandemic, promising findings illustrate positive academic and behavioral gains among participants during the past two years. For example, Arkansas' 2019-20 21<sup>st</sup> CCLC statewide evaluation reported that most youth expected to do well in English (90 percent) and math (87 percent). And Idaho's statewide evaluation found that a strong majority of teachers reported homework completion (95 percent) and student behavior improvements (93 percent) among regularly attending students. Additionally, surveys of program providers found that throughout the pandemic, 21<sup>st</sup> CCLC programs, compared to afterschool programs overall, were more likely to adapt to address the needs of the children and families they served, from connecting with youth remotely during school closures and stay-at-home orders to helping families connect with vital community resources during a challenging time.

The afterschool field is grateful for the funds made available by Congress through the CARES Act, CRRSA, and the American Rescue Plan (ARP) Act. A number of states, including Connecticut and Oklahoma, are using the American Rescue Plan Act ESSER set-aside funds to broaden access to evidence-based, comprehensive afterschool and summer enrichment programs. Some states have leveraged their 21<sup>st</sup> CCLC infrastructure at the state and local level to efficiently invest their COVID-19 relief funds to provide supports to students during the summer and afterschool. Some states have used these funds to reach populations that have not been served by other funding streams, including intentionally reaching out to smaller providers. States are also collaborating with partners and building out opportunities for technical assistance and professional development to support providers and students.

We are also grateful that Congress recognized that our children and youth lost much more than just academics during this pandemic. A recent CDC survey found alarming self-reported rates of depression, sadness, and even suicidal thoughts amongst our youth. Healthy interactions with their peers and caring adults are more essential than ever. Quality afterschool programs provide a safe place where our students feel a sense of purpose and belonging. It's a place where teamwork, collaboration, and getting out of one's comfort zone are applauded and encouraged.

The demand for COVID relief funding is great, with states experiencing many more funding requests from eligible applicants than they can support. And, at the local level, many school districts are just getting started with investments in afterschool and summer. With 24.6 million students waiting for comprehensive afterschool programs, there is an urgent, compelling need to use the ARP resources effectively and build on successes. The COVID-19 relief funds for comprehensive afterschool and summer enrichment and learning are helping students get caught up and accelerate their learning, while also providing whole-child supports and social and emotional learning. But, sadly, too many school districts are using their federal dollars for programs that only focus on academics and offering tutoring or summer school, which only address some of the losses our kids are facing. Without increased funding for 21<sup>st</sup> CCLC, students and families across the nation will miss out on the holistic afterschool and summer opportunities that can help them more effectively navigate the challenges created and/or exacerbated by this pandemic.

Our children spend 80 percent of their time outside of school, yet they are learning all the time. Working parents know this very well. When the school day ends, or summer and vacation breaks take place, the responsibilities of working parents do not pause. Afterschool programs create opportunities for our children to thrive, and they also provide a lifeline for working parents who know their children are safe and engaged during the hours after school and throughout the summer.

Our goal is simple: to ensure that a quality, accessible program is available to every youth and family that wants one. In addition to expanding access to programs, increased funding for 21<sup>st</sup> CCLC can help existing programs offer more professional development opportunities and other quality supports. This includes courses for staff in positive youth development, youth choice and voice, making connections with schools, and especially now, courses in trauma-informed care and mental health first aid.

Additional funding will also help ensure that programs have the resources needed to recruit qualified staff and retain experienced staff. Staffing, which was challenging prior to the pandemic, is a rising concern for programs. Data collected throughout the pandemic finds that staffing challenges have increased over time and that now, more than ever, staffing is impacting the ability of providers to meet the needs of the children and families they serve. In a spring 2022 survey, among program providers that report that they are physically open but operating at reduced capacity, 71 percent say that it is due to staffing issues.

Finally, I want to quote Kyla Anderson, a high school student attending a 21<sup>st</sup> Century Community Learning Center afterschool program, because at the end of the day these programs are all about the young people:

“During the pandemic, it was challenging because I was social distancing and not doing certain activities. But, my 21<sup>st</sup> Century [Community Learning Center] program has been a place where I’ve been able to meet new friends, communicate, and be social with others. I wasn’t a talker, but now I am! The mentors in my program also helped me stay on top of my work and encouraged me. Without my program, I wouldn’t have the grades I do now, and I wouldn’t be as social as I am. I wouldn’t be able to do a lot of things without my program.”

When considering funding for FY 2023, I urge you to consider just how important it is to sustain and expand afterschool and summer learning programs for our children, families, communities, and our workforce. I urge you to increase funding for 21<sup>st</sup> Century Community Learning Centers by \$500 million to give more young people like Kyla opportunities to grow and learn.

Thank you for your consideration.

Mr. COLE. Madam Chair, I think you are on mute.

The CHAIR. Got it. I was just saying it is always wonderful to hear from you, Ms. Grant. This is a program I think we are all very excited about, and named after one of the titans of the House, the congresswoman who chaired this committee, Nita Lowey.

And I was so glad you mentioned dance because you know my history of teaching in the afterschool program of teaching dance and calligraphy. I don't do either one of them at this time. [Laughter.]

The CHAIR. So, but it is one of the—you made one point, which I just want to reinforce is, it is a quality learning experience. And that is what we are talking about here. This is not warehousing children, but this is really helping them, teaching them skills, enriching their lives, and it also has the added benefit of helping parents who are at work.

So it is a program that is near and dear to all of our hearts. You will keep advocating, and we will do our best to increase the dollars for that.

And with that, let me recognize the ranking member.

Mr. COLE. Well, thank you very much, Madam Chair.

I just want to quickly associate myself with your remarks. This is actually one of the programs that I think both sides of the aisle really appreciates the quality of the work and the importance of the issue. And as the chair related earlier, obviously, we don't know where we are at yet in terms of allocations, and there is always lots of need.

But anybody that comes in front of this committee and advocates for a program named after our esteemed former chair has a pretty good chance for success. Because we all think so highly of Chair Lowey and miss her a lot, and it wouldn't surprise me if she is watching the proceedings right now. She keeps a pretty close eye on what we do.

But again, thank you for coming before us and advocating for such a worthy cause.

Ms. GRANT. Thank you.

The CHAIR. Congressman Fleischmann.

Mr. FLEISCHMANN. Jodi, thank you so much for the presentation, and I will just associate my comments with our distinguished chair and ranking member.

Thank you.

The CHAIR. Thank you. Congressman Cline? Congressman Cline, any questions?

Mr. CLINE. No, Madam Chair.

The CHAIR. Okay, thank you.

Then again, Jodi, thank you very, very much. And thank you for your enormous commitment to this effort. You have, just over the years, just been such a cheerleader for one of the best things that we do at the Federal level. So thanks very, very much for being with us today.

Ms. GRANT. Thank you for all your support.

The CHAIR. Thank you. Thank you.

Now, a pleasure for me to recognize Mark Jenkins. Mark is the founder and executive director of the Connecticut Harm Reduction Alliance and a United States Air Force veteran.

For the past 24 years, Mr. Jenkins has worked to deliver innovative prevention and intervention to the most vulnerable members across the State of Connecticut. His work has made him a well-respected individual in his field, known for his connections with folks on the street and in the service of community.

Wonderful to have you with us today, Mark, to discuss responding to the overdose crisis, supporting harm reduction and syringe services programs through the Infectious Diseases and the Opioid Epidemic Program at the Centers for Disease Control and the U.S. Department of Health and Human Services here.

Mark, you are recognized for 5 minutes.

**MARK JENKINS, EXECUTIVE DIRECTOR, CONNECTICUT HARM REDUCTION ALLIANCE**

Mr. JENKINS. Thank you, Chairwoman DeLauro, Ranking Member Cole, members of the subcommittee.

Again, my name is Mark Jenkins, and I am a service-connected, disabled veteran of the U.S. Air Force and founder and executive director of Connecticut Harm Reduction Alliance. Today, I am pleased to submit testimony on behalf of the alliance and as a member of a larger coalition of public health, HIV, viral hepatitis, and harm reduction organizations.

First, I would like to thank the subcommittee for the fiscal year 2022 funding increase for the CDC's Infectious Diseases and Opioid Epidemic Program. New funds will help to strengthen services to prevent opioid overdose deaths and infectious diseases transmissions.

I am here today to urge you to provide \$150,000,000 for the program in fiscal year 2023. Such funding would expand access to overdose prevention and syringe services programs, or SSPs, which save lives and connect people urgently to needed care, including treatment for substance use disorders.

Founded in 2014, the Connecticut Harm Reduction Alliance offers a wide range of services to help people who use drugs avoid overdose and live longer, healthier lives. We meet folks where they are at, in their time, place, language, and lived experience.

Services we provide include syringe services programs to help prevent HIV, viral hepatitis, endocarditis, which is a heart infection, and other infectious diseases; naloxone, a drug that reverses opioid overdose, and overdose prevention trainings; HIV and hepatitis C screenings; shelter and housing referrals; COVID vaccinations; and referrals and transport to treatment for substance use disorders.

We reach quite a lot of individuals, and last year, we engaged approximately 3,500 participants, distributed over 4,200 doses of naloxone, and saved lives, many lives, reversing over 300 overdoses. Our staff works to build relationships based on trust and nonjudgmental respect.

In Connecticut, there were 1,550 deaths due to overdose in the year 2021, an 11.9 percent increase over 2020. This is a 20 percent higher increase than the Nation's over the same period.

The U.S. overdose crisis is a true public health emergency, where nearly 108,000 people died last year from overdose, a 74 percent increase over 2015, and deaths continue to rise in 2022.

In both Connecticut and the U.S., overdose deaths have increased the most among black people and communities of color. Our work must end these disparities and effectively prevent overdose deaths.

Now, sadly, because of this crisis, both nationally and in Connecticut, we have insufficient access to syringe service programs. The alliance has become the State's largest distributor of sterile syringes, yet demand has outpaced supply, especially since funding for SSPs in Connecticut has remained the same while demand for life-saving services has skyrocketed.

The CDC's Infectious Diseases and Opioid Prevention Program is the ideal place for Congress to appropriate funding to expand access to SSPs and prevent overdose. CDC is the Nation's expert on SSPs, and with additional funding, it could expand access to these critical services.

In fact, new recipients of SSP services are five times more likely to reach and enter drug treatment. Studies also confirm that SSPs do not increase illicit drug use or crime and that they save both lives and money. And while Congress has funded drug prevention and treatment programs, until recently, almost no Federal funding supported programs that work directly with people that use drugs to help reduce the harms.

On April 6, I celebrated 25 years free from the active, chaotic use of substance, substances that separated me from my family and community. Today, I am a well-respected, productive member of my community as a result of these very services. I ask that you consider the work that really needs to be done in allowing these services to come forward.

I thank you so much for your time and consideration of this urgent request, and please do not hesitate to contact me if you have any questions.

[The information follows:]

**Testimony for the House Committee on Appropriations  
Labor, Health & Human Services, Education, and Related Agencies Subcommittee  
Submitted by Mark Jenkins,  
Executive Director of Connecticut Harm Reduction Alliance  
Hartford, CT; New Haven, CT**

May 26, 2022

Chairman DeLauro, Ranking Member Cole, and members of the Subcommittee, I am Mark Jenkins a service-connected, disabled veteran of the U.S. Air Force and founder and Executive Director of Connecticut Harm Reduction Alliance (CTHRA), formerly the Greater Hartford Harm Reduction Coalition (GHHRC). ***I am pleased to submit testimony on behalf of CTHRA and as a member of a large coalition of public health, HIV, viral hepatitis, and harm reduction organizations to urge Congress to appropriate \$150 million for the Infectious Diseases and the Opioid Epidemic program at the Centers for Disease Control and Prevention (CDC) to save lives and address the opioid overdose crisis by supporting and expanding access to harm reduction and syringe services programs (SSPs).***

Founded originally in 2014, the Connecticut Harm Reduction Alliance houses both the Greater Hartford Harm Reduction Coalition and Sex Workers and Allies Network (SWAN) programs. CTHRA promotes the dignity and wellbeing of individuals and communities impacted by drug use, homelessness, and sex work. Through advocacy, training and service, CTHRA ensures the availability, adequacy, accessibility, and acceptability of services and resources that remediate the adverse consequences of substance use. The Alliance offers a wide range of services helping people who use drugs to avoid overdose and live longer healthier lives. These include SSPs to help prevent HIV, viral hepatitis, and endocarditis (heart) infections; HIV and Hepatitis C screenings; Narcan/Naloxone distribution (a drug that reverses opioid overdose)

along with overdose prevention training; shelter and housing referrals; education on Substance Use Disorders and referrals to treatment; transportation; and more.

**Shamefully, the U.S. currently has a crisis in drug overdose that has both been overshadowed by the COVID-19 pandemic and in which services directed specifically towards people who use drugs in a trusting and respectful way have rarely been funded. Nearly 108,000 people died from overdose in 2021 (up 10% in 2020 and from 74% in 2015) with deaths trending to increase in 2022.** In Connecticut where CTHRA seeks to prevent overdose and end disease transmission related to intravenous drug use, there were 1,550 deaths due to overdose in 2021. (A rate of 42.98 per 100,000). This represents a 11.9 % increase over 2020, a 25.9% increase over 2019, and a 44.9% increase over 2018! This is more than the population of the towns of Canaan, Colebrook, Union or Warren and 150 more fatal overdoses than in 2020. (Connecticut Data Dashboard, 2015 to 2022; Heather Clinton). Thirty years ago, when syringe services programs (SSPs) were rolled out statewide, there were around 650 new HIV diagnoses every year attributed to injection drug use. Over the last five years, CT has averaged 16 cases a year. That's a 97.5% reduction in incidence, and SSPs led this movement toward HIV elimination. *Without expanded resources to respond to the current increases in demand for services we are in jeopardy of backsliding and seeing rates of hepatitis C and other infectious diseases increase as well as overdose deaths continue to skyrocket.*

**A recent news article noted that teenage overdose fatalities associated with synthetic opioid drugs, such as fentanyl, have tripled over the last two years.** Overall, youth between the ages 15 and 24 experienced an increase of 49% in fatal drug overdoses from 2019 to 2020, the largest increase in an age group in the U.S. according to CDC data. One issue is that many people, not just teens, who overdose are unaware of the presence of fentanyl until it is too late.

This is true in Connecticut where most overdose are related to fentanyl. CTHRA is working to respond to the change in drug supply by collaboration with DOP and NEHIDTA to increase drug checking statewide.

**In the U.S. overdose deaths have increased most dramatically among Black people and communities of color.** Since 2015, overdose deaths have been rising most rapidly among Black and Hispanic or Latino communities. In 2020, Black people had the largest percentage increase in overdose mortality at 48.8%. The Hispanic or Latino community experienced a 40.1% increase in overdose deaths as compared to White people who experienced a 26.3% increase. American Indians and Alaska Natives experienced the highest rate of overdose mortality of all ethnic groups in 2020 - a rate 30.8% higher than that of white people. ***We must work to end these disparities and to prevent overdose entirely.***

CTHRA's Mobile 1 Network consists of 4 teams of people including Ambassadors who have the trust of the community. We engaged approximately 3,500 participants, distributed 4,200 Narcan doses, and reversed over 300 drug overdoses in 2021. Our staff are especially cognizant that people who use drugs may have had poor relationships with police and medical professionals; we work to build relationships based on trust and non-judgmental respect. We "meet folks where they are at," in their time, place, language, and lived experience. CTHRA utilizes a treatment on demand model, connecting people when they are ready – directly to medical, mental health, and drug treatment services, along with transportation. ***Our goal is to reduce the negative consequences of drug use and to incorporate a range of strategies to help people who use drugs stay safe and alive while we connect them to urgently needed care.***

We are especially proud of the work at SWAN, which was founded in 2016 and recently joined CTHRA, which runs structured support groups and hosts educational sessions for sex

workers including, yoga, meditation, and self-defense. SWAN works to help engage people in the medical community to better serve sex workers, improve health and provide access to harm reduction supplies like naloxone.

Congress is ideally positioned to help us fashion a new response to this deadly epidemic. While the US has funded drug prevention and treatment programs, until recently almost no funding has been directed towards programs that work with people who use drugs. This creates a major services gap, particularly when other programming in the medical or criminal legal systems may stigmatize people who use drugs. Providing funding for SSPs would help prevent drug overdoses and deaths by educating people on signs of an overdose and how to respond. As previously noted, CTHRA distributed over 4,000 doses of naloxone and responded and reversed to 300 overdoses in 2021. CTHRA is proud to be an important part of preventing overdose deaths in Connecticut.

*Sadly, both Connecticut and nation do not have nearly enough access to SSPs.* A March 2020 North American Syringe Access Network (NASAN) survey of 173 SSPs – almost 40% of SSPs nationwide - showed a 43% increase in request for SSP services. CTHRA has felt this pressure. We have become the state's largest distributor of sterile syringes, exchanging over 750,000 syringes in 2021, and received over 600,000 in return. Our need has outpaced supplies. Funding for SSPs in Connecticut has remained the same while demands on SSP for life-saving services have skyrocketed.

Hundreds of studies over more than 30 years show that SSPs reduce overdose deaths and infectious diseases transmission rates as well as increase the number of individuals entering substance use disorder treatment. These studies also confirm that SSPs do not increase illicit drug use or crime and save money.

The Infectious Diseases and Opioid Epidemic Program is the ideal place for Congress to appropriate the \$150 million. CDC is the nation's expert SSPs and host a technical assistance center that coordinates with SAMHSA on this issue. With additional FY23 funding, CDC could significantly expand SSPs at this critical time to help prevent overdose deaths and the spread of HIV, viral hepatitis, and other infectious diseases, all while connect people to life-saving medical care, including drug treatment. ***In fact, new recipients of SSP services are 5 times more likely to enter drug treatment.***

On a personal note – I started working in this field as an AIDS Risk Reduction Outreach Worker for the Perception programs in Willimantic and have long sought to deliver services to our most difficult-to-reach populations. I have been privileged to work in, and gained the trust of, people in Connecticut's neighborhoods that have been most impacted by a lack of accessibility to services. As a personal milestone, I recently celebrated 25 years free from drug use. I have witnessed how this devastating disease impacts our community on daily basis. I truly believe to whom much is given, much is required. This is why I do this work and why I so passionately urge the subcommittee to assist us in saving lives through SSPs and other overdose prevention services.

***I want to thank the Subcommittee for its past funding of the CDC Infectious Diseases and Opioid Epidemic program and urge Congress to provide \$150 million for the program in FY23.*** Thank you also for your time and consideration of my testimony, and please do not hesitate to contact me at [markj@ct-hra.org](mailto:markj@ct-hra.org) or Jenny Collier at [jcollier@colliercollective.org](mailto:jcollier@colliercollective.org) if you have questions or need additional information.

The CHAIR. Well, thank you so much for powerful testimony here. And I want to say, one, thank you for your military service and your commitment to our country and of giving back in so many ways.

And you are in the business saving lives. I think we all know what this opioid crisis has meant for this country. We also—we have been—COVID has kind of taken a little bit away from the front burner of the opioid crisis as well, but that is something that we have to pay attention to, and when you quote numbers, 108,000 people died from overdose in 2021. It is up 10 percent. It is really pretty extraordinary. And thank you for talking about the syringe services program and how beneficial it is.

You talk about hepatitis C. It is really one of the rates that, as you have pointed out, have increased in terms of infectious diseases. And I was at the Centers for Disease Control last Friday. One of the issues that we brought up, talking about how we try to do something about it, and it would appear that is what your efforts are about, and we thank you.

We thank you for that. We appreciate your testimony, and you will be sure that we will give every consideration to your efforts in hoping to increase the resources that you need to be able to succeed.

Congressman Cole.

Mr. COLE. Thank you, Madam Chair.

I want to join you in thanking Mr. Jenkins for his service in uniform, but also suggesting that perhaps the service, Mr. Jenkins, you are doing now may be even more important than that, and we appreciate it more than I can say.

This is a problem I know the chair and I have wrestled with for many years. And we have seen that 20 straight years of increase in death by overdoses back in the late teens. And then we plateaued, and it actually started to come down. Then we got hit by COVID, and we have seen an explosion since then. I think driven by the social isolation partly with COVID and also, frankly, the explosion of illegal drugs coming across our Southern border.

And so the problem has exacerbated itself during these last 2 years, 2½ years, I think more than any of us anticipated. So this is something, again, I know the chair cares deeply about. Every member of the committee on both sides of the aisle cares deeply about because we see it in our own communities.

So I am sure, again, we always wrestle with more need than money, and that is just the nature of appropriations, particularly in this area. But I can assure you that both sides of the aisle will be interested in working together to see what we can do to help you and others like you that are in the field really saving lives.

And just, again, thank you very much for the work that you are doing, the service that you are giving. But certainly, the work that you are doing each and every day right now. It makes a big difference, and if we can find a way to help you, we will.

With that, thank you, Madam Chair. I yield back to you.

The CHAIR. Thank you. Congressman Fleischmann.

Mr. FLEISCHMANN. Madam Chair, thank you.

Mr. Jenkins, I just want to thank you and wish you every continued professional and personal success, sir.

Thanks.

The CHAIR. Thank you.

I am now pleased to introduce Jane Weintraub for your testimony with the American Association for Dental, Oral, and Craniofacial Research. And you are—and also, I might add, dean of the—professor of dental public health and former dean of the University of North Carolina at Chapel Hill, the Adams School of Dentistry.

Ms. Weintraub, you are recognized for 5 minutes.

**JANE A. WEINTRAUB, DDS, DISTINGUISHED PROFESSOR OF DENTAL PUBLIC HEALTH AND FORMER DEAN, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL ADAMS SCHOOL OF DENTISTRY, AMERICAN ASSOCIATION FOR DENTAL, ORAL, AND CRANIOFACIAL RESEARCH**

Dr. WEINTRAUB. Chair DeLauro, Ranking Member Cole, and members of the subcommittee, thank you for the opportunity to testify on behalf of the American Association for Dental, Oral, and Craniofacial Research.

AADOCR represents more than 3,100 individual and 100 institutional members in the United States. Our mission is to drive dental, oral, and craniofacial research to advance the health and well-being of Americans.

I currently serve as president of the AADOCR. I am also a professor and former dean at the University of North Carolina Chapel Hill Adams School of Dentistry and an adjunct professor at the UNC Gillings School of Global Public Health.

For fiscal year 2023, we are seeking at least \$540,000,000 for the National Institute of Dental and Craniofacial Research and a total of \$49,000,000,000 NIH's base budget. Despite NIDCR's impressive research agenda and scientific accomplishments, the Federal Government's annual investment in this institute has not kept pace with biomedical inflation nor overall funding increases for NIH.

Funding of at least \$540,000,000 in fiscal year 2023 would help bring NIDCR funding into alignment with the overall NIH appropriation and allow NIDCR to build on its myriad successes in its mission to improve dental, oral, and craniofacial health.

Investments in NIDCR-funded research over the past three-quarters of a century have led to improvements in oral health for millions of Americans and continue to show promise in areas encompassing the prevention of dental caries, or tooth decay, periodontal gum disease, new diagnostic methods of oral and dental conditions, regenerative medicine, oral cancer prevention and treatment, and in assessing the efficacy of an HPV vaccine for oral and pharyngeal cancers.

I cannot emphasize enough how integral oral health is to our overall health. Poor oral health can affect many activities that may be taken for granted, including the ability to eat, drink, swallow, smile, speak, and maintain proper nutrition. Poor oral health also creates an economic burden that disproportionately harms older adults, low-income and under-resourced communities.

The oral cavity also serves as a window into many health issues, including, but not limited to, systemic diseases such as diabetes, HIV/AIDS, and Sjogren's autoimmune disease. Researchers are ex-

ploring the debilitating lack of salivary function and resulting dry mouth from radiation treatment for head and neck cancers, common medications, and even aging.

The NIDCR played a critical role in responding to the COVID-19 public health crisis, funding approximately \$3,900,000 in high-impact coronavirus research. The institute's research into minimizing infection risk in dental offices, the use of biosensors to detect SARS-CoV-2 in saliva, the role of periodontal disease in COVID-19 complications, and exploring how the virus gets into the mouth and saliva all play a critical role in combating COVID-19.

AADOOCR is grateful for the investments Congress has made in the NIDCR, which have allowed the institute to build its data repository and registry in several disease and research areas to meet the increasing need for open-source data sharing. The institute is also poised to make significant strides in addressing public health burdens related to pain management and the opioid crisis.

Pain associated with dental and oral facial conditions lead to school and work absences, costly emergency room visits, and hospitalizations, all of which have a detrimental impact on our economy.

Early childhood caries can be very painful for young children and often need to be treated in a hospital operating room, an expensive procedure. As a benefit of funding from NIDCR, I had the opportunity to conduct a randomized clinical trial that tested and demonstrated the efficacy of fluoride varnish in preventing early childhood caries. This easy, low-cost method has since become a standard of care to help prevent this disease.

Again, I appreciate the opportunity to testify and thank the subcommittee for its support of biomedical and dental research so that all Americans can enjoy good oral and overall health.

Thank you very much.

[The information follows:]



May 24, 2022

Organization: **American Association for Dental, Oral, and Craniofacial Research (AADOOCR)**  
 Committee: **House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies**  
 Agency Funding Requests: **National Institutes of Health (NIH) and National Institute of Dental and Craniofacial Research (NIDCR)**

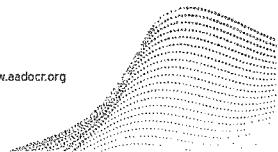
Jane A. Weintraub, DDS, MPH, FACD, FICD  
 AADOOCR President (2022-2023)  
 Rozier Douglass Distinguished Professor of Dental Public Health & Former Dean  
 University of North Carolina at Chapel Hill Adams School of Dentistry

Chair DeLauro, Ranking Member Cole, and members of the Subcommittee,

Thank you for the opportunity to submit this testimony on behalf of the American Association for Dental, Oral, and Craniofacial Research (AADOOCR). For FY 2023, AADOOCR is seeking at least **\$540 million for the National Institute of Dental and Craniofacial Research (NIDCR)** and a total of **\$49 billion for all of the Institutes and Centers at the National Institutes of Health (NIH)**. Funding at these levels is necessary for the entities' base budgets to keep pace with the disproportionately high level of biomedical inflation and the development price index (BRDPI).

The NIH, through the biomedical research it conducts and supports, plays a critical role in improving Americans' health and well-being. When the COVID-19 pandemic hit our nation and the world, the NIH helped safeguard the public health through its significant contributions to the development of testing, vaccines and treatments. The NIH continues to develop and maintain the resources, both human and scientific, that provide our nation with the tools it needs to address other diseases and disabilities.

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The NIDCR, established by President Harry S. Truman in 1948, is the largest institution in the world exclusively dedicated to researching ways to improve dental, oral, and craniofacial health for all. Investments in NIDCR-funded research during the past half-century have led to improvements in oral health for millions of Americans and continue to show promise in areas encompassing the prevention of dental caries (tooth decay) and periodontal (gum) disease, new diagnostic methods of oral and dental conditions, pain biology and management to help alleviate the opioid crisis, regenerative medicine, oral cancer prevention and treatment, and in assessing the efficacy of an HPV vaccine for oral and pharyngeal cancers.

Despite NIDCR's impressive research agenda and scientific accomplishments, the federal government's annual investment in the Institute has not kept pace with the overall funding increases provided to NIH over the past several years. Funding of at least \$540 million in FY 2023 would help bring NIDCR funding into alignment with the overall NIH appropriation and allow NIDCR to build on its myriad successes in its mission to improve dental, oral and craniofacial health.

The research being conducted at, and supported by, NIDCR impacts not only the oral health, but the overall health of Americans. Poor oral health can affect activities that may be taken for granted including the ability to eat, drink, swallow, smile, speak, and maintain proper nutrition. It also creates an economic burden that disproportionately harms older adults, low income, and underserved communities.

The oral cavity also serves as a window into many health issues, including but not limited to systemic diseases, such as diabetes, HIV/AIDS, and Sjögren's, an autoimmune disease that causes one's immune system to attack parts of its own body. Additionally, researchers are exploring the debilitating loss of salivary gland functioning and saliva production stemming from

radiation treatment for head and neck cancers and even from common medications and aging itself. Lack or loss of saliva, which causes xerostomia, or uncomfortable dry mouth, has also been shown to be a risk factor for dental caries.

The NIDCR played a critical role in responding to the COVID-19 public health crisis funding approximately \$3.9 million in high-impact coronavirus research. The Institute's research into minimizing infection risk in dental offices, the use of biosensors to detect SARS-CoV-2 in saliva, the role of periodontal disease in COVID-19 complications, and exploring mechanisms of viral entry into the tissues of the oral cavity played a critical role in combatting COVID-19. Continued research into the link between oral infection and taste loss, an early COVID-19 symptom, will help us better prepare for the next pandemic.

NIDCR-supported research is expanding into new exciting areas of research, such as the interplay between the oral microbiome—which encompasses over 700 microorganisms, including bacteria, fungi, and viruses—and the immune system. We are increasingly learning that the oral microbiota can help predict or identify a diverse range of oral and systemic diseases, including dental caries, periodontal diseases, oral cancer, colorectal cancer, pancreatic cancer, and inflammatory bowel syndrome. Further research in this area is critical to improving Americans' oral and overall health.

In December 2021, NIDCR released its landmark report "Oral Health in America: Advances and Challenges", with input from over 400 contributors documenting 20 years of progress in oral health since the 2000 Surgeon General's Report on Oral Health. The comprehensive and data-driven report provides insight into issues currently affecting oral health and serves as a call to action for a coordinated effort among oral health practitioners; researchers; and other stakeholders to improve oral health for all Americans.

AADOCR deeply appreciates Congress' longstanding and bipartisan support for the public health research enterprise. The funding increases NIDCR has received since 2015 have allowed the Institute to build its data repository and registry in several disease and research areas to meet the increasing need for open-source data sharing. These include clinical registries and repositories related to head and neck cancers, orofacial birth defects and craniofacial anomalies, and craniofacial microsomia cohorts to identify genetic risk factors. The Institute also participates in trans-NIH and NIH Common Fund initiatives for data analysis and sharing.

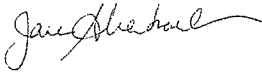
Recognizing that federal research and public health efforts work in concert with one another and that success in one area can benefit another, we encourage Congress to support the full breadth of federal agencies supporting oral health. Complementing our NIDCR and NIH requests, we urge you to provide **\$35 million for the CDC's Division of Oral Health, \$46 million for the Title VII Health Resources and Services Administration (HRSA) programs** that train the dental health workforce, **\$500 million for the Agency for Healthcare Research and Quality (AHRQ), and \$210 million for the National Center for Health Statistics (NCHS)** in FY 2023.

Finally, AADOCR strongly supports the establishment of the Advanced Research Projects Agency for Health (ARPA-H), which will help fill gaps in the biomedical research ecosystem by utilizing a bold new approach focused on the development of evidence-based, real-world-driven cures for a range of diseases. We urge you to support the Administration's request of **\$5 billion for ARPA-H** in FY 2023, but not at the expense of funding for the NIH's base budget. It's critical that funding for this new agency complement – not supplant – the foundational investment in traditional NIH Institutes and Centers.

We appreciate the opportunity to submit this testimony and thank the Subcommittee for its support of biomedical research, including dental, oral and craniofacial research, in FY 2023 so

our nation's citizens can continue to enjoy the benefits of state-of-the-art and world-leading health care. We stand ready to assist the members of this Subcommittee in any way we can and are happy to answer any questions you may have.

Sincerely,

A handwritten signature in black ink, appearing to read "Jane A. Weintraub". The signature is fluid and cursive, with a long, sweeping horizontal line extending from the end.

Jane A. Weintraub, DDS, MPH, FACD, FICD  
AADO CR President (2022-2023)

The CHAIR. Well, thank you very, very much.

Let me ask the ranking member if he has any questions?

Mr. COLE. No questions, but just a quick comment to Dr. Weintraub.

As I am sure you probably know, your profession is pretty ably represented on our full committee by Mike Simpson from Idaho. So I can assure you, you have a—the chairwoman will hear directly from Mike, and you have a very strong advocate in somebody that is, again, widely respected on both sides of the aisle.

And I must add Mike recently won his primary. I was grateful for that. So he is likely to be back here for the next 2 years as well.

But again, thank you for your testimony.

Dr. WEINTRAUB. Thank you.

The CHAIR. Congressman Fleischmann.

Mr. FLEISCHMANN. Thank you, Dr. Weintraub.

This is wonderful. My personal friend and a great Tennessean, Dr. Jeannie Beauchamp, is the president of the pediatric dentists, but we have worked—nationwide. But we have worked very closely with dentists across the board.

So thank you for your commitment to your profession and for this. And years ago, I was on the board of FACES in Chattanooga, which was a nonprofit dedicated to helping craniofacial, actually, surgeries and fund those. So thank you for what you do.

Dr. WEINTRAUB. Thank you.

The CHAIR. And again, my thanks to you, Dr. Weintraub.

You make the point about how important the research is, especially I think since we are not covering dental care these days and so forth. So the work that you do is particularly important, and I also, in reading your testimony, talk about your interest in ARPA-H and NIH, but we are going to try as we will to balance the two in terms of doing traditional research and then looking at the institute, which you point out, to see, in essence, how it has been funded over the last several years.

One of the things we are going to try to do with a hearing in the fall is we had one set of institutes come in to provide testimony to us on budget, but we are going to try to get additional of the institutes to come in, including the Institute of Dental and Craniofacial Research, and hear from them about what the update is in research.

We are really in your debt for your work, and it has often been interesting to me that we seem to divide the body up. There is the head, and then there is from the neck down. And unfortunately, we don't pay enough attention to the neck up. And thank you for being an advocate for all this, and we will do the best we can to try to address your concerns and your resource concerns as well.

Thank you. Thank you for being here.

Dr. WEINTRAUB. Thank you very much.

The CHAIR. It really is that I would very, very much like to welcome Dr. Marwan Haddad. He is here in his capacity as chair of the HIV Medicine Association, but I am so proud to say he is also medical director of the Center for Key Populations for Community Health Center, Inc., one of the largest community health centers in the Nation, based in Middletown, Connecticut, which is in my district.

Thank you, Dr. Haddad, for your work to serve our community, particularly with those who live with HIV, with hepatitis C, LGBTQ individuals, especially during the pandemic. That really underscored for all of us the critical need for integrative and comprehensive healthcare.

Happy to hear from you, and you are recognized for 5 minutes for your testimony.

**MARWAN HADDAD, M.D., DIRECTOR OF THE CENTER FOR KEY POPULATIONS AT COMMUNITY HEALTH CENTER, INC., HIV MEDICINE ASSOCIATION**

Dr. HADDAD. Chairwoman DeLauro, Ranking Member Cole, and members of the subcommittee, thank you for your invitation to testify.

Again, my name is Dr. Marwan Haddad, and I serve as the medical director of the Center for Key Populations at Community Health Center, Inc., or CHC, in Middletown, Connecticut, one of the largest Federally Qualified Health Centers in the State.

I am pleased to testify today on behalf of the HIV Medicine Association of the Infectious Diseases Society of America as the chair of the board of directors. HIVMA represents more than 5,000 physicians and other healthcare professionals around the country on the frontlines of the HIV epidemic.

First, thank you for the increase in Federal funding in fiscal year 2022 for a number of HIV programs, including the Ending the HIV Epidemic Initiative and several parts of the Ryan White HIV/AIDS Program. More than 2 years into the COVID-19 pandemic, it has taken a very hard toll on many people with HIV and populations at risk for HIV, increasing the demand for HIV-related services, substance use disorder, and mental health treatment, and services to address a rise in housing and food insecurity.

As we continue to work to control and mitigate the impact of COVID-19, we must accelerate progress toward ending HIV as an epidemic by increasing Federal investments in HIV prevention, care, research, and supportive services.

Now, when we talk about funding, things can become abstract, and we don't always make the connection to the impact the funding has on people. So I will share with you the story of a patient who I just saw last week to bring to light the importance and intersectionality of the programs under the subcommittee's jurisdiction.

This man started to see me 7 years ago, seeking treatment for his opioid use disorder. I learned quickly that he had HIV; hepatitis C; mental health disorders, including depression and PTSD, with several past suicide attempts; and was currently unhoused because his partner kicked him out for having HIV.

He lost the support of his family after they found out he was gay. He tried shelters, but because he was constantly stigmatized and harassed he preferred to live under the bridge.

Over the years, we have kept him engaged in care, more on than off, treated him with HIV medication, and despite his housing instability and substance use, he continues to be virologically suppressed, meaning his viral—HIV viral level is so low, he cannot transmit it sexually to others.

If it was not for the HIV case managers, our recovery care coordinators, and other key services, we would have lost him to follow-up. And while it took years, he is finally housed for the first time since I met him. He continues to experience food insecurity but is looking for a job and optimistic about getting rehired by a previous employer.

I cannot emphasize enough how this story and so many stories like his highlights the importance and value of investing in the programs under the subcommittee's jurisdiction and how this investment directly and positively impacts their lives. So to meet the goal of the bipartisan Ending the HIV Epidemic Initiative of reducing new HIV infections by 90 percent over the next decade, this will require an investment of at least \$850,000,000 in new funding.

In addition, increased funding for the Ryan White program in fiscal year 2023 across all parts is needed to ensure access to effective HIV care and treatment nationwide and for programs to be able to respond to the increased demand for services due to the COVID-19 pandemic. For fiscal year 2023, we specifically recommend a \$25,500,000 increase for Part C of the program.

CHC has relied on Ryan White program funding to provide HIV care to underserved populations for 23 years across Connecticut. And during that time, the needs of our patients have grown more complex.

In 2021, we saw an increase in patients with HIV unlike any increase we have previously seen. Eighty-eight percent of new patients had at least one clinical comorbidity, 62 percent reported unmet mental health needs, 56 percent reported food and housing insecurity.

Now unlike HIV care and treatment, there are currently very limited resources to support access to pre-exposure prophylaxis, or PrEP, for individuals who are uninsured or underinsured. Although PrEP is highly effective at preventing HIV infections, only 25 percent of the 1.2 million individuals who could benefit from PrEP have been prescribed it.

Among populations heavily impacted by HIV, only 9 percent of black individuals who can benefit from PrEP received a prescription in 2022, and only 16 percent of Hispanic and Latino individuals. We had two patients in the last year, both individuals of color, who would have benefitted from PrEP, but instead acquired HIV prior to reaching us and while trying to access PrEP services.

HIVMA, in partnership with PrEP for All, the Federal AIDS Policy Partnership, AIDS Budget and Appropriations Coalition, and HIV Prevention Action Coalition is urging \$400,000,000 in funding for 2023 for a new national PrEP program within the CDC Division of HIV Prevention.

Finally, I urge \$150,000,000 in funding for the CDC to address the infectious disease consequences of the opioid epidemic, including through improved surveillance and monitoring and supporting and expanding access to syringe services programs, harm reduction, and overdose prevention.

Thank you for your time and consideration of these requests, and I am happy to answer any questions.

[The information follows:]

**Submitted by the Chair of the HIV Medicine Association, Marwan Haddad, MD, MPH  
Prepared for the Subcommittee on Labor, Health and Human Services, Education, and  
Related Agencies Regarding the Fiscal Year 2023 Appropriations for Federal HIV and  
Related Programs**

May 24, 2022

Chairwoman DeLauro, Ranking Member Cole, and members of the Subcommittee, my name is Marwan Haddad, MD, MPH, chair of the HIV Medicine Association (HIVMA), and I serve as the medical director of the Center for Key Populations at the Community Health Center Inc. (CHCI) in Middletown, Connecticut, one of the largest Federally Qualified Health Centers in the country. I am pleased to submit testimony on behalf of HIVMA. HIVMA represents nearly 5,000 physicians, scientists and other health care professionals around the country on the frontlines of the HIV epidemic. Our members provide care and treatment to people with HIV, lead HIV prevention programs and conduct research in communities across the country.

For the FY2023 appropriations process, **we urge you to appropriate funding to support the Ending the HIV Epidemic (EHE) initiative, including: increased funding for the Ryan White HIV/AIDS Program (RWHP) at the Health Resources and Services Administration (HRSA) across all parts, increased funding for the Centers for Disease Control and Prevention's (CDC's) HIV, hepatitis and sexually transmitted infections (STI) prevention programs, and increased investments in HIV research supported by the National Institutes of Health (NIH).**

The funding requests in our testimony largely reflect the consensus of the Federal AIDS Policy Partnership (FAPP), a coalition of HIV organizations from across the country. For a chart of current and historical funding levels and coalition requests for each program, please see [FAPP's FY2023 Appropriations for Federal HIV/AIDS Programs](#).

**Ending the HIV Epidemic Initiative – U.S. Department of Health and Human Services:**

We recommend funding the EHE initiative at least at the President’s budget request for \$850 million across CDC, HRSA and NIH for FY2023, to be used for expanded access to antiretroviral treatment and pre-exposure prophylaxis (PrEP) to prevent HIV transmissions as well as improved access to routine and critical health services.

**National PrEP Program – Centers for Disease Control and Prevention**

The President’s budget calls for the creation of a national PrEP program to expand PrEP use and increase racial and ethnic equity in PrEP access. A national PrEP program is needed to dramatically reduce new HIV cases and address significant PrEP access disparities among the Black/African American and Hispanic/Latino populations who have been heavily impacted by HIV. While 1.2 million individuals could benefit from this highly effective prevention intervention, only 25% have been prescribed PrEP. We strongly urge support for a new program to ensure people who are uninsured and underinsured have access to it. **We recommend \$400 million in FY2023 appropriation to the CDC Division of HIV Prevention for a new line within the division’s budget to establish the foundation for National PrEP Program to support access to PrEP medications, laboratory services, essential support services, outreach and education activities and PrEP provider capacity building.**

**Health Resources and Services Administration – HIV/AIDS Bureau:**

HRSA’s Ryan White HIV/AIDS Program is critical to ensuring that individuals with HIV are linked to care, are retained in care, have medical adherence and achieve viral suppression. **To sustain current services and to ensure more people with HIV benefit from HIV care and treatment, we urge Congress to fund the Ryan White HIV/AIDS Program at \$2.942 billion in FY2023, an increase of \$447.5 million over FY2022. In addition, we strongly recommend**

providing at least \$290 million in EHE funding for the Ryan White Program, a \$165 million increase over FY2022.

HIVMA urges an allocation of \$231 million, a \$25.5 million increase over FY2022, for Ryan White Part C programs. It is critical to ensure that clinics in all jurisdictions nationwide receive additional funding to increase access to HIV care and treatment to help end the domestic HIV epidemic. Approximately half of Part C providers serve rural communities, making the clinics the primary source for delivering HIV care to rural jurisdictions.

**CHCI's Ryan White-Funded Clinic in Connecticut Is Leading on Expanding Access to HIV Prevention, Care & Treatment:**

The Center for Key Populations (CKP) at Community Health Center Inc. (CHCI) has received funding through the Ryan White HIV/AIDS program for more than 23 years, making us a leading source of HIV primary care in the state of Connecticut. Each year CHCI has increased the number of people with HIV served, the number of services offered and the number of HIV tests conducted.

The needs of both established and newly diagnosed patients with HIV are growing more complex, especially as the population ages. In 2021, even as HIV prevention methods became more available, CHCI saw an increase greater than previously experienced in the number of patients living with HIV who accessed services at our sites. Of all new patients enrolled in care at CHCI in 2021, 71% self-reported as racial and ethnic minorities and 56% reported food and housing insecurity as major barriers to achieving optimal health care. Additionally, 88% had at least one clinical comorbidity and 62% reported unmet mental health needs at the time of intake. Among Ryan White Program patients at CHCI, 60% reported experiencing stigma or discrimination based on their gender identity, sexual orientation or HIV status in the last year. Of CHCI's Ryan White Program patients -- 59% have substance use disorders, with 10%

considering those needs urgent or severe. CHCI, like most Ryan White Part C programs, also receives funding from other parts of the Ryan White Program, and these help us provide support services that were particularly important in retaining patients in care and supporting medication adherence. These services included home medical monitoring equipment, transportation, case management, patient navigation, home-delivered meals and groceries, and check-in phone calls. These key components of care are unique to the Ryan White Program care model and contribute to optimal health care outcomes for all patients.

The support services provided by Ryan White funding were pivotal in maintaining stability and transitioning care efficiently during the COVID-19 pandemic. The infrastructure developed over 23 years of funding gave Ryan White patients the additional support they needed to sustain healthy outcomes and stay engaged in care during the pandemic. These services are integral to the quality of life of patients and helps them maintain undetectable viral loads to keep them healthy and to prevent HIV transmission.

**Centers for Disease Control and Prevention – National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention:**

From CDC's leadership role in responding to the COVID-19 pandemic to its ongoing efforts to address persistent public health epidemics and threats, such as HIV, STIs and viral hepatitis, CDC is a critical national and global expert resource and response center. To meaningfully address these epidemics and the co-occurring crisis of substance use disorder – especially injection drug use – **we request a \$731.9 million overall increase above FY2022 levels for a total of \$2.077 billion.** Additionally, we request:

- **For the Division of HIV/AIDS Prevention (DHAP), we request a total of \$1.233 billion, which is a \$246 million increase over FY2022 levels.**

- The appropriation of \$150 million for CDC to fund surveillance and programming, a \$132 million increase above FY2022, to monitor and prevent injection-related infectious diseases as well as expand access to syringe services programs, harm reduction and overdose prevention.
- For the Division of Viral Hepatitis (DVH), we request a total of \$140 million, which is a \$99 million increase over FY2022 levels; and
- For the Division of STD Prevention (DSTDP), we request a total of \$329.2 million, which is a \$164.9 million increase over FY2022 levels.

**National Institutes of Health – Office of AIDS Research:**

The historical response to the COVID-19 pandemic over the last two years exemplifies the value of the nation's longstanding commitment to NIH. Decades of medical research supported by NIH are the foundation for diagnostic, treatment and preventive interventions available today, and building on this research will be vital in finding a cure and vaccine for HIV. **To advance these and other scientific discoveries, we ask that at least \$3.875 billion be allocated for HIV research in FY2023, an increase of \$681 million over FY2022.**

**Conclusion:**

Thank you for considering this request to support lifesaving investments in domestic HIV programs in the FY2023 (LHHS) appropriations bill. Fully funding these programs will ensure progress in ending the HIV epidemic. HIVMA looks forward to working with Congress to ensure that the resources necessary to make significant progress in preventing HIV and improving the health and well-being of people with HIV are provided. Please contact me or HIVMA's senior policy and advocacy manager, Jose A. Rodriguez, at [JRodriguez@hivma.org](mailto:JRodriguez@hivma.org) or (703) 299-0200 with questions.

The CHAIR. Thank you so much, Dr. Haddad. And thank you for your commitment to the work that you are doing. It is really very extraordinary.

I think it just points to the fact that how valuable these programs are. We have programs here. What we need to do is make sure that we are investing the resources that we need to begin to address your concerns.

I am happy to say that this committee, on a bipartisan basis, looking to ending HIV and working with the President's initiative, we have come together, and it is so promising. And again, I think most of the folks here today, and clearly, in your case, you are here saving lives. So we are very, very grateful for that.

And the quality of the programs and the results of what you are doing just is inspirational to all of us and gives us the incentive to look at where we can go for the future. And obviously, you know that depends a lot on what the funds that are available. But we certainly know the relevance and importance and the critical nature of all that you are doing.

So, thank you.

Congressman Cole.

Mr. COLE. Thank you, Madam Chair.

And I just want to quickly associate myself with your remarks. I think you summed it up from a bipartisan perspective about as well as we can. Doctor, we would love to put you out of business.

The CHAIR. Right.

Mr. COLE. And if there was a way, but we would at the stroke of a pen. But thank you for what you do, not just for your specialty, but also more broadly, the whole community health center movement has, honestly, been transformative in my State.

I know 20 years ago, when I got to Congress, I think we only had 5 of the centers in the State. We have about 60 now. It has made an enormous difference in the quality of healthcare for the folks that, frankly, are right at the fringes and quite often not able to get it.

So I appreciate what you and your colleagues do to help all of us in our respective States and districts.

So, with that, Madam Chair, I yield back.

The CHAIR. Thank you. Mr. Fleischmann.

Mr. FLEISCHMANN. Thank you, Dr. Haddad. And my sentiments exactly with the chair and the ranking member.

Thank you.

Dr. HADDAD. Thank you.

The CHAIR. Thank you. And it gives me great pleasure to introduce Dr. Cynthia McCurren, the board chair of the American Association of the Colleges of Nursing. And Dr. McCurren, your testimony, we would love to hear it, and you are recognized for 5 minutes.

#### **CYNTHIA McCURREN, BOARD CHAIR, AMERICAN ASSOCIATION OF COLLEGES OF NURSING**

Ms. McCURREN. Thank you, Chairwoman DeLauro, Ranking Member Cole, and members of the subcommittee, for this opportunity to provide testimony on behalf of the American Association of Colleges of Nursing, or AACN.

I am Dr. Cynthia McCurren, and I am chair of AACN's Board of Directors, and I am also dean and professor at the University of Michigan-Flint School of Nursing.

On behalf of more than 850 AACN member schools, which educate more than 565,000 students and employ more than 52,000 faculty across the country, I would like to personally thank you for your leadership and continued support of nursing education, our workforce, and research, especially during these unprecedented times.

As we work to combat current public health challenges and prepare for the future, AACN, along with 58 members of our Nursing Community Coalition, request at least \$530,000,000 for the Title VIII nursing workforce development programs and at least \$210,000,000 for the National Institute of Nursing Research, or NINR, in the fiscal year 2023.

From the classroom to the frontline, we have all witnessed how critical a well-educated nursing workforce is to providing high-quality healthcare. While AACN saw student enrollment in entry-level baccalaureate nursing programs increase by 3.3 percent in 2021, we also saw enrollment decline in our baccalaureate degree-completion programs and our graduate programs at the master's and Ph.D. levels.

As we look to the future and the need for increased enrollments to support the healthcare demands of the Nation, it is important to recognize that more than 91,000 qualified applications, not unique applicants, were not accepted at schools of nursing nationwide in 2021 alone. This is in part due to insufficient clinical placement sites, inadequate numbers of faculty and preceptors and classroom space, as well as budget cuts.

That is why Federal funding for nursing education and our Title VIII programs is so important. We must support our nursing schools, faculty, and students.

As a leader in nursing education, I have witnessed firsthand the benefits Title VIII funding provides. From supporting graduate education for nurses who work and live in rural and underserved areas to training for sexual assault nurse examiners critical in our urban and rural areas, and promoting diversity within the profession by providing grants to students from disadvantaged backgrounds, Title VIII nursing workforce development programs have been and will continue to be a short- and long-term success story and must be provided with funding levels that reflect the population they serve.

As we prepare the next generation of nurses and the faculty who educate them, we must also support the evidence that guides their practice. As one of the 27 institutes and centers at the National Institutes of Health, the National Institute for Nursing Research, or NINR, funds nurse scientists who work collaboratively with other health professionals to generate and translate new findings and lead translational research that helps address health equity and the social determinants of health.

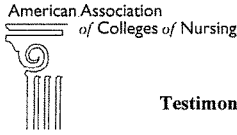
Bold investments in Title VIII nursing workforce development programs and NINR are imperative, not only as we confront existing health challenges, but as we provide tomorrow's equitable and innovative healthcare solutions. Therefore, AACN respectfully re-

quests support in fiscal year 2023 of at least \$530,000,000 for the Title VIII nursing workforce development programs and at least \$210,000,000 for the National Institute of Nursing Research.

Together, we believe we can ensure that such investments will promote and improve healthcare in America.

Thank you so much.

[The information follows:]



**Testimony Prepared for the U.S. House Appropriations Subcommittee on  
Labor, Health and Human Services, Education, and Related Agencies**

**U.S. Department of Health and Human Services  
Health Resources and Services Administration (HRSA)  
& National Institutes of Health (NIH)**

**May 24, 2022**

***Submitted by: Cynthia McCurren, PhD, RN, Board Chair  
American Association of Colleges of Nursing***

**Strengthening the Current and Future Nursing Workforce**

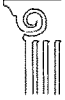
On behalf of the American Association of Colleges of Nursing (AACN), we would like to thank the Subcommittee for its leadership and continued support of nursing education, the nursing profession, and nursing research, especially during this unprecedented time. As the national voice for academic nursing, AACN represents more than 850 schools of nursing at private and public universities, who educate more than 565,000 students and employ more than 52,000 faculty.<sup>1</sup> Collectively, these institutions graduate our nation's registered nurses (RN), advanced practice registered nurses (APRN), educators, researchers, and frontline providers. As we work to combat current public health challenges, such as COVID-19, and prepare for the future, ensuring a robust nursing pathway requires a strong and sustained federal investment. For Fiscal Year (FY) 2023, AACN respectfully requests that you provide support of at least **\$530 million for the Nursing Workforce Development Programs** (Title VIII of the Public Health Service Act [42 U.S.C. 296 et seq.] administered by HRSA and at least **\$210 million for the National Institute of Nursing Research (NINR).**

***Landscape Overview: The Growing Nursing Workforce Demand***

Nurses comprise the largest sector of the healthcare workforce, with more than four million RNs

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<sup>1</sup> American Association of Colleges of Nursing. (2022) Who We Are. Retrieved from: <https://www.aacnursing.org/About-AACN/Who-We-Are>



and APRNs, which include Nurse Practitioners (NPs), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse-Midwives (CNMs), and Clinical Nurse Specialists (CNSs).<sup>2</sup> Nurse educators, students, and practitioners are leaders within their institutions and communities; many of whom are also serving on the frontlines of this public health emergency.

From the classroom to the frontline, we have witnessed how critical a well-educated nursing workforce is to the provision of high-quality health care. This need is only expected to grow, as the Bureau of Labor Statistics projects a 9% increase in RN workforce demand through 2030, representing the need for an additional 276,800 jobs.<sup>3</sup> Demand for certain APRNs (NPs, CRNAs, and CNMs) is expected to grow even more, by 45%.<sup>4</sup>

While AACN saw student enrollment in entry-level baccalaureate nursing programs increase by 3.3% in 2021, the increase was 2.3% lower than 2020.<sup>5</sup> Further, nursing schools saw enrollment decline in baccalaureate degree-completion programs and some graduate programs at the master's and PhD levels.<sup>6</sup> For the first time since 2001, enrollment in master's programs decreased by 3.8%, which translates to 5,766 fewer students enrolled in 2021 than in the previous year.<sup>7</sup> This is concerning because graduate programs prepare individuals for a variety of advanced roles in administration, teaching, research, informatics, and direct patient care.

There were bright spots in 2021, with enrollments in Doctor of Nursing Practice (DNP) programs up 4.0%.<sup>8</sup> However, the fact remains that a total of 91,938 qualified applications (not applicants) were not accepted at schools of nursing nationwide in 2021 alone.<sup>9</sup> As our annual survey found, "the primary barriers to accepting all qualified students at nursing schools

<sup>2</sup> National Council of State Boards of Nursing. (2021). Active RN Licenses: A profile of nursing licensure in the U.S. as of April 23, 2021. Retrieved from: <https://www.ncsbn.org/6161.htm>.

<sup>3</sup> U.S. Bureau of Labor Statistics. (2022). Occupational Outlook Handbook- Registered Nurses. Retrieved from: <https://www.bls.gov/ooh/healthcare/registered-nurses.htm>

<sup>4</sup> U.S. Bureau of Labor Statistics. (2022). Occupational Outlook Handbook- Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Retrieved from: <https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm>

<sup>5</sup> American Association of Colleges of Nursing. (2022) Nursing Schools See Enrollment Increases in Entry-Level Programs, Signaling Strong Interest in Nursing Careers. Retrieved from: <https://www.aacnnursing.org/News-Information/PressReleases/View/ArticleId/25183/Nursing-Schools-Sce-Enrollment-Increases-in-Entry-Level-Programs>

<sup>6</sup> Ibid

<sup>7</sup> Ibid

<sup>8</sup> Ibid

<sup>9</sup> Ibid



continues to be insufficient clinical placement sites, faculty, preceptors, and classroom space, as well as budget cuts.”<sup>10</sup>

Educational pathways are just one piece of the puzzle. Strong and historic investments in the current nursing workforce are imperative, especially as we contend with an aging nursing workforce and the lasting impact COVID-19 has had on the profession. In fact, registered nurses age 65 and older already make up 19% of the workforce, and “more than one-fifth of all nurses reported they plan to retire from nursing over the next 5 years.”<sup>11</sup> Not to mention a recent study which found 52% of nurses considered leaving their position during the pandemic, up from 40% a year earlier.<sup>12</sup> We must minimize the loss of experienced nurses who may prematurely leave the profession, and at the same time support nursing education to meet the current and future demand for nurses.

With increasing demands, an aging population, nursing retirements, and an increase in workplace stress,<sup>13</sup> bold investments in Title VIII Nursing Workforce Development Programs and NINR are imperative, not only as we confront existing health challenges, but as we provide tomorrow’s equitable and innovative healthcare solutions.

### ***Investments in Nursing Education Lead to a Strong Nursing Workforce***

For over fifty years, Title VIII Nursing Workforce Development Programs have been a catalyst for strengthening nursing education at all levels, from entry-level preparation through graduate study. Through grants, scholarships, and loan repayment programs, Title VIII federal investments positively impact the profession’s ability to serve America’s patients in all areas,

<sup>10</sup> American Association of Colleges of Nursing. (2022) Nursing Schools See Enrollment Increases in Entry-Level Programs, Signaling Strong Interest in Nursing Careers. Retrieved from: <https://www.aacnnursing.org/News-Information/PressReleases/View/ArticleId/25183/Nursing-Schools-See-Enrollment-Increases-in-Entry-Level-Programs>

<sup>11</sup> National Council of State Boards of Nursing and the National Forum of State Nursing Workforce Centers (2021) The 2020 National Nursing Workforce Survey. Retrieved from: [https://www.journalofnursingregulation.com/article/S2155-8256\(21\)00027-2/fulltext](https://www.journalofnursingregulation.com/article/S2155-8256(21)00027-2/fulltext)

<sup>12</sup> American Nurses Foundation. (2022). Pulse on the Nation’s Nurses Survey Series: COVID-19 Two-Year Impact Assessment Survey. Retrieved from: <https://www.nursingworld.org/-/492857/contentassets/872ebb13c63f44f6b11a1bd0c74907c9/covid-19-two-year-impact-assessment-written-report-final.pdf>

<sup>13</sup> American Association of Colleges of Nursing. (2020) Fact Sheet: Nursing Shortage. Retrieved from: <https://www.aacnnursing.org/Portals/42/News/Factsheets/Nursing-Shortage-Factsheet.pdf>



bolster diversity within the workforce, and increase the number of nurses, including those at the forefront of public health emergencies and caring for our aging population.

Each Title VIII Nursing Workforce Development Program provides a unique and crucial mission to support nursing education and the profession. For example, the Advanced Nursing Education (ANE) programs help increase the number of APRNs in the primary care workforce and supported more than 8,800 students in Academic Year 2020-2021 alone.<sup>14</sup> In addition, the Nurse Faculty Loan Program (NFLP) supported 2,763 graduate nursing students who intend to serve as nurse faculty.<sup>15</sup> “By the end of the Academic Year, the programs graduated 779 trainees, 92 percent of whom intended to teach nursing.”<sup>16</sup> As we address social determinants of health and work to build an equitable healthcare system for all patients, it is imperative that we recruit individuals from diverse backgrounds to the nursing profession. Increasing diversity in the profession will not only create lifelong career pathways, but will also improve care quality and access to population-centered care. A recent HHS Assistant Secretary for Planning and Evaluation (ASPE) report makes the recommendation to “optimize existing workforce development programs to support diversity in the health professional workforce and further support the development of a diverse workforce through pipeline programs.”<sup>17</sup> The Nursing Workforce Diversity (NWD) program serves as a glowing example of a successful Title VIII initiative that accomplishes this goal. In fact, in Academic Year 2020-2021, the NWD program awarded grants supporting 10,155 nursing students from disadvantaged backgrounds.<sup>18</sup> To ensure the stability of our nursing workforce now and in the future, we request at least **\$530 million for Title VIII Nursing Workforce Programs in FY 2023.**

<sup>14</sup> Health Resources and Services Administration. Fiscal Year 2023 Budget Justification. Pages 164-170. Retrieved from: <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf>

<sup>15</sup> Health Resources and Services Administration. Fiscal Year 2023 Budget Justification. Page 181. Retrieved from: <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf>

<sup>16</sup> Ibid

<sup>17</sup> Assistant Secretary for Planning and Evaluation, Office of Health Policy. *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce Challenges and policy responses*. (2022) Retrieved from: <https://aspe.hhs.gov/sites/default/files/documents/9ec72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf>

<sup>18</sup> Health Resources and Services Administration. Fiscal Year 2023 Budget Justification. Pages 171-174. Retrieved from: <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf>



### ***From Research to Reality: Nursing Science Protects Americans' Health***

AACN recognizes that scientific research and discovery are the foundation on which nursing practice is built and is essential to advancing evidence-based interventions, informing policy, and sustaining the health of the nation. In fact, a recent ASPE's report recommends to "support research that investigates long-term workforce trends arising from the pandemic and how they can be addressed including entry and departure issues, impact on facility staffing, and factors associated with health worker morale."<sup>19</sup> As one of the 27 Institutes and Centers at NIH, NINR plays a fundamental role in improving care and is on the cutting edge of new innovations impacting how nurses are educated and how they practice. In fact, 80% of research-focused educational training grants at nursing schools are funded by NINR.<sup>20</sup> Through these grants and others, nurse scientists, often working collaboratively with other health professionals, are generating groundbreaking findings and leading translation research that works to address strategic imperatives, to include health equity, social determinants of health, population health, health promotion, and models of care. To further this vital work, we are requesting a total of at least **\$210 million for the National Institute of Nursing Research.**

Strong investments in Title VIII Nursing Workforce Development Programs and NINR have a direct impact on sustaining pathways into nursing and patient access to high-quality, evidence-based care in all communities across the nation. During these unprecedented times, AACN respectfully requests support in FY 2023 of at least **\$530 million for the Title VIII Nursing Workforce Development Programs** and at least **\$210 million for the National Institute of Nursing Research.** Together, we can ensure that such investments promote innovation and improve health care in America.

<sup>19</sup> Assistant Secretary for Planning and Evaluation, Office of Health Policy. *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce Challenges and policy responses.* (2022) Retrieved from:

<https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf>

<sup>20</sup> Journal of Professional Nursing (2019) National Institute of Health (NIH) funding patterns in Schools of Nursing: Who is funding nursing science research and who is conducting research at Schools of Nursing? Retrieved from <https://www.sciencedirect.com/science/article/abs/pii/S8755722319301164?via=ihub>

The CHAIR. Thank you so much.

And my own experience with the nursing profession was some 30 years ago and diagnosed with ovarian cancer and spent a fair amount of time in the hospital. And while I can applaud the surgeons and their great work helping to save my life, it was the nurses who came every day and who just by one look at me could tell whether it was a good day or a bad day, and they were always there.

So we know the nature of the profession. We are also very conscious of—well, my view, and I will just be frank about it, I don't think the Institute of Nursing Research gets enough funding as I believe it should. And we will take a very, very hard, hard look at that.

I also know that there is a very big, high debt of student debt for folks going through the nursing program. So loan repayment is another critically important effort. And you have so many nurses who are ready to retire that looking at the profession, what we need to do is seriously think about how we are really going to strengthen nursing because we know the role that they play, that they play like the critical role that they played during the pandemic.

So you can be sure we are going to take a hard look at this.  
Congressman Cole.

Mr. COLE. Thank you, Madam Chair.

As in this and so many other areas, we certainly don't disagree. I know in my own State, a number of years ago under former Governor Fallin, we did a survey of critical needs in our workforce. This is pre-COVID. Number one was skilled nursing, literally.

And having dealt with, as we all have, all my providers during this really critical time, I know how we stretch the nursing workforce and how it has been for hospitals to get what they need and how tough it has been on people in the profession. We have worked really, really hard—and frankly, how intense now the competition is not just within States, but across State borders—to try and get that workforce.

All of which reinforces the request that you have made, and so just thank you and your profession for what you do selflessly. And again, these are needed skills. They are not going to go away, and these are important investments.

And again, as the chair always points out, we don't know what our money is now, but I can't imagine you won't rank high on the areas that we all agree on the committee we need to focus on.

So thank you for your testimony.

Yield back, Madam Chair.

The CHAIR. Thank you. Congressman Fleischmann.

Mr. FLEISCHMANN. Thank you again, Madam Chair and Ranking Member Cole, for your comments.

I would like to say this. In my great State of Tennessee, we have several great colleges of nursing, and I have spoken with the students. They are—it takes a special person to be a nurse, but there is boundless optimism with the students that we are producing in our State.

So thank you for what you are doing, so critically needed and very important. So I wish you continued success.

And again, this is one of the areas of broad agreement on this subcommittee. So thank you very much.

Ms. MCCURREN. Thank you. Thank you all.

The CHAIR. Thank you very much.

Let me now recognize our next guest, and that is Dr. Julie—and hoping I pronounce this right—Ajinkya. Thank you, and senior vice president and chief strategy officer with the APIA Scholars.

And Dr. Ajinkya, please, we would love to hear from you.

**JULIE AJINKYA, SENIOR VICE PRESIDENT AND CHIEF  
STRATEGY OFFICER, APIA SCHOLARS**

Ms. AJINKYA. Chairwoman DeLauro, Ranking Member Cole, and members of the subcommittee, my name is Julie Ajinkya, and I am the senior vice president of APIA Scholars, as you just mentioned. We are an organization that is focused on dramatically improving the educational outcomes of underserved Asian American, Native Hawaiian, and Pacific Islander students by ensuring access to affordable college opportunities and student success programming.

And I am also professor of government with Cornell's Brooks School of Public Policy.

Thank you for inviting me to submit testimony for fiscal year 2023 appropriations on behalf of the Asian American and Native American Pacific Islander-Serving Institutions, otherwise known as the AANAPISI program, and the students that it serves. Specifically, asking for an increase in funding for AANAPISIs to \$100,000,000 annually, which would allow them to be funded at a per-institution and per-student level commensurate with other Minority-Serving Institutions.

I would like to first begin by thanking all of you for your commitment that you have shown to AANHPI students by increasing spending for the AANAPISI program in fiscal year 2022. You all made a significant down payment for these schools and institutions by more than doubling funding for AANAPISIs compared to the prior fiscal year, from \$5,000,000 to more than \$10,000,000.

This increase in funding will allow more AANAPISIs to better serve first-generation and low-income AANHPI students in higher education. Indeed, nearly half of AANHPI students attend AANAPISIs, and these colleges and universities enroll and serve about three-quarters of all low-income AANHPI students. Given that the AANHPI population was the fastest-growing racial group in the U.S. over the past decade, better serving these students is in the interest of the entire nation at large.

Today, we would like to build upon that down payment and are requesting that you increase funding for AANAPISIs to \$100,000,000 annually, which, again, would allow them to be funded at a per-institution and per-student level commensurate with other MSIs, like Hispanic-Serving Institutions.

Ideally, this appropriation would be divided as \$30,000,000 in discretionary funding under Title III, Part A and \$70,000,000 in mandatory funding for Title III, Part F, for a total of \$100,000,000 in AANAPISI program funding for fiscal year 2023. This critical division would address the need for additional mandatory funding, given current statutory barriers that limit the amount of discre-

tionary funding AANAPISIs can receive if they also serve students from other underserved populations.

This funding is critical because of the impact AANAPISIs have on the students they serve, particularly because many of these students are the first in their families to go to college, come from low-income backgrounds, are often English language learners, and are dealing with higher rates of unmet mental health needs, particularly due to the spike in anti-Asian hate our communities have endured during the pandemic.

We often hear from our network of students that they appreciate their AANAPISI programs understanding their identities and how it shapes their college experience. For example, Kristine Jan C. Espinoza, a proud AANAPISI alum from the University of Hawaii at Manoa, shared how attending an AANAPISI was a critical opportunity to be mentored by AANHPI faculty and encouraged to pursue further graduate education.

Espinoza, now a doctoral student at another AANAPISI, UNLV, focused on researching MSIs and cherished how she felt like she belonged on campus by being around students who looked like her, learning from AANHPI mentors, and appreciated how even the physical campus environment reflected cultural elements she was familiar with.

De Anza College, an institution located in Cupertino, California, with AANHPI students comprising nearly 40 percent of the total enrollment, provides another instructive example. De Anza used their AANAPISI grant to pair developmental English with an AANHPI literature course, including wraparound supports with an embedded counselor.

Research then showed that the students who participated in this program passed their developmental course at a higher rate, were more likely to transition from developmental to college-level English, and were more likely to earn associate's degrees, all in less time. With increased funding, more institutions would be able to serve their students like De Anza College has.

We are requesting the funding increase because AANAPISIs have been chronically underfunded since their establishment and until last year were the lowest-funded category of MSI per capita. Disappointingly, while 165 institutions have been identified by the Department of Education as eligible AANAPISIs, only 30 of those institutions receive AANAPISI funding.

Equitable funding of all 165 eligible AANAPISIs at the same level as HSIs would require an annual funding amount of \$100,000,000. I want to make clear, however, that any increase in AANAPISI funding should not come at the expense of other MSIs.

Thank you for your continued support for the AANAPISI program, and we look forward to continuing to work alongside you and be a resource for you.

Thank you.

[The information follows:]

**Public Witness Testimony of Julie Ajinkya**

Title: Senior Vice President

Organization: APIA Scholars

House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies - FY 2023

May 26, 2022

Chairwoman DeLauro, Ranking Member Cole, and members of the Subcommittee:

My name is Julie Ajinkya and I am the Senior Vice President of APIA Scholars, an organization focused on the goal of dramatically improving the outcomes of Asian American, Native Hawaiian and Pacific Islander (AANHPI) students by ensuring access to affordable and high-quality educational opportunities and student success programming. Thank you for inviting me to submit testimony for FY23 Appropriations on behalf of the Department of Education's Asian American and Native American Pacific Islander-Serving Institutions (AANAPISI) program and the students it serves, specifically for an increase in funding for AANAPISIs to \$100 million annually, which would allow them to be funded at a per-institution and per-student level commensurate with other Minority Serving Institutions (MSIs).

I would like to first begin by thanking all of you for the commitment you have shown to AANAPISIs and AANHPI students by increasing spending for the AANAPISI program in FY2022; you all made a significant down payment for these schools and institutions by more than doubling funding for AANAPISIs compared to the prior fiscal year, from \$5 million to more than \$10 million per year. This increase in funding will allow AANAPISIs to better serve first-generation and low-income AANHPI students in higher education—indeed, nearly half of AANHPI students attend AANAPISIs and these colleges and universities enroll and serve about three quarters of all low-income AANHPI students. These institutions are geographically distributed throughout the U.S., as well as U.S. territories in the Pacific, including America Samoa, Guam, Palau, Northern Mariana Islands, the Federated States of Micronesia, and the Marshall Islands. The largest concentration of eligible AANAPISIs are in the West and the Pacific, but the states with the most institutions emerging in status are in the South and the Midwest. In fact, between 2010 and 2020, the AAPI population was the fastest growing racial group in the U.S.<sup>i</sup>

Today, we would like to build upon that down payment and are requesting that you increase funding for AANAPISIs to \$100 million annually, which would allow them to be funded at a per-institution and per-student level commensurate with other MSIs, like Hispanic Serving Institutions. Ideally, this appropriation would be divided as **\$30 million in discretionary funding under Title III, Part A and \$70 million in mandatory funding for Title III, Part F, for a total of \$100 million in AANAPISI program funding for Fiscal Year 2023.** This critical division would address the need for additional mandatory funding, given statutory barriers that limit the amount of discretionary funding AANAPISIs can receive if they also serve students from other underserved populations.

This funding is critical because of the impact AANAPISIs have on the students they serve, particularly because many of these students are the first in their families to go to college, come from low-income backgrounds, are often dual-language learners, or need additional educational

support. We often hear from our network of APIA students that they appreciate their AANAPISI programs “understanding their identities and how it shapes their college experience.” For example, Kristine Jan C. Espinoza, a proud AANAPISI alum from the University of Hawai‘i at Mānoa (UHM), shared how attending an AANAPISI was a critical opportunity to be mentored by AANHPI faculty and be encouraged to pursue further graduate education. Espinoza cherishes how she felt like she belonged on campus by being around students who looked like her, learning from AANHPI mentors, and appreciates how even the physical campus environment reflected cultural elements she was familiar with. Espinoza, now a doctoral student at a dual AANAPISI and Hispanic-Serving Institution (University of Nevada, Las Vegas (UNLV)), focuses on researching AANAPISIs and other MSIs and has been leading an effort to disaggregate data at the university.

We are requesting this funding increase because AANAPISIs have been chronically underfunded since their establishment and until last year were the lowest-funded category of MSIs per capita. Disappointingly, while 165 institutions have been identified by the U.S. Dept. of Education as eligible AANAPISIs, only 30 of those institutions receive AANAPISI funding. For reference, the FY2021 funding is \$59,606 per AANAPISI compared to \$589,167 per Hispanic-Serving Institution (HSI). If Congress were to request equitable funding of all 165 eligible AANAPISIs at the same level as HSIs, the AANAPISI program would require an annual funding amount of \$100 million dollars. I want to make clear, however, that any increase in AANAPISI funding should not come at the expense of other MSIs.

### **Impact**

The impact of AANAPISIs cannot be understated. AANAPISIs enroll 40% of all AANHPI undergraduates though AANAPISIs only make up only 5% of all colleges and universities in the United States, and their collective enrollment is approximately 8% of the nation’s total undergraduate enrollment.<sup>ii</sup> Three quarters of low-income AANHPI students attend an AANAPISI,<sup>iii</sup> and AANAPISIs confer a large concentration of both associate’s and bachelor’s degrees to AANHPI students. AANAPISIs also provide critical support for students through programs like academic tutoring, counseling, partnerships with community-based organizations serving AANHPIs, and conducting critical research and data collection for AANHPI subpopulations to better serve them in the future.

AANHPI students also have wide disparities in educational attainment, which often goes unnoticed because of the way these incredibly diverse populations are often lumped together in the “model minority” myth. Despite a perception of universally high educational achievement, there are significant differences in educational attainment between AANHPI ethnic sub-groups. For example, approximately half of Southeast Asian and Pacific Islander students leave college without earning a degree, which is three-to-five times the likelihood of dropping out compared to East Asians and South Asians.

Native Hawaiian and Pacific Islander students, specifically, face additional challenges. As Robert Teranishi, Professor of Social Science and Comparative Education at UCLA states, “There is a particularly disturbing demographic trend that is pointing to downward intergenerational mobility within the NHPI communities. We are seeing a decline in NHPI college enrollment and the bachelor’s degree attainment rate of younger Guamanians, Native Hawaiians, and Samoans (18-24 years of age) is lower compared to the older cohort of these populations (55-64 years of age).

As a result, the gap between NHPI sub-groups and the national average is increasing, rather than decreasing.<sup>iv</sup>

Increased financial support for the AANAPISI program is also necessitated by changing demographics within the United States. According to the U.S. Census Bureau, the Asian population in the United States doubled from 2010 and 2020, increasing from 12.6 million to 25.6 million; the population is projected to hit 46 million by 2060.<sup>v</sup> Consequently, an increased focus, and financial commitment, to the AANHPI population is necessary to provide equitable access to post-secondary education opportunities as a larger number of AANHPI students begin to enroll in college.

The imperative for increasing AANAPISI funding is more urgent than ever given the increase in racist attacks against individuals of AANHPI descent in the wake of the COVID pandemic over the past two years. AANHPI students are experiencing more racism and discrimination and this funding will help institutions expand their capacity to respond to the unique challenges faced by AANHPI students today. As Arlene Daus-Mabual, Director for Asian American and Pacific Islander Student Services and Faculty Lecturer in Asian American Studies at San Francisco State University, argues, “Interventions and services that center on race and ethnicity play a central role in college student development. That is why AANAPISIs are so important for our community. It is imperative to create spaces within higher education where students learn about their ethnic identity, [and] how to critically question and analyze the root of problems of the oppression we face.”

Research also demonstrates that AANAPISIs are utilizing their resources to respond to the unique needs of their students and engage in a range of initiatives that aim to increase access to and success in college. These grant-funded activities improve how AANAPISIs deliver student services, make improvements to curricular and academic program development, increase their capacity to improve leadership and mentorship opportunities, and contribute to faculty and staff development.<sup>vi</sup> Longitudinal data that tracked AANHPI students in AANAPISI-funded programs against a comparable group of AANHPI students who did not participate in the AANAPISI-funded program demonstrated that these programs have added value relative to academic performance, credit accumulation, persistence, degree attainment, and transfer rates.<sup>vii</sup>

One example of this added value is at De Anza College, an institution located in Cupertino, CA with AANHPI students comprising nearly 40% of the total enrollment. De Anza used their AANAPISI grant to pair developmental English with an AANHPI literature course, including wrap-around supports with an embedded counselor. Research showed that the students who participated in this program passed their developmental course at a higher rate, were more likely to transition from developmental to college-level English, and were more likely to earn associate’s degrees—all in less time.<sup>viii</sup> With increased funding, more institutions would be able to serve their students and improve their outcomes like De Anza College has.

Thank you for your continued support of the AANAPISI program. We look forward to continuing to work alongside you, and be a resource for you, as you push to ensure that more AANAPISIs receive the funding they need to best serve the AANHPI students and others that enroll now and

in the future. We hope that you will provide an annual AANAPISI program appropriation of \$30 million in discretionary funding and \$100 million in total funding for FY2023.

<sup>i</sup> 7 U.S. Census Bureau, *The Native Hawaiian and Other Pacific Islander Population: 2010, 2012*, <https://www.census.gov/prod/cen2010/briefs/c2010br-12.pdf>. 21 Feb. 2022; U.S. Census Bureau, *Race and Ethnicity in the United States: 2010 and 2020 Census, 2021*, <https://www.census.gov/library/visualizations/interactive/race-and-ethnicity-in-the-united-state-2010-and-2020-census.html>.

<sup>ii</sup> M. H. Nguyen, K. J. Espinoza, D. T.-L. Gogue, & D. Ding, *Looking to the Next Decade: Strengthening Asian American and Native American Pacific Islander Serving Institutions through Policy and Practice* (Washington, D. C.: National Council of Asian Pacific Americans, 2020); National Center for Education Statistics, Table 306.10. Total Fall Enrollment in Degree-Granting Postsecondary Institutions, 2019, [https://nces.ed.gov/programs/digest/d19/tables/dt19\\_306.10.asp](https://nces.ed.gov/programs/digest/d19/tables/dt19_306.10.asp).

<sup>iii</sup> Congressional Research Service, *Memorandum Regarding the Number of Institutions Potentially Eligible to Receive Grants Under the Assistance to Asian American and Native American and Pacific Islander-Serving Institutions Program* (Washington, D.C.: Author, 2009).

<sup>iv</sup> 12 Teranishi, R. T., Le, A., Gutierrez, R. A., Venturana, R., Hafoka, I., Toso-Lafaele Gogue, D., & Uluave, L. *Native Hawaiians and Pacific Islanders in Higher Education: A Call to Action* (Washington, D.C.: 2019).

<sup>v</sup> U.S. Census Bureau, *The Native Hawaiian and Other Pacific Islander Population: 2010, 2012*, <https://www.census.gov/prod/cen2010/briefs/c2010br-12.pdf>. 21 Feb. 2022; U.S. Census Bureau, *Race and Ethnicity in the United States: 2010 and 2020 Census, 2021*, <https://www.census.gov/library/visualizations/interactive/race-and-ethnicity-in-the-united-state-2010-and-2020-census.html>.

<sup>vi</sup> National Commission on Asian American and Pacific Islander Research in Education, *Partnership for Equity in Peer Education through Research (PEER): Findings from the First Year of Research on AANAPISIs* (New York, NY: Author, 2013)

<sup>vii</sup> R. T. Teranishi, M. Martin, L. Bordoloi Pazich, C. M. Alcantar, & T.-L. K. Nguyen, *Measuring the Impact of MSI Funded Programs on Student Success: Findings from the Evaluation of Asian American and Native American Pacific Islander Serving Institutions* (New York, NY: National Commission on Asian American and Pacific Islander Research in Education and Asian and Pacific Islander American Scholarship Fund, 2014).

<sup>viii</sup> Ibid.

The CHAIR. Thank you very, very much, Dr. Ajinkya.

You make a very, very strong case for the relevance, first of all, of the education, the climate in which these—the hate crime which people have been living, and that is particularly focused on Asian, Pacific Islanders in the last little while. But it is the opportunity for education that is critical. We understand that on this committee in a bipartisan way and how we need to make that opportunity available because we know that education is that great equalizer, gives people the credentials for success.

And your statistics, which we will take a hard look at, how you described the underfunding of the educational opportunities for AANAPISI is a very, very strong case. So we will take a very hard look at how we are able to increase the educational opportunities and make it possible for more to be able to get the kind of education that they need in order to succeed and to have our country succeed and our economy succeed.

So, with that, let me recognize our ranking member.

Mr. COLE. Thank you very much, Madam Chair.

Again, I think the committee, on a bipartisan basis, recognizes the importance of the request and the significance that these types of institutions play, quite frankly. And Congress has a long history, all the way back to the founding of Howard University, of recognizing there are unique institutions that serve specific communities that all of the broader community then benefit from over time. And certainly, in my area, we had both HBCs and tribal colleges and universities, and these things are enormously important to us.

So, again, I associate myself with the chair. We will give it a hard look and see what we can do.

With that, yield back, Madam Chair.

The CHAIR. Thank you. Congressman Fleischmann.

Mr. FLEISCHMANN. I thank the doctor for her testimony and for shedding light on this important issue, and I will yield back.

The CHAIR. Thank you.

It gives me great pleasure to offer a very, very warm welcome to former constituents Brian Wallach. He is the co-founder of I AM ALS and received his bachelor's degree from Yale University. Brian is joined by his wife, Sandra Abrevaya, who, like me, grew up in the city of New Haven.

A few years ago, while Mr. Wallach was working as an assistant U.S. attorney, he was diagnosed with ALS. Just 37 years old. Refusing to let this shocking diagnosis deter him, Brian partnered with Sandra to co-found I AM ALS. It is a nonprofit organization that provides critical support and resources to ALS patients, caregivers, and loved ones while engaging with policymakers. They promote ALS research. They mobilize communities to take action in this area, to spread the word or increase awareness of ALS to millions of people.

Brian Wallach is a force, and a force along with Sandra, and so delighted to have them with us today. He is going to talk about funding for ALS research programs and some of the new initiatives that will help to accelerate development of therapies for all life-threatening neurodegenerative diseases.

With our hearts and our arms open, we welcome Brian and Sandra Wallach.

**BRIAN WALLACH, CO-FOUNDER, I AM ALS, ACCOMPANIED BY  
SANDRA ABREVAYA, CO-FOUNDER, I AM ALS**

Ms. ABREVAYA. Thank you so much, Madam Chairwoman, for that introduction and that background.

We are so grateful to be here today with everybody. And thank you to you and to Ranking Member Cole and to Congressman Fleischmann for the opportunity to speak to you once again about the fight to end ALS.

Mr. WALLACH. My name is Brian Wallach.

Ms. ABREVAYA. My name is Brian Wallach. I am 41 years old, and I have been living with ALS for almost 5 years now. I am here today with my wife, Sandra, who is my voice.

Mr. WALLACH. If truth be told—

Ms. ABREVAYA. Truth be told, when I first testified before you in 2019, I did not think that I would be alive to speak to you today.

Mr. WALLACH. I am one of the lucky ones.

Ms. ABREVAYA. I am one of the lucky ones, as 90 percent of those diagnosed in the same year as me are dead. That includes veterans, mothers, sons, and daughters from every single congressional district.

Thanks to you and the other amazing champions on the Hill, we have made real progress since I first testified before you, and you have worked to pass and fund the ACT for ALS and have recognized that ALS should be part of the mission of the new ARPA-H.

Mr. WALLACH. Three years ago—

Ms. ABREVAYA. Three years ago, you told me that you would do everything in your power to fight for a cure, and Chairwoman, you have kept that promise. For that, I am humbled. But we still have miles to go before we rest.

Mr. WALLACH. May is ALS Awareness Month in the U.S.

Ms. ABREVAYA. May is ALS Awareness Month in the U.S. On May 12, I AM ALS and hundreds of ALS advocates gathered in DC a mile away from the Capitol to plant thousands of flags for those living with ALS and those we have lost. This is the reality of ALS today.

Mr. WALLACH. My name was on one of those flags.

Ms. ABREVAYA. My name was on one of those flags.

Mr. WALLACH. For me, my reality is—

Ms. ABREVAYA. For me, my reality is that I can now barely speak. I am mostly confined to a wheelchair, and I can no longer raise my arm.

Mr. WALLACH. But I am still here.

Ms. ABREVAYA. But I am still here, and I will keep fighting for as long as I breathe.

By passing ACT for ALS, Congress and President Biden made clear that the FDA and NIH must act now to implement these programs, most importantly the expanded access grant program. As President Biden said during the December signing ceremony of the bill, “This law invests \$100,000,000 annually for the next 5 years. And this includes issuing grants that support research on and access to promising new therapies for patients who don’t make it into clinical trials. This means hope for patients who would otherwise have no access to treatments that could possibly work for them.”

Earlier this year, you approved and appropriated \$25,000,000 to make this program real, and on May 12, NINDS released the Funding Opportunity Announcement for those funds.

Mr. WALLACH. I am here today to ask you——

Ms. ABREVAYA. I am here today to ask you to build upon this momentum by fully funding ACT for ALS for the 2023 fiscal year. Fully funding ACT for ALS means that we need to appropriate \$100,000,000 in fiscal year 2023, including \$75,000,000 for the expanded access grant program.

This funding is not only desperately, desperately needed by those of us who are dying from ALS right now, but it will also change the course of ALS forever. Full funding will allow NINDS and FDA to move forward aggressively and quickly to implement the programs in ACT for ALS. We urge the agencies to work with the same urgency as Congress has shown, so that we can make the hope that ACT for ALS embodies for those who have suffered in the shadows and those who have been left to die for too long real.

Mr. WALLACH. The ALS community——

Ms. ABREVAYA. The ALS community, which includes clinicians, clinical researchers, people living with and impacted by ALS, and advocacy organizations, we are all united in support of expanded access programs. As NIH and FDA create and execute on the expanded access grant program mandated by ACT for ALS, we ask the agencies to incorporate the set of recommendations the ALS community provided to them this month.

I also ask for your support in ensuring that ALS research is robustly supported by NIH and by the Department of Defense. These research programs are critical to unlocking treatments for ALS, as well as Alzheimer's, Parkinson's, multiple sclerosis, and beyond because all of these neurodegenerative diseases are connected.

Thank you. Thanks to all of you, the path toward ending ALS is clearer.

Mr. WALLACH. But there is much more work ahead.

Ms. ABREVAYA. But there is much more work ahead. On behalf of the ALS community——

Mr. WALLACH. Thank you.

Ms. ABREVAYA [continuing]. Thank you. And I look forward to working with you to turn ALS from always fatal to chronic, and then to end it once and for all.

Thank you, Chairwoman.

[The information follows:]



**Brian Wallach**  
**Co-Founder, I AM ALS**  
**Outside Public Witness Written Testimony**  
**House Appropriations Subcommittee on Labor, Health and Human Services, Education**  
**and Related Agencies**  
**Committee on Appropriations**  
**United States House of Representatives**  
**Regarding FY2023 Health and Human Services and Food and Drug Administration**  
**May 26, 2022**

Chairwoman DeLauro, Ranking Member Cole: thank you for the opportunity to speak to you once again about the fight to end ALS. My name is Brian Wallach, I am forty-one years old, and I have been living with ALS for almost five years now. Truth be told, when I first testified before you in 2019, I did not think I would be alive today to speak with you. I am one of the lucky ones, as eighty-five percent of those diagnosed this same year as me are dead.

Thanks to you and the other amazing champions on the Hill, we have made real progress since I first testified before you. Thank you for working to pass and fund the Act for ALS and for recognizing that ALS should be part of the mission of the new ARPA-H. Three years ago, you told me you would do everything in your power to fight for a cure and you have kept that promise. For that I am humbled, but we still have miles to go before we rest.

May is ALS Awareness Month in the US. On May 12, I AM ALS and hundreds of ALS advocates gathered in DC a mile away from the Capitol to plant thousands of flags for those living with ALS and those we have lost. This is the reality of ALS today. For me, my reality is that I can now barely speak, and am mostly confined to a wheelchair, and can no longer raise my arm. But I am still here, and will keep fighting as long as I breathe.

Today, I want to say how grateful the ALS community is to you and your colleagues for what you have done over the last three years. Just five months ago, Congress passed by a vote of 523 to 3 ACT for ALS.

By passing ACT for ALS, Congress, President Biden and the ALS community made clear that the FDA and NIH must act now to implement these programs, most importantly the expanded access grant program. As President Biden said during the December signing ceremony of the bill, “The law invests \$100 million annually for the next five years to do three important things: First, it directs the Department of Health and Human Services to issue grants that support research on — and the access to promising new therapies for patients who don’t make it into clinical trials. This means hope for patients who would otherwise have no access to treatments that could possibly work for them.” “God willing, we’re going to make real progress.”

The expanded access grant program was designed to serve those living with ALS NOW, while also improving our understanding of ALS for those who will be diagnosed in the future. Earlier this year, you appropriated \$25 million to make this program real, and on May 12, NINDS released the Funding Opportunity Announcement for those funds.

I am here today to ask you to build upon this momentum by fully funding ACT for ALS for the 2023 fiscal year. Fully funding ACT for ALS means that we need to appropriate \$100 million in fiscal year 2023, including \$75 million for the expanded access grant program. This funding is desperately needed by those who are dying from ALS right now. This funding will not only change the course of the disease for those with ALS right now, but also the course of ALS overall. It is critical that we fully fund ACT right now so that NINDS and the FDA can move forward aggressively to implement the programs in ACT that will transform not only ALS but also countless rare and neurological diseases.

We urge the Agencies to work with the same urgency as Congress has so that we can make real the hope that ACT for ALS embodies for those who have suffered in the shadows and those who have been left to die for too long. The research and regulatory innovations in ACT for ALS will help fund new clinical trials, discover new treatments, and drive regulatory advancements for millions of Americans.

The ALS community, inclusive of clinicians, clinical researchers, people living with and impacted by ALS, and advocacy organizations are united in their support of expanded access programs, as they have the power to help those living with ALS right now and to transform ALS research going forward. As NIH and FDA create and execute on the expanded access grant program mandated by ACT for ALS, we ask the Agencies to incorporate the set of recommendations the ALS community provided to them this month, which I have attached to my testimony.

I also ask for your support in ensuring that ALS research is robustly supported by NIH and by the Department of Defense. These research programs are critical to furthering our understanding of ALS and unlocking treatments for ALS, as well as Alzheimer's, Parkinson's, Multiple Sclerosis, and beyond.

Because of your tireless efforts and support, there is real hope for those living with ALS and rare neurodegenerative diseases today, as well as those who will be diagnosed in the days, months, and years ahead.

Thanks to you, the path toward ending ALS is clearer, but there is much work to do. On behalf of the ALS community, I thank you and look forward to working with you to turn ALS from always fatal to chronic, and then to end it once and for all.

The CHAIR. Thank you, Brian and Sandra. You both always are such a great inspiration to all of us.

And Congressman Cole will comment, Congressman Fleischmann, and other members of the committee, even though they are—they may not be present, but your efforts are beyond inspirational. That is not adequate.

You have made ALS and the ravages of ALS not only on the individual with the disease, but on the families as well, on your family, but you have opened the eyes of this country. You have opened the eyes of Members of Congress to what our responsibilities are.

And here, I look at you, Brian, and we have had the chance to talk here on several occasions, and I said to you in our last conversation, "You are looking good, my friend. You are looking as good as I have ever seen you." And I know that there is treatment. And I am here to tell you that we are not going to stop fighting.

We are not going to stop fighting because you are not going to let us, and we are not going to do it because you are that wind beneath our wings here. And we listen to you, and it gives us great courage to look at the dollars that we spend and where we spend them and know that while we have conquered other illnesses in this great country of ours, because we have great medical facilities, that we have the opportunity, as you have said, to make it chronic and to deal with ending.

And we will continue that research, and I promise you that we will—that we will do that. And we have in the language of ARPA—H that one of the neurodegenerative illnesses which they will look at is ALS.

I was at an event last evening where I met—and I am trying to remember his last name. First name was Roger, and I talked to Roger about you, Brian and Sandra. He is 6 years diagnosed.

He was at this event last night in a tuxedo and just enjoying it and so forth, still ravaged by the illness, but on his feet. So there is hope that is out there, and we all cannot thank you for never, ever, ever giving up hope and making sure that we never give up hope as well.

Love you both, and thank you for what you have done in calling attention to this ravaging disease. We are there. We are there for you, my dear friends.

Congressman Cole.

Mr. COLE. Thank you, Madam Chair.

And Brian and Sandra, thank you. That was an extraordinary statement. And your advocacy is, quite frankly, inspiring and amazing and makes a difference. And for you to take the tragedy that has fallen into your lives and turn it into something where you can help others is really remarkably commendable.

We talk a lot in Congress about the differences and get covered, but there are lots of things the chair and I work together on. And we have together in 7 years, we have increased NIH funding by 49 percent and tried to look at some of these things as not one-shot wonders, but sustained commitment over time that makes a difference.

ALS certainly affects my office. My chief of staff's father has it. My district director's husband as well. So it is something, and Sandra, I particularly was pleased to hear you talk broadly about

neurodegenerative diseases. My wife has MS. I lost my dad to Alzheimer's.

So these things touch all of our lives, and I don't make this remark often. I never had anybody at a town meeting come up to me and say, you know, you guys are just spending too much on cancer and ALS and Alzheimer's. They might be worried overall about the budget. These are actually the places where the American people want us to be making continual investments.

And because they see the difference and they see the impact on their loved ones, their friends, their associates. They want to be part of the solution. They want us to write the check that provides hope and services and hopefully some day put some of these things, as we have some things, in the rearview mirror, so to speak, where they are not threatening people's lives.

So, again, I want to commend you for your advocacy. Brian, I want to wish you the very, very best. God bless you for beating the odds. You clearly have a fighting spirit. And we will continue to walk with you guys step by step because, as the chair said, this is a commitment we all believe in very, very deeply and a cause that we all want to continue to work on going forward together.

With that, Madam Chair, I yield back.

The CHAIR. Thank you. Congressman Fleischmann.

Mr. FLEISCHMANN. Thank you, Madam Chair and Ranking Member Cole.

Sandra and Brian, we have seen very astute, wonderful presentations today across the spectrum of this great subcommittee, but your presentation today was truly the most inspirational and outstanding. And I do thank the chair and the ranking member for their very strong statements in support.

I am a lawyer, like you, sir, and still keep my law license up. We have had many folks with ALS come into our office over the years, and I will say this. Like you, they are great fighters, and they are committed to seeing a cure for this horrific disease. So we wish you every success.

And again, thank you for being an inspiration to so many folks who are afflicted with this. Again, the chair and the ranking member are absolutely right. We put these resources into this area, and the American people support this and this is what we ought to be doing in Congress.

So, thank you.

The CHAIR. Just one final word to Sandra, to you, and to you, Brian. Oftentimes, the media reports that people in this country believe that the Members of Congress who serve on different sides of the aisle in different communities, that they cannot lock arms and look at the challenges that face this country, look at the challenges that people face.

And it is not true. We do lock arms. We do have our differences, but we understand the nature of the challenge that you face and that everyone with an ALS diagnosis or one of the other neurodegenerative diseases and so forth.

And in this area, I proudly say that we come together. We have come together to provide the resources that are necessary in order for us to continue the research to look for that discovery to cure, to allow people to be hopeful about what their future is and what

it can be. And the two of you, again, your strength, your determination really pushes us forward to make sure that we are working with you and that you are not alone.

So, thank you. Thank you for being here today and for testifying. God bless you both.

Mr. WALLACH. Thank you so much—

Ms. ABREVAYA. Thank you so much—

Mr. WALLACH [continuing]. For your incredible words.

Ms. ABREVAYA [continuing]. For your incredible words.

Mr. WALLACH. And we look forward to building a better—

Ms. ABREVAYA. And we look forward to building a better—

Mr. WALLACH [continuing]. World together with you.

Ms. ABREVAYA [continuing]. World together with you. Thank you. The CHAIR. Take care.

Let me now recognize Dr. Karen Knudsen, chief executive officer for the American Cancer Society, and that is the American Cancer Society, CAN, the Cancer Action Network.

So, Karen, thank you. I had the opportunity to meet with Lisa this week and folks and anxious to hear your testimony. So much appreciative of your being here.

**KAREN E. KNUDSEN, CHIEF EXECUTIVE OFFICER, AMERICAN CANCER SOCIETY AND AMERICAN CANCER SOCIETY CANCER ACTION NETWORK**

Ms. KNUDSEN. Thank you so much for having me.

And I would just like to say, for Brian and Sandra, absolutely incredible testimony, and I hear you on where to pick up on that theme of the importance of research.

So I am Dr. Karen Knudsen. I am the CEO of the American Cancer Society. We are the largest nonprofit funder of cancer research outside the U.S. Government.

As we meet here today, one in three men and one in two women over their lifetime will hear the words, "You have cancer." But we are also at an unprecedented time in history where discoveries have been converted into meaningful progress in cancer prevention, detection, treatment, and even, in some cases, cure.

Since 1991, when there was a formidable increase in cancer research from the U.S. Government and from the American Cancer Society, we have declined cancer mortality rates by 32 percent, resulting in more than 3.5 million deaths averted from cancer due to cancer research funding. It is clear that cancer research does, indeed, save lives. And more than ever before, that gap between discovery and clinical intervention has narrowed, and that has emboldened an entirely new generation of cancer researchers to strive for better anti-cancer strategies.

Just in the last 10 years alone, we have witnessed an entirely new class of cancer therapeutics in the form of immunotherapy. Research also resulted in the development of a highly effective cancer vaccine, something we sought for a long time, against HPV-driven cancers.

And thanks to that breakthrough, right now in this country we have the first generation of individuals vaccinated in the U.S. who will have protection against cervical cancer and up to 50 percent of head and neck cancers that we heard about earlier today. And

similar impactful research advances have been realized in this progress against 200 diseases that we call cancer.

It is due to research that this cancer mortality rate is declining, and on this basis, it is that we ask Congress to not only maintain but increase the pace of discovery through enhancing cancer research funding. Despite our gains, we have much work yet to do. A subset of lethal cancers are now on the rise and show concerning trends that do require research, including unexplained increases in early onset colorectal cancer and in advanced prostate cancer, just to name two.

Lung cancer remains a major challenge, accounting for 350 deaths of Americans every day. At present, cancer remains the second-leading cause of death in the United States, with more than 600,000 individuals predicted to die from cancer this year alone in the U.S. The scientific community, I would opine, has shown again and again that the investment in cancer research yields returns in lives saved and is poised to increase the pace of discovery.

Now, equally important is investment in research to mitigate disparities in cancer outcomes. Right now, black men have a twofold higher death rate from prostate cancer, stomach cancer, and myeloma as compared to whites. Black women have a 41 percent higher death rate from breast cancer as compared to their white counterparts.

Geographical disparities also exist. Lung cancer mortality is three to five times higher in Kentucky versus Utah or Puerto Rico. Cervical cancer is twice as high in Arkansas versus Vermont.

Research is needed to help develop strategies such that all Americans will have an equal chance to prevent, detect, and survive cancer, an ideal to which the American Cancer Society also strives. An essential component of this work will also include access to clinical trials, which we all know in cancer is the most advanced form of care. Trial funding through the NCI is a vital resource through which Americans across the country benefit from research breakthroughs that can be lifesaving.

We believe that investment in cancer research is a critical component in the investment in the health of U.S. citizens and the population as a whole. Our progress has been remarkable, and the U.S. scientific community stands ready to accelerate.

So on behalf of the 1.9 million Americans who will be diagnosed with cancer this year alone, we urge the following three recommendations. First, funding of \$49,000,000,000 for the NIH in fiscal year 2023 to allow the base budget to keep pace with biomedical research and development price indices, and to provide meaningful growth.

Second, a critical inclusion must be at least \$7,760,000,000 for the National Cancer Institute. Given this explosion in impactful discoveries, NCI is experiencing a demand for cancer research funding that is far beyond any other institute or center. Grant success rate from the NCI dropped from 13.7 percent in 2013 to now just above 11 percent in 2019.

This situation is unique to the NCI, at a time when cancer researchers are making historic advances in new treatments and therapies. And by contrast, the success rate for the whole of NIH during that period actually rose.

Third and lastly, we asked for \$462,600,000 in funding for the CDC's Division of Cancer Prevention and Control, as they provide key resources to States and communities to prevent cancer by ensuring that at-risk, low-income communities have access to prevention programs.

So I will stop there, and thank you for your attention, and I would be happy to answer any questions.

[The information follows:]



**Statement by Dr. Karen E. Knudsen, MBA, Ph.D. on  
Fiscal Year 2023 Appropriations for the National Institutes of Health, the National Cancer  
Institute and the Division of Cancer Prevention and Control at the Centers for Disease  
Control and Prevention**

Submitted for the record to the House Appropriations Subcommittee on Labor, Health and  
Human Services, and Education and Related Agencies  
May 26, 2022

**BACKGROUND:**

Karen E. Knudsen, MBA, Ph.D., is the Chief Executive Officer of the American Cancer Society (ACS) and the American Cancer Society Cancer Action Network (ACS CAN). ACS is a nationwide, non-profit health organization dedicated to eliminating cancer as a major health problem. ACS exists because the burden of cancer is unacceptably high. With the goal to improve the lives of cancer patients and their families, ACS stands on three pillars to reduce the national cancer burden—through research, advocacy, and patient support. Notably, ACS is the largest non-profit funder of cancer research outside the US government, complemented by ACS research that tracks cancer trends in incidence and mortality each year across every area in the nation. Our advocacy arm, ACS CAN, works at the local, state, and national level to enhance access to these discoveries and to reduce cancer disparities. Finally, the ACS patient support activities are conducted in thousands of communities across the nation, touching more than 50 million lives per year through enhancing cancer prevention and screening, educating patients and caregivers, and providing transportation, navigation, and lodging free of charge to patients in need. Put simply, the 1.9 million Americans diagnosed each year with cancer are counting on us, and counting on the collaboration amongst the private sector, healthcare systems, and federal agencies to work together toward progress against the 200 different diseases we call “cancer.”

As we meet here today, 1 in 3 women and 1 in 2 men over their lifetime can expect to hear the words “you have cancer.” However, we are at an unprecedented time in history, wherein discoveries have been converted into meaningful progress in cancer prevention, detection,

treatment, and in some cases, cure. Since 1991, when there was a formidable increase in cancer research funding, cancer mortality rates have declined by 32%. That alone does not tell the story—the flattening of the cancer mortality curve has accelerated in recent years, from a 0.5% decrease year over year in the post-1991 era to our current rate of a 2% annual decline. In total, more than 3.5 million deaths from cancer have been averted due to cancer research funding.

It is clear that cancer research does indeed save lives, and more than ever before the gap between discovery and clinical intervention has narrowed, and emboldened a generation of new cancer researchers to strive for better anti-cancer strategies. Indeed, the last 10 years alone have resulted in the addition of an entirely new class of cancer therapeutics in the form of immunotherapy, complementing previous standards of surgery, chemotherapy, and radiation therapy. Research has also resulted in the development and implementation of a highly effective cancer vaccine, protecting against HPV (human papilloma virus) driven cancers. Thanks to this breakthrough, we have the first generation of vaccinated individuals in the US with protection against cervical cancer, and up to 50% of head and neck cancers. Similarly impactful research advances have been realized in new strategies for cancer imaging and early detection, effective new treatments for cancers previously thought to be intractable, and in some cases, cures.

It is on this basis that the cancer mortality rate is declining, and on this basis that we urge Congress to not only maintain but increase the pace of discovery through enhancing cancer research funding. Despite considerable gains, much work remains to reduce the burden of cancer. Unfortunately, a subset of lethal cancers are on the rise and show concerning trends that require intensive research. These include year over year increases in early onset colorectal cancer, uterine cancer, pancreatic cancer, and advanced prostate cancer. Lung cancer remains a major health challenge, accounting for 350 deaths alone in the US each day. Overall, cancer is the second leading cause of death in the US, with greater than 600,000 individuals predicted to die from

cancer in this year alone. The scientific community has shown that investment in cancer research yields returns in lives saved, and is poised to take on these challenges to further reduce death and suffering from cancer.

Equally important is investment in research that seeks to understand and measurably mitigate deep disparities that exist in cancer outcomes. For example, Black men have a 2-fold higher death rate from prostate cancer, stomach cancer, and myeloma as compared to white men. Black women are twice as likely as women of other racial or ethnic groups to be diagnosed with triple negative breast cancer (an aggressive form of disease), and for all breast cancers have a 41% higher cancer death rate as compared to white women. Geographical disparities also exist. For example, lung cancer mortality is 3-5 times higher in Kentucky vs. Utah or Puerto Rico. Cervical cancer incidence is more than twice as high in Arkansas as compared to Vermont. Factors leading to these and other striking cancer disparities are multi-factorial, and require research to develop strategies such that all Americans will have an equal chance to prevent, detect, and survive cancer—a ideal to which the American Cancer Society also strives toward.

We believe that investment in cancer research is a critical component of investing in population health. The ripple effects of the COVID-19 pandemic have further amplified this need. It has been estimated that 9.5 million Americans missed or delayed breast, colon, and prostate cancer screening in 2020 as a result of the pandemic, laying the foundation for a wave of cancer diagnoses at a more advanced stage that is difficult to treat. Based on the initial delays in breast and colorectal cancer screening alone, the National Cancer Institute (NCI) has predicted an unprecedented increase in cancer mortality for the first time since the 1991 flattening of the mortality curve. Further contributing to this concerning trajectory were pandemic-associated delays or reductions in access to clinical trials. Clinical trials span the cancer continuum and provide early access to the most advanced form of cancer detection and treatment. Funding for clinical trials

through the NCI is a vital resource through which Americans across the country benefit from research breakthroughs that can be lifesaving.

As a data-driven organization dedicated to improving the lives of cancer patients and their families, there has never been a more important time to invest in cancer research, and therein, to invest in protecting Americans against the second leading cause of death in this country. Progress has been remarkable, and the US scientific community stands ready to accelerate. The 1.9 million Americans who will face cancer diagnosis this year are counting on us. On behalf of all of those we serve, and their families, the American Cancer Society urges the following:

**1. For fiscal year (FY) 2023, ACS recommends funding of \$49 billion for the National Institutes of Health (NIH) base budget, a \$4.1 billion increase over the comparable FY 2022 funding level, with an inclusion of \$7.76 billion for the NCI.** Such an allocation

would allow the NIH's base budget to keep pace with the biomedical research and development price index and provide meaningful growth. Such investment is not only required to accelerate progress against cancer but will provide a needed boost toward maintaining a position of leadership in cancer discovery. Notably:

- a. Greater than 80% of federal funding for the NIH and NCI is spent on biomedical research projects at research facilities across the country.
- b. In FY 2020, the NIH provided over \$34.6 billion in extramural research to scientists in all 50 states and the District of Columbia.
- c. NIH research funding also supported more than 536,000 jobs and more than \$91 billion in economic activity last year.

**2. The ACS recommendation for the NCI of \$7.76 billion is all the more critical, as:**

- a. Given the explosion in impactful discoveries, NCI is currently experiencing a demand for research funding that is far beyond that of any other Institute or Centers.

- b. Between FY 2013 and FY 2019, the most recent year for which data are available, the number of Research Project Grant (R01) applications to NCI rose by 50.6%. For all other Institutes or Centre during that time, the number of R01 applications rose by only 5.6%.
  - c. As a result of this extraordinary demand from the scientific community, the investigator-initiated grant success rate at NCI dropped from 13.7% in FY 2013 to 11.6% in FY 2019. This is a situation unique to NCI, at a time when cancer researchers are making historic advances in new treatments and therapies. By contrast, the overall success rate for NIH during that same period actually rose from 16.8% to 21.2 %.
  - d. Cancer affects us all. We therefore urge Congress to sustain and increase the pace of discovery through enhanced NCI funding and ensure that progress against cancer continues. Put simply, investment in NCI and NIH is an investment in the American people, and in the American scientific enterprise.
3. **Given their important role in cancer prevention, we also recommend that the Centers for Disease Control and Prevention's (CDC) Division of Cancer Prevention and Control (DCPC) receive \$462.6 million in funding.** The CDC provides key resources to states and communities to prevent cancer by ensuring that at-risk, low-income communities have access to effective prevention and early detection programs, helping all people lower their risk of cancer, and collecting cancer data that are used to monitor trends and direct programs to populations most in need.

Once again, thank you for your continued leadership on funding issues important to improving the lives of cancer patients and their families. Funding for cancer research and must continue to be a top budget priority in order to increase the pace of progress to reduce the burden of cancer.

The CHAIR. Thank you very, very much, Dr. Knudsen.

I also might add that in our meeting this past week, my meeting with some of your folks, you have an extraordinary nationwide network of folks who are out there advocating for what you are advocating for today. So I want to compliment you on that effort.

We did have a hearing not that long ago with a number of the institutes from the NIH, and the NCI was there. I am proud to say, overall, I think over the last several years on a bipartisan basis, this committee has provided about \$11,000,000,000 to the NIH. In terms of NCI, last year we did \$352,000,000.

We are also very much aware at that hearing about the success rate, the grants, et cetera, and a concern about that. But you are the second to the Federal Government in what you do by way of research. It is clear that while we have made some great strides, and particularly exciting about cervical cancer because that is an area, which—I mean, we can conquer cervical cancer. There are some it will take us many, many more years to deal with, but we can do that, and we are on the road to doing that.

And when you speak about the increases in lung cancer and prostate cancer, it is very, very, very troubling. And then there is health disparities. I think, if anything, what the pandemic—we have known about disparities, but I think what the pandemic has highlighted is those health disparities in a whole variety of ways. So we are committed in this committee to addressing these needs.

Our issue is always what is the allocation, how much are the resources that we have. But you can be sure that when it comes to this basic research—and I will just say one more thing. We were all troubled, and we made this known, that \$274,000,000 to NIH in this budget versus \$4,000,000,000 for ARPA-H. And we are for ARPA-H and doing what they need to do, but we are going to create that balance as we move forward, as we put the bill together.

So thank you so much for being here today and for your advocacy and for the great strength of your national organization.

Congressman Cole.

Mr. COLE. Thank you, Madam Chair.

Dr. Knudsen, thank you for being here. That was a very powerful and effective presentation.

Look, this is something, you are very fortunate—maybe our chair is not, but you have a committee chaired by a survivor of cervical cancer. So we have an intimate knowledge here, sadly, at the expense of our chair. But we are happy she is here.

Look, I couldn't agree more with science moves at a very uneven pace across multidisciplines, and the opportunity for cancer is now. There is just no question about it. And the success rates that you point to shows how much good science we are leaving on the table, so to speak, and how tough the decisions are, the folks we task with picking between which grant to fund and which one not to. Probably more difficult in your field than any other right now in research.

So, again, this committee has worked really hard over the last 7 years at bolstering NIH. And I want to, again, associate myself with my friend the chair's remarks about what we both see as the imbalance between ARPA-H and NIH funding in the President's proposal.

We both support ARPA-H. We put \$1,000,000,000 there. Some of our colleagues might even have questioned us doing that because we didn't yet have the format, the Director, what have you.

I know my chair is aware of this. We had good bipartisan progress from the Energy and Commerce a couple weeks ago, coming together to give us a framework. But again, we want to work with the President on that. We know it is a top priority of his, but it can't happen at the expense of our ongoing commitment to NIH.

And again, we—both the chair and I recognize how unusual the opportunity in front of us here is, if we can find a way to make a commitment. So she has a lot of tough decisions to make. We always do on this committee. But I suspect that we will continue the tradition of doing well by the NIH.

Again, that is something that we are not only committed to, but our two colleagues on the other side of the aisle—or other side of the Rotunda in Senator Murray and Senator Blunt have been extraordinarily helpful in this run of 7 years that we have had of sustained increases above inflation for NIH. And zeroing in on this cancer opportunity I think is really something that we need to give every possible consideration and support for.

So thank you for the work that you and the American Cancer Society do and have done for many, many years. Thank you for the advocacy. It is really important.

But again, I want to underscore the point you made so eloquently. You have got to seize the moment sometimes, and this is a moment in time where I think if we could find the resources, the kind of progress we could make that you spoke of, investment does make a difference. We do have people living longer, and we have saved lives. And you can measure it demonstrably.

So there is not very many cases where we have got this direct a relationship between what we appropriate and the difference we make in the lives of the American people. So, again, thank you for what you do. Thank you for your advocacy, and we look forward in continuing to work with you and the American Cancer Society on a bipartisan basis going forward.

Yield back, Madam Chair.

The CHAIR. Thank you. Congressman Fleischmann.

Mr. FLEISCHMANN. Thank you again, Madam Chair and Ranking Member Cole.

Dr. Knudsen, one of the nice things about being an appropriator and, of course, serving on this distinguished subcommittee is we touch so many different areas, and it gives us as members an opportunity to learn an awful lot. And since I have been in Congress, I have been involved with the Cancer Caucus. Your group has done a tremendous job.

But I did want to call out specifically Dr. Jordan Berlin and his team at Vanderbilt. Whenever I have cancer questions—with difficult cancers, we have made so many wonderful strides. But there are still some cancers out there, some types of lung cancer, some types of stomach cancers and the like, that are still baffling.

So the key again is investment in research and continued progress, but together, we are making this type of progress. So thank you for your advocacy.

And again, this is going to be one of these areas where there is going to be really unanimity. This is not—shouldn't be an issue for appropriators, for Republicans, Democrats, or authorizers. This should be an all-out effort by Americans, who we represent, to defeat cancer.

So thank you for your advocacy. And Madam Chair, I will yield back.

The CHAIR. Thank you. Thank you.

Let me now recognize Belinda Pettiford, president of the Association of Maternal and Child Health Programs.

And Ms. Pettiford, you are recognized for 5 minutes for your testimony.

**BELINDA D. PETTIFORD, PRESIDENT, ASSOCIATION OF  
MATERNAL AND CHILD HEALTH PROGRAMS**

Ms. PETTIFORD. Thank you.

Chair DeLauro, Ranking Member Cole, and distinguished subcommittee members, my name is Belinda Pettiford, and I am grateful for this opportunity to appear before you today on behalf of the Association of Maternal and Child Health Programs, known as AMCHP.

I proudly serve as the board chair and president of AMCHP, as well as chief of the Women, Infant, and Community Wellness Section here in the Division of Public Health for the North Carolina Department of Health and Human Services.

In fiscal year 2023, AMCHP requests that the subcommittee fund the Title V Maternal and Child Health Services Block Grant administered by the Health Resources and Services Agency at \$1,000,000,000, including a robust increase for the State formula fund. We are thankful to the subcommittee for the increases in funding for the block grant over the past several years and for recognizing the essential role Title V plays in improving the health and well-being of women, children, including those with special healthcare needs, and their families.

As you may know, the Title V block grant is driven by evidence, flexibility, and results to ensure access to quality maternal and child health services; reduce infant mortality, maternal mortality, and preventable diseases and conditions; and promote family-centered, community-based, coordinated care for children with special healthcare needs. The block grant funding is distributed to every State and territory by a formula tied to the child poverty rate.

Another significant portion of the block grant is awarded through Special Projects of Regional and National Significance, or SPRANS, which are discretionary grants that support a range of programs, including those to train the next generation of leaders in MCH, to support innovation to improve maternal health outcomes, and so much more.

In order to illustrate the far-reaching impact of Title V, I would like to share a few examples of how the State formula funds are being used in various States.

In Florida, the State Maternal Mortality Review Committee identified leading causes of maternal death and issued urgent maternal mortality messages to healthcare providers and hospitals around obstetric hemorrhage and hypertensive disorders to prevent future

maternal deaths. In Massachusetts, the shift to provide home visiting services in a virtual manner ensured a new mother in crisis was able to get the counseling she needed.

As this subcommittee's members are aware, our Nation is facing an unprecedented shortage of infant formula. Title V agencies around the country have been using their voices as trusted messengers to share critical information with families and healthcare providers about how to obtain formula, as well as to warn of misinformation that has been spreading through this crisis.

In North Carolina, we are closely monitoring supply, working with the Federal Government, with manufacturers, and retailers to get more formula on North Carolina shelves. We are sharing information and resources and are working specifically with our Title V MCH partners to share this information with families.

During the past 2 years, Title V-funded programs have been at the forefront of COVID-19 response efforts, with a particular focus on addressing the unique impacts of the pandemic on maternal and child health populations. The flexible nature of the block grant made it an easily deployable source of support for States to respond to the public health emergency.

However, while the block grant is the backbone of our Nation's public health infrastructure for women, children, and families, that infrastructure has been severely strained as a result of this pandemic. Maternal and child health programs and the workforce need sustained, increased investment to rebuild, to recover, and best serve the Nation's maternal and child health populations now and into the future.

Further, our Nation has longstanding racial, ethnic, geographic, and socioeconomic inequities in MCH outcomes. While incremental funding increases to programs like the Title V block grant make a difference in advancing maternal and child health, to make transformational improvements that finally address these inequities, we will require transformational investments in the block grant and complementary Federal programs that support maternal and child health, including CDC's Safe Motherhood portfolio of programs, HRSA's Healthy Start program, and CDC's Surveillance for Emerging Threats to Mothers and Babies Network.

We thank you for funding the Title V Maternal and Child Health Block Grant at \$747,700,000 in fiscal year 2022 and urge you to provide an increase to at least \$1,000,000,000 in fiscal year 2023, including a robust increase for the State formula fund to ensure that States have the public health foundation they need to support healthy children, healthy families, and healthy communities now and into the future.

And I thank you so very much.

[The information follows:]



**House Committee on Appropriations  
Subcommittee on Labor, Health & Human Services, Education, and Related Agencies  
Testimony Submitted by Belinda Pettiford, MPH  
President, Association of Maternal & Child Health Programs (AMCHP)  
May 26, 2022**

Chair DeLauro, Ranking Member Cole, and distinguished Subcommittee Members: My name is Belinda Pettiford and I am grateful for this opportunity to appear before you today on behalf of the Association of Maternal & Child Health Programs also known as “AMCHP.” I proudly serve as the President of the Board of AMCHP as well as Chief of the Women, Infant, and Community Wellness Section in the Division of Public Health in the North Carolina Department of Health and Human Services. In Fiscal Year 2023, AMCHP requests that the Subcommittee fund the Title V Maternal & Child Health Services Block Grant administered by the Health Resources and Services Agency (HRSA) at \$1 billion, including a robust increase for the state formula fund.

We are thankful to the Subcommittee for the increases in funding for the Block Grant over the past several years and for recognizing the essential role Title V plays in improving the health and well-being of women, children, including those with special health care needs, and their families. As you may know, the Title V Block Grant is driven by evidence, flexibility, and results to: 1) ensure access to quality maternal and child health services; 2) reduce infant mortality, maternal mortality, and preventable diseases and conditions; and 3) provide and promote family-centered, community-based, coordinated care for children with special health care needs. Funding is distributed to every state and territory by a formula tied to the child poverty rate.

Another significant portion of the Block Grant is awarded through Special Projects of Regional and National Significance or “SPRANS,” which are discretionary grants that support a range of programs, including those to train the next generation of leaders in maternal and child health; to support innovation to improve maternal health outcomes; to improve family/provider

partnerships to promote the optimal health for children and youth with special health care needs; and much more.

In order to illustrate the far reaching impact of Title V, I would like to share a few examples of how these funds are being used in various states and regions as shared in their Title V annual reports:

- California’s Adolescent Family Life Program found ways to safely continue supporting pregnant and parenting young people throughout the public health emergency by employing creative strategies to enroll and engage participants virtually as well as safely deliver supports that were needed.
- In Tennessee, the Block Grant funded efforts to improve coordination between emergency preparedness and maternal and child health to develop a checklist for families, modeled on a similar CDC-funded effort, to ensure families know how to plan for emergencies, including supplies to keep on hand and how to safely store important documents.
- Florida’s maternal mortality review committee identified leading causes of maternal deaths and issued Urgent Maternal Mortality Messages to providers and hospitals around hemorrhage and hypertensive disorders.
- In Virginia, Title V-funded care coordinators routinely help families with more than just medication and durable medical equipment needs – in one instance, the care coordinators were instrumental in ensuring a family could add an accessible bathroom for their daughters with severe disabilities.
- In Massachusetts, the shift to provide home visiting services in a virtual manner ensured a new mother in crisis was able to get the counseling she needed.

As this Subcommittee’s Members are aware, our nation is facing an unprecedented shortage of infant formula, including specialty formulas for infants with metabolic and other disorders. Title V agencies around the country have been using their voices as trusted messengers to

share critical information to families and providers at this time about how to obtain formula as well as to warn of misinformation that has been spreading during this crisis.

This situation is evolving, and we know many families and caregivers are worried about finding formula for their babies. In North Carolina, we are closely monitoring supply, working with the federal government, manufacturers, and retailers to get more formula on North Carolina shelves. The North Carolina Department of Health and Human Services is sharing information and resources, and we are working specifically with our Title V Maternal and Child Health partners to share this information with families. We have developed a flyer to help families understand their options for standard formula that is being shared with retailers, providers, and directly with families. We are also working on a plan to support moms who are breastfeeding or using a combination of formula and breastfeeding to ensure that they can access additional support if they want to or need help to increase breastfeeding during the formula shortage. We appreciate the flexibilities provided by the U.S. Department of Agriculture and are seeking additional flexibilities to help WIC participants access available formula through rule waivers. Our goal is to ensure safe and nutritious options for North Carolina families.

During the past two years, Title V-funded programs have been at the forefront of COVID-19 response efforts with a particular focus on addressing the unique impacts of the pandemic on maternal and child health populations. The flexible nature of the Title V MCH Block Grant made it an easily deployable source of support for states to meet locally identified needs and promote positive maternal and child health outcomes during the public health emergency. The Title V MCH Block Grant is well-positioned to continue to address maternal and child health needs in response to the ongoing physical and mental health ramifications of the COVID-19 pandemic. However, while the Title V MCH Block Grant is the backbone of our nation's public health infrastructure for women, children, and families, that infrastructure has been severely strained as a result of the pandemic.

Maternal and child health programs and the maternal and child health workforce need sustained, increased investment to rebuild, recover, and best serve the nation's maternal and child health populations now and into the future. Further, our nation has long-standing racial, ethnic, geographic, and socioeconomic inequities in maternal and child health outcomes. While incremental funding increases to programs like the Title V MCH Block Grant make a difference in advancing maternal and child health, to make transformational improvements that finally address these inequities will require transformational investments in the Block Grant and complementary federal programs that support maternal and child health, including CDC's Safe Motherhood funding line, HRSA's Healthy Start program, and CDC's Surveillance for Emerging Threats to Mothers and Babies Network.

We thank you for funding the Title V MCH Block Grant at \$747.7 million in FY2022 and **urge you to provide an increase to at least \$1 billion in FY2023, including a robust increase for the state formula fund, to ensure that states have the public health foundation they need to support healthy children, healthy families, and health communities now and into the future.**

The CHAIR. Thank you. Thank you very, very much for your testimony.

I would just make some comments, but let me just ask the ranking member if he has comments and questions and follow it up with Congressman Fleischmann.

Mr. COLE. I don't have any questions, but I want to thank our witness for her work. It is really important. I mean, again, as our colleague Mr. Fleischmann said, one of the great things about this committee is you learn a lot because it covers so many areas.

And one of the things I was sad to learn over the course of my service on this committee is how poorly we as a country stack up with other countries in this area in terms of maternal health, and then now how great the racial disparities are. Something that we, as the chair mentioned earlier in another context, we all knew were there, but COVID really brought it home. And I know she will focus on this. We will focus the committee and do the very best we can.

But I want to use this forum to also put out a challenge to some of our friends at the State legislature. I know that in my State, we don't fund enough in these areas, and we have some of the worst statistics in the country, quite frankly.

And I am proud of what this committee does, and particularly under the leadership of our chair. But we are putting a lot of money, and I am always for having a rainy day fund at the State level. I live in a State that is a boom-bust State because of commodity prices in energy and agriculture, and so that is a wise thing. But when times are good and the Federal Government has put as much money out for a variety of healthcare purposes as it has over the last 18 months to deal I think very appropriately with COVID, some of that money needs to be directed toward some of these programs in terms of matches for what we do and what have you.

So, again, this is an area of great concern and one that I look forward to working with the chair on as we move forward. But thank you for working on the front lines in North Carolina on a problem that really ought to embarrass us all as Americans. We need to do better in maternal and infant health than we are doing, and thanks for your efforts and thanks for your advocacy and bringing it here in front of the committee and making such an important case for all of us to hear.

Yield back, Madam Chair.

The CHAIR. Thank you. And I actually want to say thank you for the testimony.

I think we have been talking about seizing the moment. There is such a very big focus and interest on the issue of maternal and child health programs, and we need to seize this opportunity to further them. It has been really—and that we have a heavy emphasis even in the 2022 appropriations bill, the 2022 appropriations bill, great advocacy by so many members of our—of the Congress, our caucus, and so that that is an issue that has been put front and center in so many ways.

And that, I assure you, will continue. But the advocacy needs to continue because, again, the disparities that have been demonstrated, and the issue with black women, this is pretty extraor-

dinary. And oftentimes, we lose track of the serious issues that the childbirth may bring, and people just view that, well, you are going to have a baby. Everything is going to be okay. It is fine. But it is not the case. It is not the case.

My own personal experience is with my stepdaughter, and 17 years ago, we thought everything was fine. And at one point, we almost lost both my granddaughter, who is now 17 years old, though, and her mom. And it was harrowing, and we weren't—we had no idea that this was something that could come from a regular pregnancy.

So, but I just tell you keep at it, keep at it at this moment because the window is open. The window in Washington shuts very quickly. So just continue the advocacy so that we can really join the ranks of other countries and they are paying attention to health and welfare of women and children, women's and children's health in this country.

Thank you very much for your testimony.

What I would like to do is to recognize Dr. Anne Matthews with the Rotary Foundation of Rotary International around the issue of global polio eradication at the CDC.

Dr. Matthews.

**ANNE L. MATTHEWS, CHAIR, POLIO ERADICATION ADVOCACY TASK FORCE FOR THE UNITED STATES, THE ROTARY FOUNDATION OF ROTARY INTERNATIONAL**

Ms. MATTHEWS. Thank you very much.

Chairwoman DeLauro, Ranking Member Cole, and members of the subcommittee, I am here today on behalf of 300,000 members of Rotary Clubs in the United States and to thank you for the committee's generous support and longstanding leadership toward a polio-free world and to also encourage continuation of funding to support the polio eradication activities of the CDC, the Centers for Disease Control and Prevention.

We are seeking \$276,000,000 in fiscal year 2023 for CDC's polio eradication efforts to protect the progress achieved to date and to capitalize on unprecedented low levels of virus transmission to end polio once and for all.

Rotary International and the CDC are spearheading partners of the GPEI. That is the Global Polio Eradication Initiative, a global partnership launched in 1988, which reaches the most vulnerable children through safe, cost-effective polio immunization.

Thanks to this committee's support, polio cases have been reduced by more than 99.9 percent since 1988. Twenty million people have been spared disability, and over 900,000 polio-related deaths have been averted.

Last year, only 5 cases were recorded in the 2 remaining endemic countries of Pakistan and Afghanistan. This low number of cases reflects a high number of children effectively protected through immunization.

Every year, the GPEI works to immunize 370 million children globally. There were also 40 percent fewer cases of circulating vaccine-derived polio virus in fewer countries in 2021, as compared to 2020. The novel oral polio vaccine type 2 was introduced in 2021 to accelerate progress in bringing outbreaks under control.

This progress is encouraging, but fragile. Earlier this year, a child from Malawi was identified with polio that is genetically linked to virus in Pakistan, and another case has been found in Mozambique. These cases remind us that as long as polio exists anywhere, it is a threat to children everywhere. Now is the time to capitalize on progress to complete polio eradication.

CDC's work is critical to protecting the progress and overcoming remaining challenges. CDC's Atlanta laboratories are key to confirming both the presence and absence of polio virus. They serve as a global reference center and training facility, providing expertise in virology, diagnostics, and laboratory proceedings.

CDC also contributes technical expertise through the international assignment of technical staff to WHO and UNICEF to provide strategic and management expertise to priority countries. They also train and deploy public health professionals to high-risk countries through the Stop Transmission of Polio Program.

The \$276,000,000 that Rotary is requesting will ensure that CDC continues to provide this key technical expertise while building country-level capacity to maintain high levels of population immunity. This funding would also expand CDC's capacity in three critical areas of outbreak response, surveillance, and vaccine procurement.

The global network of 145 laboratories and trained personnel established for polio also tracks measles, rubella, yellow fever, meningitis, and other deadly infectious diseases, including COVID-19, and will do so long after polio is eradicated. Our collective investment has already saved \$27,000,000,000 in health cost since 1988, and it is estimated that investing in polio eradication now may cumulatively save an estimated \$33,100,000,000 by the year 2100 in the form of reduced costs in surveillance and vaccination.

We appreciate so much the help you have given and ask that you continue to support the eradication of polio.

Thank you very much.

[The information follows:]

*Testimony of Dr. Anne L. Matthews, Chair, Rotary's Polio Eradication Advocacy Task Force for the US Labor, Health and Human Services, Education, and Related Programs Appropriation Subcommittee*

Chairwoman DeLauro, Ranking Member Cole, and members of the Subcommittee: Rotary appreciates the opportunity to encourage continued funding for FY23 to support the polio eradication activities of the U.S. Centers for Disease Control and Prevention (CDC). The CDC is a spearheading partner of the Global Polio Eradication Initiative (GPEI), an unprecedented model of cooperation among national governments, civil society and UN agencies which reaches the most vulnerable children through safe, cost-effective polio immunization. Rotary International requests \$276 million for the polio eradication activities of the CDC to capitalize on unprecedented low levels of endemic polio virus transmission which is simultaneously threatened by the diversion of critical resources toward the COVID-19 pandemic. These funds will support the GPEI's immediate priority of stopping all form of polio virus transmission through procurement of vaccines, including the recently introduced novel oral polio vaccine (nOPV2). These funds will also provide vital support for surveillance activities which provide confidence in both the presence and absence of polio virus transmission. The 300,000 members of Rotary clubs in the US appreciate the United States' generous support and longstanding leadership toward a polio free world. Continued US leadership will help achieve a polio free world and ensure the continued global health contribution of polio eradication infrastructure and resources.

**AN UNPRECEDENTED OPPORTUNITY TO ACHIEVE ERADICATION:** Since the launch of the GPEI in 1988, eradication efforts have led to more than a 99.9 percent decrease in cases. Thanks to your support, 20 million people have been spared disability, over 900,000 polio-related deaths have been averted and 1.5 million childhood deaths have been prevented thanks to systematic administration of Vitamin A during polio campaigns. Wild poliovirus polio incidence hit an all-time low in 2021 with only five cases recorded in the two remaining endemic countries

*Testimony of Dr. Anne L. Matthews, Chair, Rotary's Polio Eradication Advocacy Task Force for the US Labor, Health and Human Services, Education, and Related Programs Appropriation Subcommittee*

of Pakistan and Afghanistan— a 96 percent reduction from 2020. There were no cases of wild polio virus in the entire world for more than 7 months in 2021; and Pakistan didn't record a new case of wild polio virus for over a year. There was also progress in controlling outbreaks of circulating vaccine derived polio virus (CVDPV) in 2021 as compared to 2020. The novel oral polio vaccine type 2 (nOPV2) was introduced in 2021 and continues to be used to accelerate progress in bringing these outbreaks under control. Despite this progress, the GPEI and countries it supports face significant challenges. Until the world is polio-free, all children, even those in the United States, remain at risk. The recent identification in Malawi and Mozambique of cases of wild polio virus genetically linked to Pakistan has reminded us of this fact. While these individual cases do not immediately jeopardize Africa's 2020 certification as being free of circulating wild polio, it emphasizes that now is the time to surge resources to complete polio eradication once and for all. In April 2022, Pakistan reported its first cases of wild poliovirus (WPV1) in nearly 15 months. The ongoing COVID-19 pandemic continues to hamper the efforts of countries to sustain high levels of population immunity which poses increased risk for outbreaks at a time of unprecedented constraints on human and financial resources on global and country-level resources. Conflict and instability also jeopardize progress, hampering efforts to conduct polio eradication activities. These challenges threaten thirty years of progress and the cumulative U.S. investment of over \$4.2 billion which has brought us to the threshold of a polio free world. This combination of progress in the midst of ongoing challenges underscores the urgency of continued focus to protect the vulnerable gains made toward polio eradication as the COVID-19 pandemic continues to disrupt polio immunization and eradication activities; and the need to stop polio virus transmission in these most complex environments while sustaining high levels of population immunity in polio free areas. Continued support for global surveillance is

*Testimony of Dr. Anne L. Matthews, Chair, Rotary's Polio Eradication Advocacy Task Force for the US Labor, Health and Human Services, Education, and Related Programs Appropriation Subcommittee*

also essential to monitor and detect cases and virus transmission and provide confidence in the absence of cases.

**CDC'S VITAL ROLE IN GLOBAL POLIO ERADICATION PROGRESS:** The United States is the leader among donor nations in the drive to eradicate polio globally. Congressional support to CDC has supported the following essential polio eradication activities:

**Leadership on surveillance and disease detection:** CDC's Atlanta laboratories serve as a global reference center and training facility, providing expertise in virology, diagnostics, and laboratory procedures, including quality assurance, and genomic sequencing of samples obtained worldwide, and training virologists from around the world in advanced poliovirus research and public health laboratory support. CDC also provides the largest volume of operational and technologically sophisticated lab support to the 145 laboratories of the Global Polio Laboratory Network (GPLN). CDC also developed a method to directly detect poliovirus from patient stool specimens.

**Essential technical capacity and program management expertise:** CDC builds in-country capacity through the international assignment of technical staff on direct 2-year assignments to WHO and UNICEF to assist polio-endemic and polio-reinfected priority countries. CDC's Stop Transmission of Polio (STOP) members play a key role in providing expertise on polio surveillance, data management, campaign planning, implementation and evaluation, program management, and communications in high-risk countries. In 2021, STOP trained and deployed more than 2,200 public health professionals to high-risk countries, including support on responding to COVID-19 in 42 countries in 2020-2021.

**Vital Country-level Capacity:** In Pakistan, CDC supported 81 National Stop the Transmission of Polio (NSTOP) officers for the Expanded Program on Immunization (EPI), and also supported data

*Testimony of Dr. Anne L. Matthews, Chair, Rotary's Polio Eradication Advocacy Task Force for the US Labor, Health and Human Services, Education, and Related Programs Appropriation Subcommittee*

usage and risk assessment officers distributed in 66 very high, high, and medium risk communities in 3 provinces, and also 10 managers/officers to support the national Ministry of Health.

**FISCAL YEAR 2023 BUDGET REQUEST:** Rotary respectfully requests \$276 million in FY2023 for the polio eradication activities of CDC. These funds will ensure that CDC provides technical and management expertise in polio endemic, outbreak and at-risk countries; builds country level capacity to build population immunity to prevent future outbreaks as well as capacity to quickly identify and respond to outbreaks. Increased funding is needed to address three specific areas critical to protecting existing progress and capitalizing on the window of opportunity to stopping transmission of all polio viruses: Outbreak Response, Surveillance and Vaccine Procurement.

**Outbreak Response:** Increased funding is needed to maximize the effectiveness of outbreak response campaigns and fully leverage the use of nOPV2 through improvements in response planning, execution and monitoring to ensure rapid, high-quality activities including those which:

- utilize and expand existing in country government coordination mechanisms to establish polio control rooms, enabling the use of real-time data for decision-making and an incident management structure to streamline emergency operations;
- accelerate emergency outbreak response through the establishment of incident command structures at global, regional and country level to guide and direct outbreak response;
- digitize the entire outbreak response, from planning to campaign monitoring and utilizing an evidence-based approach for clear assessments of response coverage and quality, including age- and sex disaggregated monitoring data; and
- ensure a stronger role for women in outbreak response operations through increased participation in outbreak response oversight, management, supervision and delivery.

*Testimony of Dr. Anne L. Matthews, Chair, Rotary's Polio Eradication Advocacy Task Force for the US Labor, Health and Human Services, Education, and Related Programs Appropriation Subcommittee*

**Surveillance:** Additional funding will support the expansion of surveillance activities which provide confidence in both the presence and absence of polio virus transmission, and specifically to:

- implement a new direct detection strategy and augment investment in lab infrastructure and data information management to increase regional and country capacity to detect and respond to outbreaks and improve the quality and timeliness of surveillance, and
- expand active surveillance, enhance the use of community-based surveillance in hard to reach areas; and expand use of environmental surveillance.

**Vaccine Procurement:** Additional funds will support procurement of vaccines, including the recently introduced novel oral polio vaccine (nOPV2), a tool that is being rolled out to accelerate control of circulating vaccine derived polio.

**BENEFITS OF POLIO ERADICATION:** Since 1988, tens of thousands of public health workers have been trained to manage massive immunization programs and investigate cases of acute flaccid paralysis. Cold chain, transport and communications systems for immunization have been strengthened. The global network of 145 laboratories and trained personnel established by the GPEI also tracks measles, rubella, yellow fever, meningitis, and other deadly infectious diseases including COVID-19 and will do so long after polio is eradicated. \$27 billion in health cost savings has resulted from eradication efforts since 1988. Investing in polio eradication now may cumulatively save an estimated \$33.1 billion by 2100 in the form of reduced costs of surveillance and vaccination. The costs to control polio at today's low levels, plus costs to treat the survivors, would be over \$1 billion per year for decades to come. Polio eradication is a cost-effective public health investment with permanent benefits. As many as 200,000 children could be paralyzed annually in the next decade if the world fails to capitalize on the more than \$19 billion already invested in eradication.

The CHAIR. Thank you very, very much for your powerful testimony.

First of all, let me just say that we want to say a thank you to Rotary for the great work that Rotary does in this area and a variety of others. They really have a tremendous network, and they bring relief all over the United States, but also internationally. So I compliment you and Rotary.

Sometimes we think that because there are not that many cases in the U.S. of polio that we tend to forget the rest of the world. But you make an absolutely brilliant case for what we should do internationally and what we can do. Because if we don't conquer it there, we are also at risk here. And I mean, I think that that is clear.

And I just want to—I was at the CDC last Friday. They are a remarkable organization, and we should do everything that we can to make sure that they can continue in their global efforts overall because they play such a role internationally. And I know that the Gates Foundation plays a role in this effort as well.

So thank you for your advocacy and your aggressive advocacy on this. It makes a difference. Thanks very, very much.

Congressman Cole.

Mr. COLE. Thank you very much, Madam Chair.

I want to associate myself with your remarks, particularly when it comes to thanking Rotary for what you have done over the years to keep the focus on this disease.

I am old enough to have been part of that first generation of children who got the polio vaccine and grew up—it is amazing to me. I don't know that my son has ever met anybody who had the disease. It was very common, as Dr. Matthews knows and my friend the chair knows, when I was growing up. And so you went to school with kids that had suffered the ravages of this disease, and the progress we have made is astounding and something that we can be really proud of.

And there is a couple of lessons to draw here, and that is the importance of sustained effort over time. That if we spend the dollars, we really can make an enormous difference. The statistics you cited, Dr. Matthews, in terms of both the financial and, much more importantly, the human cost and in savings of the effort that has been made, both by Rotary individually with all the hard work you have done and in cooperation with the CDC.

So I really do think it is important. This is a genie that can get out of that bottle. And as my friend the chair pointed out, we are not safe here until it is eradicated everywhere.

And I would be remiss, finally, Madam Chair, if I didn't give a shout-out to my old friend, Ralph Monroe, who has been a tireless advocate for Rotary for many years. We were secretaries of state together back in the 1990s. He has been a tireless advocate, as I know Dr. Matthews knows, been up to Washington many times, and just embodies the commitment of Rotary as a service organization to do good all over the world.

He has traveled all over the world in this cause and in this effort. And again, as the doctor knows, we are down to some places that are pretty tough for us to get at geographically, culturally, po-

litically, you name it. But it is really important that this fight be fought to the finish.

So, again, thanks for not taking your eye off the goal, so to speak, and making sure that our committee—which I think on a bipartisan basis, wants to finish this fight, too—stays focused on this really, really important mission.

So thank you again, Dr. Matthews.

And Madam Chair, I yield back.

The CHAIR. Let me now introduce Mairead Painter, National Association of State Long-Term Care Ombudsman Programs, and I would just welcome you.

Mairead is a graduate of the University of St. Joseph in West Hartford, and extensive background working to improve the quality of life for residents who need long-term care and with critical work with the informed choice process in Connecticut in nursing homes. And she has been an advocate for person-centered care.

So, Ms. Painter, thank you for your work, and we look forward to hearing from you.

**MAIREAD PAINTER, CONNECTICUT STATE LONG-TERM CARE OMBUDSMAN, NATIONAL ASSOCIATION OF STATE LONG-TERM CARE OMBUDSMAN PROGRAMS**

Ms. PAINTER. Hello, and thank you.

Chairwoman DeLauro, Ranking Member Cole, and distinguished members of the subcommittee, I offer this testimony today on behalf of residents in Connecticut long-term care facilities, as well as in collaboration with the National Association of State Long-Term Care Ombudsman Programs.

Some may not know what a long-term care ombudsman is or how the work that we do assists constituents in your community. In every State, ombudsmen work to improve the quality of life and the quality of care for individuals residing in nursing homes, assisted living communities, and in some States, home- and community-based service waivers.

The individuals that we serve may be your family members, a friend's parent, or even a veteran who served our country. No matter who they are or how they are brought into the long-term care system, there will be an ombudsman there from one of our programs to support them and advocate on their behalf.

Ombudsmen respond to complaints, protect rights, and ensure that they are treated as individuals with autonomy, choice, independence, and access to quality healthcare. We perform all of our activities on behalf of and at the direction of residents while ensuring strict confidentiality.

We thank you for the support of our programs, and today, we request funding that is directly tied to the need for resources so that State ombudsmen can hire and train additional permanent staff. Increasing the number of ombudsmen will enable us to respond to residents impacted by the pandemic, to meet an increase in demand, and to address the rise in long-term care complaints across our country.

Over the past 3 years, residents have faced a virus that targeted them and drastic infection control measures that caused them to be

isolated. Our offices have received thousands of calls reporting the impact of these restrictions, and the calls continue today.

Restrictions also paused normal State and Federal surveys that ensure the quality of care and investigate complaints. Today, residents are still reporting a lack of access, oversight, and accountability.

Our program representatives make regular visits to long-term communities to support residents. In 2020, nationally, we had 1,700 paid staff and approximately 5,100 volunteers. This was a significant drop from the volunteers we had in 2019, and we anticipate a further decline this year.

These numbers are not sufficient to provide a regular presence in the 14,000-plus nursing homes, plus thousands of community residences, and assisted living facilities. As a result, our representatives have had to do more with less. To do this, we have used COVID relief funding to develop remote outreach, trauma support, and expand our use of technology.

Ombudsmen greatly appreciate the COVID recovery funding, and without it, we could not have accomplished this critical work. But to continue to respond at this level and meet growing demand for our advocacy, we need to increase stable annual funding to recruit, hire, and train new staff and volunteers.

Last year, with 8 regional ombudsmen, 3 support staff, and about 4 active volunteers, a Connecticut program responded to almost 4,500 complaints, in addition to hundreds of calls for information and consultation. That is almost the same number as at the height of the pandemic, and we do not see things slowing.

In addition to nursing homes, ombudsmen have been given mandates to serve residents in assisted living but were never provided regular annual funding to hire staff and appropriately provide protections and outreach. We need dedicated assisted living and home- and community-based funding to hire staff and support residents in these settings. But the national funding has not been there, and as a result, our programs have been unable to adequately serve these citizens.

Increased regular annual funding will allow us to effect change for individuals, as well as at the State, local, and national level. Therefore, let me respectfully request that for 2023, we receive \$65,000,000 for assisted living ombudsmen services under the Title VII Older Americans Act, \$70,000,000 for our current core funding under the Title VII Older Americans Act, and \$52,500,000 under the Elder Justice Act for training and services and address increasing abuse, neglect, and exploitation.

Current funding levels preclude ombudsman programs from quickly responding to complaints and monitoring facilities. Though the funds have been authorized since 2010, to date, no Elder Justice Act funds have been appropriated for ombudsmen in the annual appropriations process. Without our eyes/ears in these facilities, residents are at greater risk of abuse, neglect, exploitation, and any number of other rights violations.

Thank you for your consideration of this request, and I welcome any questions.

[The information follows:]

Testimony of Mairead Painter

Connecticut State Long-Term Care Ombudsman

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**Prepared for the House Appropriations Subcommittee on Labor, Health and Human Services,  
Education, and Related Agencies – Addressing the Administration for Community Living**

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Chairwoman DeLauro and Ranking Member Cole, I am pleased to present this testimony on behalf of residents in Connecticut long-term care facilities and in collaboration with the National Association of State Long-Term Care Ombudsman Programs (NASOP). Thank you for your ongoing support of State Long-Term Care Ombudsman Programs (SLTCOPs). For Fiscal Year 2023, we request the following funding levels for the SLTCOP administered through the Administration for Community Living in the Department of Health and Human Services: \$65 million for assisted living ombudsman services under Title VII of the Older Americans Act, \$70 million for our current core funding under Title VII of the OAA, and \$52.5 million under the Elder Justice Act for staff, training, and services to address increasing abuse, neglect, and exploitation.

I thank you and the entire Subcommittee for your support last year of a \$10 million increase for the program and the citizens we serve. Unfortunately, the final amount approved for the program was \$1 million. Although greatly appreciated, after being divided by formula between

all the states and territories, most states did not receive enough to hire the permanent staff needed to meet current demands in all settings.

Additionally, there is a growing number of older adults nationwide who currently or may soon require long-term services and supports (LTSS) and who need our advocacy assistance. The requested stable funding for permanent staff and training would enable ombudsman programs to support individuals recovering from the pandemic, to meet the significant increase in the demand for our services and support the growing number of older adults nationwide.

This staff is crucial to our ability to continue the important work that we do and achieve our mission of protecting the health, safety, welfare, and rights of some of our nation's most vulnerable citizens. In addition to the work related to our mission, our programs support residents still at risk of Covid, the thousands recovering from the trauma they endured, and we also address the care concerns due to the staffing shortages.

Over the past three years long-term care residents have faced a pandemic that targeted older persons in particular, caused drastic infection control measures resulting in their isolation and extreme disconnection from family, friends, and peers. There was an extreme loss of access, oversight, and accountability. For almost two years restrictions prevented family, friends, and long-term care ombudsmen from having regular access to residents. Restrictions also paused normal state and federal surveys that ensure the quality of care and complaint investigation. Our offices have received thousands of calls reporting the impact that these restrictions have had, and the calls continue today as residents and family members report serious staffing and care concerns.

Across the country we have seen an increase in complaints related to significant staffing shortages causing an impact to residents' quality of life and general overall care. This comes at a time when residents are trying to recover from the trauma and the unintended consequences of isolation that for many resulted in weight loss, failure to thrive, incontinence, and overall general decline. Residents need access to ombudsman intervention now more than ever.

Historically, SLTCOP representatives included paid staff and, in some states, large numbers of volunteers who worked as the residents' advocates. They investigated and resolved complaints to the resident's satisfaction and protected their health, welfare, and rights, while maximizing the individual's participation in all decisions to ensure they receive person-centered care.

However, the pandemic exacted an incredible impact on our programs and our ability to respond to complaints. To resolve complaints at the height of the pandemic we developed remote outreach, education, trainings, trauma response, and expanded technology to reach residents.

Due to the risks, many SLTCOPs were decimated, losing significant numbers of paid staff and volunteers. By the end of FY 2020, nationwide, the program had 1,700 paid staff and approximately 5,100 volunteer representatives. This was a significant drop in volunteers from FY 2019 and we anticipate that FY 2021 data will reveal another significant loss in volunteers. Our current numbers are not sufficient to provide a regular presence in the 14,000+ nursing homes and thousands of other community facilities nationwide. Ombudsmen must have the funding necessary to rebuild their programs and hire the replacement staff needed to meet current demand and respond to the decrease in volunteerism.

The SLTCOPs greatly appreciated the additional COVID recovery funding, but we also need stable annual funding to secure our ability to respond appropriately to complaints, protect residents' rights and ensure that they are treated as individuals with autonomy, choice, independence, and access to quality health care. Older adults and their family members want to be informed of their rights and afforded protections necessary to living a high-quality life. The funding you provide to SLTCOPs ensures the voices of residents are heard, their rights are protected, and that they have access to appropriate services in response to the pandemic and beyond.

In Connecticut, we desperately need a volunteer coordinator, as do many programs across the country that rely on volunteers to support large portions of their work. Last year, with 8 Regional Ombudsmen, 3 support staff and about 4 active volunteers, the Connecticut program responded to 4,487 complaints; that is about equal to the height of the pandemic, and we do not see things returning to previous levels. This significant increase was sparked by the pandemic; however complaints were increasing as this portion of the population has grown.

In addition to nursing homes, as in most states the Connecticut Ombudsman program represents residents in other settings. These are settings such as assisted living facilities, where ombudsman programs have mandates to serve the residents, but were not provided regular annual funding to hire the staff that is necessary to provide appropriate protections and outreach. Specific assisted living as well as home and community-based services (HCBS) ombudsman funding is acutely needed due to the growth in these settings and the associated increased in demand for our services.

Therefore, let me respectfully submit our funding requests for FY 2023: first and most importantly, we request \$65 million to support SLTCOP work with residents of assisted living, board and care, and similar community-based long-term care settings. Assisted living and similar businesses have boomed, but SLTCOP funding has not increased to meet the demand and respond to the growth in this industry. As a result, our program is unable to adequately serve residents in assisted living. Second, we request \$70 million for our current core SLTCOP, currently funded at \$19.8 million in addition to the \$34 million provided through the COVID-19 relief bills. With diminished resources and funding, coupled with the tremendous demand due to the pandemic, we face great challenges in ensuring that residents have regular and timely access to our programs. Current funding levels prevent SLTCOPs from quickly responding to complaints and monitoring facilities. Third, we request \$52.5 million to support the work of SLTCOPs under the Elder Justice Act (EJA). This appropriation would allow states to hire and train staff and recruit more volunteers to prevent abuse, neglect, and exploitation of residents and investigate complaints. Though the funds have been authorized since 2010, to date no EJA funds have been appropriated for SLTCOPs in the annual appropriations process.

Without our eyes and ears in these facilities, residents are at risk of abuse, neglect, and exploitation, and any number of rights violations. Thank you for your consideration of the needs of long-term care facility residents and what we need to serve them.

Respectfully,



Mairead Painter, Connecticut State Long Term Care Ombudsman

The CHAIR. Well, thank you so much, and thank you for your testimony today.

I think you really address an issue that is critically important, one that has been—the role of an ombudsman and you know what you can do. The strength of that role has been there, but I think it is what happened with the pandemic is that this was it opened up the Pandora's box. And people in assisted living wound up being, as you pointed out, isolated, and families without knowledge of what was going on, and the high rate of deaths within assisted living during the pandemic is extraordinary and really needs to be looked at.

So your role is critical, and we need to recognize that and really take a hard look at what has been the past in terms of funding and see where we can go. Obviously, we have restrictions on the amount of money we have, but the points that you make about the complaints, the abuse, and we did a hearing about a week ago or 2 weeks ago that pointed up what is not happening in the elder justice area and the increase in the cases of abuse of our seniors. And so that we want you to have what you need in order to be able to deal with the volume of complaints.

But to be able to give our seniors and their families the comfort of knowing that they are safe and that we—and they have an outlet in which they can make their voices heard as well.

So thanks for the testimony.

Congressman Cole.

Mr. COLE. Thank you. I will just again associate myself with your remarks, Madam Chair.

I want to thank Ms. Painter for her work and work of others like her during the COVID outbreak. It is important at all times, but that period where that particular population is so much at risk, what you and your colleagues did was pretty extraordinary, saved a lot of lives.

So thank you very, very much, and thank you for your testimony. I yield back, Madam Chair.

The CHAIR. Thank you.

And now let me—hopefully, I get your name right here, Hannah Wesolowski, chief advocacy officer for the National Alliance on Mental Illness. And please proceed with testimony. You are recognized for 5 minutes.

**HANNAH WESOLOWSKI, CHIEF ADVOCACY OFFICER,  
NATIONAL ALLIANCE ON MENTAL ILLNESS**

Ms. WESOLOWSKI. Thank you.

Chairwoman DeLauro, Ranking Member Cole, and members of the subcommittee, on behalf of the National Alliance on Mental Illness, I want to thank you for your bipartisan support and commitment to mental health.

NAMI is the Nation's largest mental health organization. I am honored to be here today to speak on behalf of people across the country with mental health conditions and their loved ones.

The mental health challenges we face as a country are vast and will continue to grow as we recover from and grapple with the effects of the pandemic. If we do not invest in mental health now,

we will pay the price for decades to come. Bluntly, our Nation is at a breaking point when it comes to mental health.

We have an urgent youth mental health crisis, as highlighted by our Surgeon General last year. And just this week, we had another heart-breaking tragedy in a school. This puts immeasurable trauma on not only the children in that community, but kids across the country. Add to that the impact of the last 2 years and our existing mental health crisis, and we are facing an avalanche of need.

I urge every member of this subcommittee to think about the children in your life—your kids, grandchildren, nieces, nephews, neighbors. Picture the face of one child in particular. Children like them are crying out for help, and we need you to listen. We can make a difference if we act urgently and in a significant way. If not, we are saying we are satisfied with our children suffering in silence, with sacrificing their futures.

Think back to the face you pictured. Would it be okay if that child had to struggle in silence? There are unprecedented numbers of children experiencing anxiety, depression, and suicidal thoughts. More than half of parents are concerned over their kid's mental well-being.

During the pandemic, rates of teens visiting the ER after a suicide attempt, especially girls, skyrocketed. And 45 percent of LGBTQ youth seriously considered suicide in the past year. We do not have to accept this. We can do something.

Children spend much of their time in schools, which gives us a chance to intervene early. But we have a severe shortage of counselors, social workers, and psychologists in our school system. The President has proposed \$1,000,000,000 for the School-Based Mental Health Services Grant Program. This funding is desperately needed to vastly increase the number of mental health professionals helping kids and their families get the help they need.

But our crisis doesn't end with children. Nearly two in five adults struggled with their mental health in 2020, compared to about one in five before the pandemic. The Community Mental Health Services Block Grant Program helps our States fill needed gaps to address this growing demand. We urge you to include the President's proposal to increase the block grant to nearly \$1,700,000,000, funding that is critical to helping people on the ground.

While our goal is to help children and adults as early as possible, sadly, NAMI hears every day from desperate families with loved ones in crisis and nowhere to go for help or from individuals who have fallen through the cracks and are trying to piece their life back together.

In 7 weeks, 988 will be available as a nationwide hotline for suicide and mental health crises. I applaud Congress for the bipartisan support of this number, and NAMI is deeply grateful to this committee for drastically increasing the investments for the hotline and services that provide a mental health response to people in crisis.

But even with those increases, we don't have the funding to help everyone. Just take the call centers that will answer 988 calls. They are often staffed by volunteers.

We are asking people to volunteer their time to respond to people calling on the worst day of their lives. While these trained counselors are amazing, we cannot build a sustainable system relying solely on their good will.

Because of 988, we have a once in a generation opportunity to re-imagine how we respond to people in crisis. We cannot miss this chance. Too many lives will be lost or ruined.

The call centers that will answer 988 calls rely on a patchwork of inadequate funding. To meet the growing demand, we need to fund not only the National Lifeline Network, but also fund local call centers answering the 988 calls to ensure culturally competent local capacity in every corner of this country.

A fully developed crisis response system also requires mobile response teams staffed by mental health professionals and crisis stabilization services. Unfortunately, most people don't have access to these services, and people are dying because of it.

NAMI is deeply grateful for your leadership in bringing the new Mental Health Crisis Response Pilot Partnership Program to our communities. It will spur the availability of mobile crisis teams as the primary in-person response to people in crisis.

But the work is not yet done. As you know, there is need for more teams like this to serve both adults and children. We urge you to increase funding of this program to \$100,000,000 to help people in more communities across the country.

As I wrap up, I need to recognize that I am here today to speak on behalf of the people who cannot be here, the people who are struggling, the parents that are trying desperately to find help for their kids, and all those who lost their futures because our system routinely fell short.

It is imperative that we address this crisis and make mental health among our Nation's highest priorities, turning a breaking point into a defining moment.

Thank you for this opportunity.

[The information follows:]

**Hannah Wesolowski, Chief Advocacy Officer**  
**National Alliance on Mental Illness (NAMI)**  
**Statement for House Labor-HHS-Education Appropriations Subcommittee**  
**May 26, 2022**

Chairwoman DeLauro, Ranking Member Cole, and Members of the Subcommittee, on behalf of the National Alliance on Mental Illness (NAMI), thank you for your focus and support of mental health. As the nation's largest grassroots mental health organization representing people with mental health conditions and their families, I applaud your continued bipartisan commitment to transforming our nation's mental health system and addressing the urgent needs of Americans amidst our ongoing mental health crisis. The mental health challenges we face as a country have grown exponentially due to the COVID-19 pandemic. Our country is at a breaking point, and if we don't invest, we will collectively pay the price for years—even decades—to come.

NAMI is dedicated to building better lives for the millions of people affected by mental illness. NAMI is a voice for youth, veterans and service members, individuals experiencing homelessness and justice system involvement, family caregivers, and anyone impacted by mental health conditions. As you consider spending levels for Fiscal Year 2023, I appreciate the opportunity to discuss NAMI's priorities to address our country's mental health emergency.

**First, we must address the youth mental health crisis.** Our children are struggling. For decades we have seen our nation's collective mental health decline and the COVID-19 pandemic has stretched America's already-fragmented mental health system even further. We see the impact every day with our neighbors and friends, within our own families and, most profoundly, with our nation's children. There are unprecedented numbers of children experiencing anxiety, depression, and suicidal thoughts. More than half of parents express concern over their children's mental well-being — something we hear daily from parents coming to NAMI for help. The

Surgent General issued a rare public advisory in 2021 warning about a “devastating” mental health crisis facing America’s children. Our nation’s leading youth medical organizations declared a national emergency in children’s mental health. America’s children are calling out for help. Congress must answer the call.

Since children spend much of their productive time in educational settings, schools offer a unique opportunity for early identification, prevention, and interventions that serve students where they already are. Investments in school-based mental health services are critically necessary to support children’s mental health. And it is truly an investment – funding that will help avoid more serious and tragic outcomes, including suicidal ideation and death by suicide. For these reasons, NAMI urges this Subcommittee to include the President’s proposed \$1 billion request for the School-Based Mental Health Services Grant Program to vastly increase the number of counselors, nurses, school psychologists, social workers, and other health professionals in schools in a FY23 appropriations package.

Another significant problem for youth mental health is a severe shortage of mental health providers, particularly those who treat children and youth. To address this challenge, NAMI urges this Subcommittee to include \$14 million for the Pediatric Mental Health Care Access (PMHCA) program. PMHCA promotes behavioral health integration into pediatric primary care by funding state or regional networks of pediatric mental health teams. These teams provide teleconsultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat, and refer children with behavioral health conditions and substance use disorders. This is an important opportunity to address children’s mental health needs in a place they often visit for their well-child visits: pediatricians’ offices. These consultations provide pediatricians with the confidence and knowledge to directly diagnose and treat many of

the more common mental health conditions they see in children, alleviating the chronic workforce shortages in the mental health community.

Sadly, our nation's mental health crisis does not end with our children. Nearly 2 in 5 adults struggled with mental health issues in 2020, compared to about 1 in 5 adults before the pandemic. While our goal is to help children and adults as early as possible when they experience symptoms of a mental health condition, we know that too many people experience mental health, suicide or substance use crises. Unfortunately, they often do not receive a mental health response. **NAMI urges this Subcommittee to leverage our once-in-a-generation opportunity to reimagine the way our nation responds to people in a mental health crisis.** Thanks to your leadership, we will have nationwide availability of 988, the new three-digit number to access the National Suicide Prevention Lifeline, in July. Trained crisis counselors will answer 988 contacts, providing de-escalation and mental health interventions and ideally coordinate connections to additional services and help in their community.

While the establishment of 988 is a great step forward to help people more easily access help, it's only the first step. A fully developed crisis response system must be responsive to anyone, anywhere, at any time through 24/7 local call centers, mobile response teams staffed by mental health professionals, and crisis stabilization services that connect people to follow-up care. Unfortunately, this full continuum is not available in most communities today. Currently, the nationwide network of call centers relies on a patchwork of inadequate funding, leaving insufficient capacity to meet current needs, let alone the anticipated increase in demand after 988 is available. There is a growing availability of mobile crisis teams, but demand still far outstrips supply, particularly for children. There is a dearth of crisis stabilization programs nationwide and widespread shortages of behavioral health professionals to staff crisis response services.

We deeply appreciate this Committee's leadership in providing funding to states for 988 and crisis services as part of the American Rescue Plan's Fiscal Recovery Funds and FY22 appropriations. While these resources provide critical funding to help implement important infrastructure, we know that future demand will only increase, putting more strain on this system. We also must recognize that significantly more resources will be needed to implement a complete 988 crisis system. We urge Congress to use its power of the purse, as well as its broad oversight and legislative authorities, to ensure all communities can appropriately respond to people in mental health and suicidal crisis by robustly funding the Lifeline, including local call centers, and associated crisis response services.

We thank this Subcommittee for including \$10 million for a new Mental Health Crisis Response Pilot Partnership grant program in FY22 to support communities in developing crisis services. While this federal support will help, more is needed. We urge you to include an additional \$100 million in FY23 to build communities' capacity to respond to mental health crises through the creation of mobile crisis teams. Expanding the availability of these teams through this grant program will reduce our dependence on the high-cost and ineffective status quo response to behavioral health emergencies: the overuse of law enforcement and emergency departments. We also urge this Subcommittee to include funding for a public awareness campaign, estimated by SAMHSA in a report to Congress to cost \$100-\$225 million, to make people aware of the lifesaving services available through 988 that Congress has made possible.

The mental health needs across the country are as diverse as the people who make up our communities. **We urge this Subcommittee to support access to a range of mental health services by increasing overall funding for the Community Mental Health Services Block**

**Grant (MHBG).** Since 1992, the MHBG has helped expand the nation's mental health infrastructure by providing funding for community-based mental health services to all states and territories. The block grant's flexibility and stability have made it vital in its support of public mental health systems, serving 8 million individuals in 2021. There is no more urgent a time than now to invest in this critical safety net to help states meet the unprecedented demand for mental health services. We urge you to include the President's request for a historic \$1.7 billion investment in the MHBG, coupled with a doubling of the evidence-based crisis care set-aside from 5 percent to 10 percent and establishing a 10 percent set-aside for prevention and early intervention. The MHBG will give our communities the flexibility to respond to our nation's mental health crisis in the way that addresses the needs in their community.

**Finally, while we focus on today's urgent needs, we must also look to the future and invest in research for improved understanding and treatment of mental illness.** We cannot lose focus on the need to adequately fund the National Institute of Mental Health (NIMH). NIMH's mission is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. Without adequate funding for research at NIMH, we are sacrificing the cures of tomorrow. Therefore, NAMI urges this Subcommittee to fund NIMH at \$2.248 billion for FY23, a five percent increase similar to other Institutes at NIH. This will enable the NIMH to better develop more effective treatment options for serious mental illness and continue to perform its life-altering and lifesaving research.

Thank you for this opportunity and the leadership you have demonstrated in advancing mental health. NAMI looks forward to working with the Committee to turn this breaking point into a defining moment where we change the paradigm of the way we treat people with mental illness.

The CHAIR. Thank you.

Let me, first and foremost, say that NAMI is the gold standard. Thank you for really the years and years of work in this area. You are extraordinary in the work that you carry on.

The issue is that mental health was an issue before the pandemic, under the radar probably, but serious. And serious enough to be considered a crisis, but it didn't—it didn't manifest itself in the way to those of us who were working on it that we had to deal with this crisis in some way in mental health.

So, but the pandemic brought this to light. Now more than ever we are looking at people who are struggling as a result of so many issues that are out there. It is isolation. It is losing a parent or grandparent, a loved one, et cetera. I don't know how many families have been touched by the loss of someone. With a million lives lost, it is like every family has suffered something somewhere. That has to be addressed in a formidable way, and we have to recognize that we need to do that.

We are excited about the 988 line, and we also want to make sure that we are providing the resources so that people—it works. So that someone is not dialing the number, and there is nobody home at the other end. So we need to make sure that that is there, and we need to focus as a country on what is a mental health crisis, not specifically caused by a pandemic, but a mental health crisis in this country exacerbated by that and high suicide rates.

And think about it. I saw a little boy this morning who was—survived yesterday, but he was looking at his friends all around him being killed, and how do you deal with that child? How do you help that child to succeed?

Anyway, thank you so much for your testimony, and we will—this is a high priority.

Congressman Cole.

Mr. COLE. Thank you very much, Madam Chair.

I want to thank our witness for being such an effective and thoughtful advocate.

I remember a number of years ago, when I was chair of this committee, and we passed the CURES Act. And my friend Tim Murphy, who is no longer, sadly, in Congress but is a child psychologist and has become an expert on post traumatic stress—and still stays in touch with me and, “Hey, think about this. Think about this program.”—came by my office as a Member who had done a lot of work on adding mental health provisions in that. And I said this is all great, but the authorizing committee, I am glad this is all authorized. Sadly, my budget has been cut by \$5,000,000,000 by the Budget Committee.

Now, at the end of the day—and we have to mark up to that number. The chair is going to have this challenge. At the end of the day, I suspect our overall number will go up as we get to a deal with the Senate, and we are going to need Democratic support, and they have got some concerns in these areas that I share. So we will do a little bit better.

But I had to say you have got to prioritize this for me a little bit. And he said, well, if you can only do one or two things, the most important thing is to fund the programs that get us more mental health professionals. We simply do not have enough people.

And I think your remarks about 988 are illustrative of that. It is partly money, but partly we need to make those investments in the pipeline to make sure that we have the professionals to actually respond to the situation. And this is one where I think we have been slower than any of us would like to get there, but we are starting to begin to understand.

Maybe the pandemic brought it home a little bit more, and you are quite right about that. This committee has had under the chair's leadership multiple hearings where we have talked about the long-term impact and people that were isolated, whether it was in nursing homes or school kids that lost the structure and focus in their life.

So thank you for keeping us focused on this important task, and I will continue to work with my friend the chair, and hopefully, we can make some progress.

With that, Madam Chair, I yield back.

The CHAIR. Thank you.

Thank you, and thank you for your testimony.

I would like to recognize Thomas Fleisher. Dr. Fleisher, executive vice president of the American Academy of Allergy, Asthma, and Immunology, you are recognized for 5 minutes for your testimony.

**THOMAS A. FLEISHER, M.D., EXECUTIVE VICE PRESIDENT,  
AMERICAN ACADEMY OF ALLERGY, ASTHMA, AND IMMUNOLOGY**

Dr. FLEISHER. Thank you.

Chairwoman DeLauro, Ranking Member Cole, and members of the subcommittee, thank you for the opportunity to testify on the HHS fiscal year 2023 appropriations.

I am Tom Fleisher, executive vice president and a former president of the American Academy of Allergy, Asthma, and Immunology that I will refer to as AAAAI for the rest of the talk. On behalf of our organization, I am before this subcommittee today with three requests.

A \$6,100,000 funding increase for the Consortium on Food Allergy Research, also known as CoFAR, and supporting report language, report language to support education and awareness related to the need for penicillin allergy evaluation in order to de-label non-allergic patients, and third, funding to address antimicrobial resistance.

The AAAAI wishes to express its appreciation to the subcommittee and to Congress for the passage of the fiscal year 2022 omnibus spending bill, which provided an additional \$3,000,000 to CoFAR, increasing its budget to \$9,100,000.

Food allergies affect 32 million Americans, including 6 million children. Each year, more than 200,000 Americans require emergency medical care for allergic reaction to foods. That is the equivalent of one trip to the emergency room every 3 minutes.

CoFAR was established within the NIAID in 2005 and has resulted in many advances, including the discovery of genes associated with increased risk for peanut allergy and the most promising potential immunotherapy treatments for egg and peanut allergies. Additional breakthroughs, scaled across other major food allergies,

could significantly improve the quality of life for tens of millions of patients.

The AAAAI and other stakeholders enthusiastically support the \$6,100,000 funding increase for CoFAR in fiscal year 2023 and accompanying report language, as submitted to the subcommittee, by Representatives Ro Khanna and Anthony Gonzalez, as well as others. This would bring CoFAR's annual budget to \$15,200,000.

CoFAR has been able to accomplish breakthroughs in the under-researched field of food allergies. It is crucial that we continue investing at proportional levels given the scale of this condition, which impacts 8 to 10 percent of the U.S. population. Further, food allergies disproportionately impact low-income communities of color.

I would also like to speak to the growing threat of antimicrobial resistance, which, combined with the dwindling pipeline of new antibiotics, requires policies that prevent inappropriate use of antibiotics. According to the CDC, approximately 10 percent of the U.S. population self-report being allergic to penicillin, yet 9 out of 10 of these patients are not allergic when formally evaluated, meaning fewer than 1 percent of the population is truly allergic to penicillin. The CDC has cited the importance of correctly identifying truly penicillin allergic patients to decrease the use of broad-spectrum antibiotics.

To this end, the AAAAI urges the subcommittee to include report language that encourages the CDC and other appropriate Federal agencies to undertake physician and patient-directed education to heighten awareness of this important issue.

We also support CDC's work in the area of AMR. The AAAAI supports \$100,000,000 in funding for the National Healthcare Safety Network and \$397,000,000 for the Antibiotic Resistance Solutions Initiative. These programs would benefit from significant new resources to achieve the goals outlined in the National Action Plan for Combating Antibiotic Resistant Bacteria.

Thank you for your past support of food allergy research, antimicrobial resistance, and penicillin allergy evaluation. We appreciate your consideration of these requests for fiscal year 2023 and look forward to working with you to advance these important health issues.

[The information follows:]

**Testimony from Thomas A. Fleisher, MD, FAAAAI, Executive Vice President**  
**On behalf of the American Academy of Allergy, Asthma & Immunology (AAAAI)**  
**Before the House Committee on Appropriations**  
**Subcommittee on Labor, Health and Human Services, and Education and Related Agencies**  
**FY 2023 Public Witness Hearing – May 26, 2022**

Chairwoman DeLauro, Ranking Member Cole, and members of the Subcommittee, thank you for the opportunity to testify on the U.S. Department of Health and Human Services (HHS) fiscal year 2023 appropriations. I am Dr. Tom Fleisher, Executive Vice President and a former president of the American Academy of Allergy, Asthma, & Immunology (AAAAI). On behalf of the AAAAI, I respectfully request the subcommittee include a **\$6.1 million increase in funding for the Consortium on Food Allergy Research (CoFAR) and supporting report language**. CoFAR is within the National Institute of Allergy and Infectious Diseases (NIAID) at the National Institutes of Health (NIH). In addition, AAAAI urges the subcommittee to include report language to encourage the CDC and/or other appropriate Federal agencies to support education and awareness related to the need for penicillin allergy evaluation in order to de-label non-allergic patients. AAAAI also supports **funding of \$100 million for the National Healthcare Safety Network** and **\$397 million for the Antibiotic Resistance Solutions Initiative** which enables the Centers for Disease Control and Prevention (CDC) to target prevention of healthcare acquired and antimicrobial resistant infections and improve antibiotic prescribing.

Established in 1943, AAAAI is a professional organization with more than 7,000 members in the United States, Canada, and 72 other countries. This membership includes board certified allergist/immunologists, other medical specialists, allied health practitioners and related healthcare professionals – all with a special interest in the research and treatment of patients with allergic and immunological diseases.

### **Food Allergies**

Food allergies affect 32 million Americans, including 6 million children. Each year, more than 200,000 Americans require emergency medical care for allergic reactions to food – equivalent to one trip to the emergency room every three minutes.

The Consortium on Food Allergy Research – CoFAR – was established by the National Institutes of Health (NIH) within the National Institute of Allergy and Infectious Diseases (NIAID) in 2005. Since then, CoFAR has discovered genes associated with an increased risk for peanut allergy and has also identified the most promising potential immunotherapy treatments for egg and peanut allergies, among many other accomplishments. Breakthroughs like these, scaled across other major food allergies, could significantly improve the quality of life for tens of millions of Americans. AAAAI wishes to express its appreciation to the subcommittee and Congress for the passage of the fiscal year (FY) 2022 spending bill, which provided an additional \$3 million for CoFAR, increasing its budget to \$9.1 million. While CoFAR's annual budget remains a relatively small portion of NIH's budget, it has been able to achieve major strides in the study of food allergy prevention and treatment.

AAAAI enthusiastically supports the \$6.1 million increase for CoFAR as requested by Reps. Ro Khanna, Anthony Gonzalez, and 35 additional bipartisan members, which would bring its yearly budget up to \$15.2 million. With its relatively low current level of funding, CoFAR has been able to accomplish breakthroughs in the under-researched field of food allergies. It is crucial that we continue investing at proportional levels given the scale of this condition which impacts 8-10% of the U.S. population. Further, food allergies disproportionately impact low-income communities of color. Higher rates of food allergy, higher frequency of severe allergic reactions, higher rates of food allergy-related treatment in the emergency department, and higher rates of fatal food-induced anaphylaxis are reported in Black Americans. Similarly, data shows that food allergies are more prevalent among Hispanic Americans when compared to White Americans.

AAAAI strongly supports the following NIAID report language also submitted by Reps. Khanna, Gonzalez and others that acknowledges the groundbreaking work of CoFAR and encourages robust investment to expand its research breadth and network.

**Food Allergies.**— *The Committee recognizes the serious issue of food allergies which affect approximately eight percent of children and ten percent of adults in the United States. The Committee commends the ongoing work of NIAID in supporting a total of 17 clinical sites for this critical research, including seven sites as part of the Consortium of Food Allergy Research (CoFAR). The Committee includes \$15,200,000, an increase of \$6,100,000, for CoFAR to expand its clinical research network to add new centers of excellence in food allergy clinical care and to select such centers from those with a proven expertise in food allergy research.*

In addition to the AAAAI, the CoFAR funding request and report language are supported by the American College of Allergy, Asthma & Immunology; Allergy & Asthma Network; Asthma and Allergy Foundation of America; and Food Allergy Research and Education.

#### **Antimicrobial Resistance (AMR) and Penicillin Allergy Evaluation**

I would also like to speak to the growing threat of antimicrobial resistance, which combined with the dwindling pipeline of novel antibiotic research, requires policies that prevent inappropriate use of antibiotics. One of the primary ways to combat this threat begins with penicillin – the most commonly reported drug allergy. According to the CDC, approximately 10% of the U.S. population self-report being allergic to penicillin, yet 9 out of 10 patients reporting a penicillin allergy are not truly allergic when formally evaluated, such that **fewer than 1% of the population is truly allergic to penicillin**. In its *2018 Update of Antibiotic Use in the United States: Progress and Opportunities*, the CDC cited the importance of correctly identifying if patients are penicillin-allergic in decreasing the unnecessary use of broad-spectrum antibiotics. The AAAAI strongly supports more widespread and routine use of penicillin allergy evaluation for patients with a self-reported history of allergy to penicillin. Evaluation can accurately identify patients who, despite reporting a history of penicillin allergy, can safely receive penicillin. To this end, the AAAAI urges the subcommittee to include language that **encourages the CDC and other appropriate Federal agencies to undertake physician and patient directed education to heighten awareness of this important issue in order to increase penicillin allergy evaluation in order to de-label non-allergic patients.**

To support CDC's work to target prevention of healthcare acquired and antimicrobial resistant infections and improve antibiotic prescribing, the AAAAI supports funding of **\$100 million for the National Healthcare Safety Network**. We also support funding of **\$397 million for the Antibiotic Resistance Solutions Initiative**, which would benefit from significant new resources to achieve the goals outlined in the *National Action Plan for Combating Antibiotic-Resistant Bacteria, 2020-2025*, including strengthening antibiotic stewardship to promote best practices for prescribing antibiotics such as penicillin.

Thank you for your past support of food allergy research, antimicrobial resistance, and penicillin allergy evaluation. We appreciate your consideration of these requests for FY23 and look forward to working with you to advance these important health issues.

The CHAIR. Thank you very, very much for really focused testimony here and the work that the academy does. The areas that you have outlined for years trying to deal with the issue of antimicrobial resistance and that we need to spend time in trying to really deal with it, and it would be interesting to know, given the vast array of antivirals and drugs and antibiotics that have been used throughout COVID here, of what kind of an effect that is going to have for the future.

I am not a scientist, but you are in a position to sort that out. So very, very big issue and one that we have focused on the committee.

Secondly, when you talk about the food allergy research, really incredible. I don't know if you at some time will talk about being lactose intolerant, which it was only several years ago that that occurred, and what one does about that. But I watch people all of the time and have family—now my 5-year-old grandson, it is fish. My God, he gets deathly ill.

But the work in that area I think is—I think we can—and again, I am not a doctor and I am not a scientist, but we make strides, and we can continue to look at this as a way in which we can alleviate that stress, pain, or potentially death. But this could be prevented. We can deal with prevention in this area, which is where we ought to try to focus our attention.

And the CDC does a great job. I mean, the CDC has been extraordinary in this effort historically. So look forward to working with you as we go forward. And the caveat is always how much money are we going to have?

Dr. FLEISHER. Thank you.

The CHAIR. And that is always the way forward. But thank you for the focus. And on penicillin as well, it is very interesting. You do learn something every day, and through this committee you learn something.

So, Congressman Cole.

Mr. COLE. Thank you, Madam Chair.

I know my friend the chair is trying to move us along because we are already over time, and so I am going to keep my remarks brief and associate myself with hers. And please don't take the brevity of my remarks as anything other than trying to help in terms of time because these are important topics and interesting.

And I think my friend the chair put her finger on it. The problem is always how much money do we have? And I noticed, Dr. Fleisher, you were on for quite a while so you got an earful of the number of requests that my friend the chair is going to have to wrestle through and then put together the votes on both sides of the aisle to get all this across and done and, hopefully, on time.

So we are going to work with her on that, try to be as supportive as we can, but we really appreciate your testimony.

With that, Madam Chair, I yield back.

The CHAIR. I thank the ranking member.

And just that I see all these people waiting, and I think we are about an hour behind and so forth because it is so—these issues are so critical.

But Dr. Sandra Harris-Hooker, senior vice president for research administration, professor of pathology at Morehouse School of Med-

icine. We welcome your testimony, and you are recognized for 5 minutes.

**SANDRA HARRIS-HOOKER, SENIOR VICE PRESIDENT FOR RESEARCH ADMINISTRATION AND PROFESSOR OF PATHOLOGY, MOREHOUSE SCHOOL OF MEDICINE**

Ms. HARRIS-HOOKER. Chair DeLauro, Ranking Member Cole, and members of the subcommittee, good morning, and thank you for the opportunity to present testimony in support of programs impacting health, minority health, and health disparities.

And greetings on behalf of our president and CEO, Dr. Valerie Montgomery Rice.

Morehouse School of Medicine is one of four historically black medical schools. These four schools have trained approximately half of the black physicians in this country. The subcommittee's investments in health professions training, medical research, and public health have been very meaningful. They provide our institutions with resources needed to drive improvements in health status for all Americans and help us to provide our students with opportunities for careers in health-related professions, which is clearly a national priority.

I would be remiss if I did not thank the subcommittee for its responsiveness to the COVID-19 pandemic. Your commitment to providing the resources needed to establish the Higher Education Emergency Relief Fund has been tremendous and allowed us to respond to the needs of our students, faculty, and staff, as well as play a leadership role in improving public health practices in communities nationwide.

Our complete list of funding recommendations is included in our written testimony, but with the limited time for my oral remarks, I want to focus on two key programs important to the Morehouse School of Medicine and other minority health profession schools.

The first is the Research Centers at Minority Institutions, acronym RCMI, which is administered by the National Institute on Minority Health and Health Disparities, NIMHD. Historically, the RCMI program has provided the resources needed for our schools to begin to build, with emphasis on begin to build, a research infrastructure comparable to non-minority institutions, allowing us to attract world-class researchers, expand research facilities, and support cutting-edge investigations into questions about why health disparities still exist and how to improve the health status of each American.

As the subcommittee has increased funding for NIMHD, funding for the RCMI program has not grown at the same rate. Furthermore, RCMI program funding opportunities have become more focused on research project grants and less on capacity building. While both of these are certainly needed, our schools need the resources to build capacity to successfully compete for research project grants and other funding opportunities.

As the subcommittee considers its funding recommendations, we urge that the RCMI program be provided with a detailed level of funding that is consistent with the growth of the NIMHD budget. Moreover, we urge the subcommittee to re-emphasize the historic infrastructure-building focus of the program, including providing

\$15,000,000 annually—of annual funding to support clinical and translational research infrastructure in historically black medical schools comparable to that provided to majority medical schools.

Funding for infrastructure for clinical research resources and facilities is critical to advancing health equity among the most vulnerable populations in this country.

Secondly, in March, President Biden signed the bipartisan John Lewis NIMHD Research Endowment Revitalization Act. This new law solved a glitch in the underlying NIMHD Research Endowment Program statute that precluded several historically eligible institutions, including Morehouse School of Medicine, from even competing for this important program.

This endowment helps us to build an endowment that would enable us to be on the average of other health professional schools. Now that this eligibility glitch is resolved, we ask that \$50,000,000 be put into that fund.

Thank you very much for the opportunity to present this testimony to the committee, and I am pleased to answer any questions or provide additional information.

[The information follows:]

**Testimony of Sandra Harris-Hooker, Ph.D.  
Senior Vice President for Research Administration and Professor of Pathology  
Morehouse School of Medicine**

**On behalf of the  
MOREHOUSE SCHOOL OF MEDICINE (MSM)**

**Presented to the House Appropriations Subcommittee on Labor, Health and Human  
Services, Education and Related Agencies**

**RE: FY2023 Funding Recommendations for Health and Education Programs**

**May 24, 2022**

**Summary of FY 2023 recommendations:**

**Health Resources and Services Administration:**

- \$1.51 billion for the Health Resources and Services Administration (HRSA) Title VII health professions and Title VIII nursing workforce development programs.
  - \$47.42 million for HRSA's Minority Centers of Excellence
  - \$47.95 million for HRSA's Health Careers Opportunity Program.
  - \$2 million for HRSA's Minority Faculty Loan Repayment Program.
  - \$67 million for HRSA's Scholarships for Disadvantaged Students (SDS)
  - \$67 million for HRSA's Area Health Education Center (AHEC) Program

**Centers for Disease Control and Prevention**

- \$74 million for the Racial and Ethnic Approaches to Community Health (REACH) Program

**National Institutes of Health**

- \$49 billion for the National Institutes of Health
  - \$1 billion for the National Institute on Minority Health and Health Disparities (NIMHD).
    - \$300 million for the Research Centers at Minority Institutions (RCMI)
  - \$200 million in new, annual research funding dedicated specifically targeted at enabling historically black health professions schools to support research that reverses health status disparities among minority Americans.
  - \$100 million for NIH's Extramural Research Facilities program
  - \$50 million to reinvigorate the NIMHD's Research Endowment Program (REP)

**Office of the Secretary**

- \$72 million for the Office of Minority Health at the Department of Health and Human Services.

- \$5 billion in new funding designated for Historically Black Health Professions Institutions for the improvement and development of health care infrastructure.

#### **Department of Education**

- \$100 million for the Strengthening Historically Black Graduate Institutions (HBGI) Program.

#### **Community Project Funding/Congressional Directed Spending Request (HRSA)**

- \$950,000 request to continue the development of a Research and Academic Building on MSM's main campus (~\$10 million total cost)

Chairwoman DeLauro, Ranking Member Cole, and distinguished members of the subcommittee, thank you for the opportunity to submit testimony and thank you for your leadership in addressing challenges facing the health workforce, health disparities, and medically underserved communities. I am Dr. Sandra Harris-Hooker, Professor, Vice President and Executive Vice Dean of Academic Administration & Research at Morehouse School of Medicine (MSM).

Morehouse School of Medicine was founded to address the disparities in health status and health care among vulnerable populations. Central to our mission is increasing the diversity and cultural competence of the health professional scientific workforce, addressing the primary health care, mental health and public health needs of underserved populations, as well as engaging in innovative research and developing patient-centered programs aimed at advancing health equity in Georgia and across the nation. This is a mission that we, and our Historically Black Colleges and Universities (HBCU) medical school colleagues, take seriously.

We are proud to be a one of the four institutions that comprise our nation's HBCU medical schools. While each of our esteemed institutions brings something slightly different to the table, we all share one common goal: helping Americans achieve their optimal level of health. HBCU medical schools are distinguishable from our other institutional colleagues because health equity is at the core of everything we do. From the research opportunities that we engage in, to our prioritization of clinical continuity for underserved communities, to our commitment to providing access to trusted medical services for those who need it most, we have always existed to protect the most vulnerable amongst us.

We have learned valuable lessons over the past two years, and continue to respond the best we can to the pandemic, but we know that there is more work to be done. The country has now seen what MSM and other Historically Black Graduate Institutions (HBGIs) and HBCUs know and work towards everyday: the pitfalls and shortcomings of minority health. Our funding recommendations are robust and necessary given the discussion concerning the devastating effect of the pandemic on people of color and the need to address this effect for any future pandemic. To be as clear we can be, there must be more robust investment on minority health and disparities. To achieve this we know that it will require the steadfast leadership of health equity champions. We stand ready to work with you and your colleagues to facilitate these efforts.

Health disparities across racial and ethnic groups in the U. S. have been well documented over the last several decades and have remained remarkably persistent in spite of the changes in many facets of the society over that period. Moreover, the benefits of increasing diversity in the health professions to reduce such disparities have been studied at length, are based on empirical data, and are well understood by the medical community. Examples of these benefits include:

- Minority physicians are more likely to practice in medically underserved areas and care for patients regardless of their ability to pay.
- Minority physicians are more likely to choose primary care practices.
- Evidence suggests that improving cross-cultural communication between doctors and patients and providing patients with access to a diverse group of doctors improve adherence, satisfaction and health outcomes.
- There is evidence that the intellectual, cultural sensitivity, competency, and civic development of students is enhanced by learning in a diverse educational environment.
- A diverse health workforce encourages a greater number of minorities to enroll in clinical trials designed to alleviate health disparities.

There is little left to discover or dispute with respect to the benefits of achieving greater racial and ethnic diversity of the nation's health professionals – the attention has once again shifted to identifying the most effective and sustainable methods to do so. While there are many national campaigns underway to increase diversity in all medical and health professions schools particularly during this period of enrollment growth, it is imperative that we further recognize and leverage the public value of Historically Black Health Professions Schools.

The daunting news that Blacks Americans in the US are disproportionately suffering and dying from COVID-19 unfortunately was not a tremendous surprise to those of us who regularly monitor and understand health status disparities in this nation. There are well-known health status challenges faced daily by Black Americans and minority health care providers, it also represents a surrogate for the glaring lack of health infrastructure in medically under-served communities. At MSM and other HBGI institutions, we have long been and remain committed to addressing these very same disparities in whatever way that we can, with an eye first and foremost towards the communities with the greatest need across our country.

Ironically, as a result of their mission focus the financial models of historically black health professions schools are uniquely disadvantaged compared to most of their peer institutions. Unlike subspecialty-oriented, research-intensive institutions -- with higher margin clinical services, an integrated hospital system, substantial research enterprises, sizeable endowments, and a critical mass of wealthy donors – these institutions are faced with an unprecedented set of adverse factors that challenge their financial viability. Consequently, they are disproportionately dependent on the various federal programs that support their core purpose.

Specifically, these programs include: the Title VII Health Professions Training Programs administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS); the Research Centers at Minority Institutions (RCMI), the Extramural Research Facilities; the Research Endowment; and Centers of Excellence programs administered the National Institutes of Health's National Institute on Minority Health and Health

Disparities; and the Historically Black Graduate Institution (HBGI) program administered by the Office of Postsecondary Education of the U.S. Department of Education (DOE).

The Research Centers at Minority Institutions (RCMI) program is administered by the National Institute on Minority Health and Health Disparities (NIMHD). Historically the RCMI program has provided the resources needed for minority institutions to build a research infrastructure comparable to non-minority institutions. As the subcommittee has increased funding for the National Institute on Minority Health and Health Disparities, funding for the RCMI program has not grown at the same rate. Furthermore, RCMI program funding opportunities have become more focused on research project grants and less on capacity building. We urge that the RCMI program be provided with a specific level of funding that is consistent with the growth in the NIMHD budget, and that the subcommittee re-emphasizes the historic infrastructure-building focus of the program

President Biden recently signed the *John Lewis NIMHD Research Endowment Revitalization Act* to revitalize this important initiative, and it is our expectation that NIMHD will act swiftly to reinvigorate the research endowment program so minority-serving institutions can participate in this competitive opportunity to build their research endowments in a manner consistent with the statutory goal of assisting them in achieving a research endowment that is comparable to the endowments of other schools in their health professions discipline. The NIMHD Research Endowment Program (REP) allows academic institutions to build research infrastructure and recruit, train, and maintain a diverse faculty and student body. Robust funding would allow active and former NIMHD Centers of Excellence to continue their historic focus on research to close the gap between the burden of illness and premature mortality experienced more commonly by communities of color, as well as other medically underserved populations. It would also help improve access to grants to fund research projects, as well as hire staff and provide scholarships for students who come from underserved communities. To ensure successful implementation, we are asking for the Committee to allocate robust funding to NIMHD for this program.

In addition to the recommendations referenced above, MSM has submitted a community project funding/congressionally directed spending request for continuing to develop a new academic and research facility that will provide critical support in the Institution's mission to improve and diversify the healthcare workforce. The recent growth in the size and diversity of the student body has not only made it necessary to train more healthcare professionals committed to underserved communities, but it also requires expanded space and resources on campus. More classrooms, lecture spaces, learning communities, research laboratories, and common spaces for knowledge sharing are all needed to meet the needs of a growing student body.

Madam Chair, unfortunately, over the past several years funding for diversity-focused programs has deteriorated in varying degrees. Absent a monumental overall investment the financial position and academic viability of historically black health professions schools will deteriorate rapidly. The front loaded investment in health professions training programs, graduate programs in biomedical sciences and public, and safety net providers is more cost effective than absorbing uncompensated care originating from minority and underserved communities. Now is the time for targeted investments in historically black health professions

schools to ensure a steady pipeline of minority healthcare providers, biomedical scientists, and other health practitioners prepared to support and advance the delivery of high quality, culturally appropriate, evidence-based health care. Thank you all again for the opportunity to share the priorities of the Morehouse School of Medicine.

The CHAIR. Thank you so much for your testimony.

Let me yield to Congressman Cole for any comments or questions he may have.

Mr. COLE. Just very quickly, Madam Chair, I want to thank Dr. Harris-Hooker for her testimony and for spotlighting what this committee has learned during—probably knew before, but I think is much more acutely aware of about the social disparity in both outcomes and the unrepresentative nature of many of our healthcare providers and how important it is to address that imbalance going forward.

And very much appreciate the work of the medical schools associated, the four you mentioned, with Historically Black Colleges and Universities—what an extraordinary contribution they have made to the country's healthcare—and what we need to do to expand capacity, quite frankly, going forward.

So thank you for coming before us. And with that, I yield back to the chair.

The CHAIR. Thank you very, very much.

And I associate my comments with those of the ranking member. I think the historic black college medical schools and the professional training, one of the most serious areas is that we need to have many, many more minority medical professionals here to deal with what has been demonstrated in terms of the disparities that exist in our healthcare system.

So, and the training is critical, and you are equipped to do it. You need the resources to do it, and we understand that. And again, we will be looking at what those numbers are and making a decision, but I thank you for the very strong testimony and the work of the historic black medical schools.

So thank you very, very much, Dr. Hooker.

Let me now recognize Katie Ray-Jones, who is the chief executive officer of the National Domestic Violence Hotline.

Katie, you are recognized for 5 minutes.

#### **KATIE RAY-JONES, CHIEF EXECUTIVE OFFICER, THE NATIONAL DOMESTIC VIOLENCE HOTLINE**

Ms. RAY-JONES. Thank you.

Good afternoon, Chairwoman DeLauro, Ranking Member Cole and distinguished subcommittee members.

Thank you for the opportunity to provide testimony on the importance of continued Federal investment in the Hotline, which is authorized as part of the Family Violence Prevention and Services Act and administered by the Family Violence Prevention Program, a program of the Family and Youth Services Bureau under the Administration for Children and Families at the Department of Health and Human Services.

The Hotline, established in 1996, is the only 24/7/365 national organization that directly serves victims of domestic violence, their friends, and family via phone, chat, and text. We are currently experiencing our highest contact volume in our 25-year history, and to help meet this overwhelming need, I am here to request the subcommittee increase investment in the Hotline in fiscal year 2023 to \$27,000,000.

The Hotline's services are free and confidential. We have the most comprehensive survivor resource database in the country. Our advocates help victims and their families and friends, whether they are in throes of an emergency, seeking local help, or just in need of someone to talk to in that moment.

Our expertise is routinely sought by national and regional media; Federal, State, and local governments; service providers, law enforcement, and nonprofit colleagues.

On December 30, 2021, a Hotline advocate answered our 6 millionth contact since our inception. Truly a bittersweet milestone. In calendar year 2021, the Hotline over 620,000 contacts. We also knew once life returned to any kind of normalcy from the devastating impact of COVID-19 there would be more survivors needing support who had not felt safe to reach out during the height of the pandemic.

Sadly, our instincts were accurate. In February 2022, the Hotline experienced the highest monthly contact volume in our history, 74,000 contacts reaching out for help in 28 days. Also in February, in an effort to use their technology to help survivors connect with our services, Google launched a new crisis search engine optimization. After this launch, the volume nearly doubled overnight, a powerful and somber illustration of how many are impacted by relationship abuse and need services or support.

We desperately need to add a record number of new advocates on the line and implement technology advancements to manage this kind of volume. We need to increase our impact through loveisrespect, an initiative that engages, educates, and empowers young people to prevent and end abusive relationships.

We also deeply value working in partnership with several national organizations to serve victims with specialized needs. The Hotline has worked with the National Indigenous Women's Resource Center to help design and implement a Native-run domestic violence helpline that provides culturally specific assistance to Native victims of domestic violence. And in March 2017, Strong Hearts Native Helpline was launched.

In addition, the Hotline also works with Abused Deaf Women's Advocacy Services to provide intervention, education, information, and referrals to callers who are deaf through the National Deaf Domestic Violence Hotline. While we are proud of how we have expanded our reach and services in order to meet the Hotline's primary goal of serving all survivors, we are also aware there remain some specialized populations we have yet to serve, such as those who choose to cause harm.

This includes about 9 percent of our total contacts who reach out seeking information and support for changing their harmful behaviors. With additional and specifically dedicated funding, such as the \$1,000,000 championed by Representative Lloyd Doggett out of Texas, we hope to explore opportunities to help abusive partners recognize their behaviors and access support to change them.

It takes a comprehensive, multilayered national, State, regional, and local approach to fully support survivor safety and recovery. While we offer important emergency and support services for victims of domestic violence, our goal is to connect these survivors with local programs that have resources to help victims identify

shelter, transitional housing, culturally specific programs, legal assistance, and economic supports necessary to help them escape their abusers. We urge the committee to also provide robust support to these lifesaving programs.

Throughout my testimony, I have shared with you the tremendous impact of the dedicated advocates at the Hotline. As a result, I urge the subcommittee to continue its bipartisan support for the Hotline in fiscal year 2023 through an appropriation of \$27,000,000. These funds would allow us to increase staffing by hiring additional advocates and support staff. When someone reaches out for help, we need to be able to answer.

In conclusion, I would like to share feedback from a survivor who called the hotline.

“This conversation has been incredible. I feel like the tears in my heart are starting to dry up. Thank you for supporting me and helping me reach my own solutions. I feel so much hope and empowerment and like the healing has begun for me.”

As you said, Chairwoman DeLauro, earlier, we need to seize the moment. And when someone calls for help, we need to be able to answer.

Thank you for your time, and thank you again for your continued support for victims of domestic violence.

[The information follows:]

**Testimony for the House Appropriations Subcommittee on  
Labor, Health and Human Services, Education and Related Agencies  
Submitted by: Katie Ray-Jones, CEO, The National Domestic Violence Hotline  
May 26, 2022**

Good morning, Chairwoman DeLauro, Ranking Member Cole and distinguished members of the Labor, Health and Human Services, Education and Related Agencies Appropriations Subcommittee. My name is Katie Ray-Jones, and I am the Chief Executive Officer of the National Domestic Violence Hotline (The Hotline) headquartered in Austin, TX. Thank you for this opportunity to provide testimony on the importance of continued federal investment in The Hotline and domestic violence services across the country. The Hotline is authorized as part of the Family Violence Prevention and Services Act (FVPSA) and administered by the Family Violence Prevention and Services Program, a program of the Family and Youth Services Bureau under the Administration for Children and Families at the Department of Health and Human Services. The Hotline, established in 1996, is the only 24/7 national hotline that directly serves victims of domestic violence and dating abuse, as well as their friends and family via phone, chat, and text. We are experiencing the highest demand for our services in our 25-year history, and to help meet this overwhelming need, I am here to respectfully request that the Subcommittee increase its investment in The Hotline for FY 2023 to \$27 million. This increase is key to our ability to expand capacity through staff and technology quickly to serve as many survivors as possible.

The Hotline's work rests on three pillars – crisis intervention, prevention, and systems change. On December 30, 2021, we answered our 6 millionth contact since our inception – a truly bittersweet milestone and a reminder of just how pervasive domestic violence is in the United States. The time it takes to answer one million contacts continues to get shorter as demand for our services increases, especially as the COVID-19 pandemic persists with increased risks for survivors. It took nearly 7.5 years to answer our first million contacts, and just over two and a half years to answer the latest.

The Hotline's services are free, anonymous, and confidential, and we are often the first source of validation and support for those experiencing domestic violence or seeking to support someone who is impacted. We have the most comprehensive provider database in the country, with more than 5,000 providers and resources in the United States, Puerto Rico, the U.S. Virgin Islands and Guam. Our advocates go through an intensive trauma informed training process using our crisis intervention model conducted by our experienced training staff. A recent caller seeking information on how to support their daughter shared, "Thank you! I will read that and share the information with my daughter. This has been the most helpful support we have gotten in several months of dealing with this, so I want to thank you."

In calendar year 2021, The Hotline answered 408,370 calls, chats and texts (contacts)—the most answered in a single year in our history. Seventy-five percent (75%) of those we served identified as victims/survivors, 13% identified as friends, family members or other helpers, and 12% identified as "other," such as those working with survivors or even those causing harm. Of the abuse types reported, 96% of the contacts reported emotional abuse, 61% reported physical abuse, 26% reported economic/financial abuse, 15% reported digital abuse, and 11% reported sexual abuse.

We believed once life returned to any kind of normalcy from the devastating impact of COVID-19, there would be more survivors needing support who had not felt safe to reach out during the height of the pandemic. Sadly, our instincts were accurate. The Hotline's contact volume was up from October, 2021-

January, 2022 ranging from 6%-40% and in February 2022, The Hotline experienced the highest monthly contact volume in our history (74,000 incoming contacts in a 28-day period). A contributing factor in this increased demand, is that in February, in an effort to use its technology to help survivors connect with our services, Google launched a crisis search engine optimization tool to get critical, vetted information to searchers quickly. This means when a user inputs certain search terms related to domestic violence, The Hotline's information and direct links to our services pop up. The launch of Google's optimization technology has nearly doubled our contact volume—a powerful and somber illustration of how many people are impacted by relationship abuse and need access to 24/7 support.

Subsequent months have continued at the same increased volume. Average daily calls, chats and texts coming into The Hotline and love is respect (our youth-focused healthy relationship and dating abuse prevention program) are more than 2,600 incoming calls, chats and texts per day. Our typical pre-pandemic daily contact was 1,200 contacts per day on average. The Hotline is expanding our capacity through hiring and new technology to meet this increased demand as best we can, but more resources are needed. In response, our fundraising team launched an emergency \$2 million campaign to respond to the increased number of contacts and expand The Hotline's capacity by building technology solutions, such as triaging our contact queue, and accelerated hiring. To date \$750,000 has been raised thanks to the strong support of corporations, foundations, and individuals helping to ensure we meet the needs of as many survivors as possible. But we also desperately need to add a record number of new advocates on the lines and implement further technology advancements to manage this kind of volume.

Domestic violence (DV) encompasses intimate partner violence (IPV), dating abuse and relationship abuse. Domestic violence is often misinterpreted as a private issue. It is, in fact, a public health crisis that affects the safety of families, businesses, and communities across the country. The Centers for Disease Control and Prevention's National Intimate Partner and Sexual Violence Survey found that domestic violence, sexual violence, and stalking are widespread. Domestic violence affects more than 12 million people each year.<sup>i</sup> According to the CDC, 1 in 4 women and 1 in 7 men will experience physical violence by their intimate partner at some point during their lifetimes.<sup>ii</sup>

It takes a comprehensive multi-layered national, regional and local approach to fully support survivors and further their survival, safety and recovery. This approach includes national 24/7 resources dedicated to serving those affected by DV/IPV, such as The Hotline, as well as state, regional and local providers and emergency shelter systems. In 2021, The Hotline provided 208,765 referrals to shelter and domestic violence service providers and 192,898 referrals to additional resources across the nation. The top resources and referral types include legal resources, economic resources, housing information, mental health and counseling services, health care and children's services and parenting resources. In making these referrals, we have seen firsthand how the pandemic and resulting effect on the economy has impacted victims. A 34% increase in the number of contacts from 2020 shared they had experienced housing instability and/or homelessness in calendar year 2021.

Since our phone lines opened on February 21, 1996, The Hotline has expanded its reach and services through our digital platforms, which many have shared is a safer way to reach out—especially during the pandemic, including chat and text while providing comprehensive information through our website for those not feeling safe enough to reach out for live services. In 2021, The Hotline received 338,559 calls and 281,634 chats and texts. Our advocates provide services in English and Spanish and in more than 200 other languages through the use of a Language Line. A first-time contact shared they didn't realize resources for domestic violence existed and shared, "I am so glad that you are here and that I got you on

the call. You all are such wonderful people to provide your time and energy supporting survivors of abuse! I finally feel at peace, and I feel like I have a direction to go in! Thank you!"

We have also increased our impact through love is respect. In 2007, The Hotline launched love is respect, an initiative that engages, educates, and empowers young people to prevent and end abusive relationships. love is respect was created in response to a national discourse about the need for prevention services, especially among teens. Among adult victims of rape, physical violence, and/or stalking by an intimate partner, 22% of women and 15% of men first experienced some form of partner violence between 11 and 17 years of age.<sup>iii</sup> Nearly 1.5 million high school students nationwide experience physical abuse from a dating partner in a single year.<sup>iv</sup> Teen dating violence is unfortunately common, with 1 in 12 high school students reporting experiencing physical and sexual dating violence.<sup>v</sup>

love is respect is a safe, inclusive space where young people can access information and get help in an environment designed specifically for them. love is respect mobilizes parents, educators, and peers to raise awareness on healthy dating behaviors and how to identify unhealthy and abusive patterns. Teachers, college advisors, and other groups working with young people use our program, including [loveisrespect.org](http://loveisrespect.org), as a go-to resource and rely on our program to understand what a healthy relationship is, trends in teen dating abuse (such as the rise digital abuse), and learn how they can protect themselves or the teens they care for from relationship abuse.

We also deeply value working in partnership with several national organizations to serve victims with specialized needs. For example, gaps in Native-centered supportive services create unique barriers for Native victims seeking help, and Native victims experience domestic violence at far greater rates than other populations in the United States. With input from tribal leaders, a Native women's council, domestic violence experts, and the Family Violence Prevention and Services Act program, The Hotline and NIWRC launched StrongHearts Native Helpline in March 2017. StrongHearts was initially housed at The Hotline's headquarters in Austin, TX so that its staff could benefit from The Hotline's existing infrastructure, caller application technology, resource database, data collection infrastructure and training resources. After two years working closely with The Hotline, StrongHearts transitioned its headquarters to its permanent location in Eagan, MN in January 2019, offering services 24/7. In November 2020 StrongHearts received their 10,000th call.

In addition, The Hotline works with the Abused Deaf Women's Advocacy Services (ADWAS) which provides crisis intervention, education, information and referrals for deaf callers through the National Deaf Domestic Violence Hotline. The Hotline partners with ADWAS to supplement these services including support, as appropriate, when ADWAS staff are not able to remain open 24/7.

While we are proud of how we have expanded our reach and services to more survivors than ever before, we are also aware that there are populations we have yet to serve. A prime example of this are contacts we receive from those who choose to cause harm (abusive partners). This accounts for about 9% of our volume. These are people seeking information and support for changing their harmful behaviors. Our advocates do their best to provide support and connect them to local batterers intervention programs and educational resources for help, but more needs to be done. In the United States, resources for those who abuse are very limited and are often court-ordered programs not accessible outside the criminal justice system. If we are ever going to see the end of domestic violence in this country, we must do more to stop abuse before it happens. With additional and specifically dedicated funding, such as the \$1 million

championed by Rep. Lloyd Doggett (D-TX), we hope to explore supplemental support and services to help abusive partners recognize their behaviors and access support to change them.

While The Hotline and love is respect offer important emergency crisis intervention and prevention services for victims of domestic and dating violence, our goal is to connect them with local programs that have the resources to help them identify shelter, transitional housing, culturally specific programs, legal assistance, and economic support necessary to help them escape those who abuse. The FVPSA program is the only federal funding source dedicated to domestic violence shelters and programs. It supports lifesaving services including emergency shelters, counseling, and programs for underserved communities throughout the United States and territories. The Administration for Children and Families estimates that domestic violence programs funded through FVPSA provided shelter and nonresidential services to more than 1.2 million survivors. However, 181,364 requests for shelter went unmet in FY2021. The National Network to End Domestic Violence (NNEDV) 2021 Domestic Violence Counts survey found that in just one day 70,032 victims of domestic violence received services, but another 9,444 requests for services went unmet due to lack of funding. Safety for survivors also requires financial security. Being subjected to abuse is financially devastating for survivors and safety has real costs. A growing body of evidence shows that providing direct cash assistance to survivors is a low-barrier and immediate way to help survivors overcome obstacles to their safety.

Throughout my testimony I have shared with you the tremendous need for and impact of The Hotline's vital services to those seeking help to pursue a safer future and escape abusive relationships. However, the staggering demand and record-breaking volume we are now experiencing as a result of the COVID-19 pandemic and the economic stress of rising inflation, have made the need for increased federal investment critical. As a result, I urge the Subcommittee to continue its bipartisan support for The Hotline in FY 2023 through an appropriation of \$27 million. These funds would allow us to increase staffing by hiring more than 100 new front-line advocates (including bilingual staff), 25 new staff for program services support (such as program services managers, shift support specialists, and workforce managers), as well as prevention and health relationship specialists for love is respect. Increased resources are also needed to support StrongHearts Native Helpline and ADWAS.

Increased funds are also needed to innovate and invest in additional technology infrastructure and staffing to better meet the increased volume. This includes technological advancements, queue management, triaging, as well as increased capacity overall to ensure our website's direct services platforms and self-service paths are optimized and accessible to all. As The Hotline continues with a mostly remote workforce, we also plan to launch program services in three new hub cities to expand our operations. This will enable us to maximize time zone coverage to better meet the 24-hour demand from those seeking help and safeguard against the impact of natural disasters on our operations, such as the 2021 Texas winter storm which decreased The Hotline's capacity by 45% for five days due to widespread power outages. Lastly, we would like to invest in a national paid public service announcement effort. The Hotline has historically never spent funds on marketing or paid public awareness campaigns, however the recent Google search optimization tool (which caused an approximate 40% increase in volume) is an example of just how pervasive domestic violence is and demonstrates the need to ensure that survivors know about The Hotline's 24/7 services. Survivors are often referred to us through other direct service programs, word of mouth, media referrals, or through outreach done by other programs, hospitals, courts, legal services, and general awareness campaigns about domestic violence.

In conclusion, at The Hotline we envision a world where all relationships are positive, healthy and free from violence. Every hour of every day of the year, through phone, chat and text, The Hotline and its complementary program for young adults, love is respect, work to shift power back to people affected by relationship abuse. It is a vital resource, a link to support and for some, contacting The Hotline may be the first action they take to find safety. Through pandemics, ice storms and power outages, The Hotline cannot shut down, and our staff know it. Many victims of domestic and dating violence are one call, one text, even one chat away from serious, if not lethal violence. We must be there for them, because sometimes there is nothing else that stands between them and danger. A recent contact shared, "This conversation has been incredible; I feel like the tears in my heart are starting to dry up. Thank you for supporting me and helping me reach my own solutions. I am extremely impressed. I feel so much hope and empowerment, and like the healing has begun for me. Thank you for your beautiful words."

We recognize that you face significant budget constraints, but we urge you to fully support funding for the National Domestic Violence Hotline, and to also support funding for additional vital life-saving programs that serve survivors. Thank you again for your continued support for victims of domestic and sexual violence.

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<sup>i</sup> National Center for Injury Prevention and Control, Nation Intimate Partner and Sexual Violence survey, available at [https://www.cdc.gov/violenceprevention/pdf/NISVS\\_Report2010-a.pdf](https://www.cdc.gov/violenceprevention/pdf/NISVS_Report2010-a.pdf)

<sup>ii</sup> *Id.*

<sup>iii</sup> National Center for Injury Prevention and Control, Nation Intimate Partner and Sexual Violence survey, available at [https://www.cdc.gov/violenceprevention/pdf/NISVS\\_Report2010-a.pdf](https://www.cdc.gov/violenceprevention/pdf/NISVS_Report2010-a.pdf)

<sup>iv</sup> Centers for Disease Control and Prevention, "Physical Dating Violence Among High School Students—United States, 2003," *Morbidity and Mortality Weekly Report*, May 19, 2006, Vol. 55, No. 19.

<sup>v</sup> Centers for Disease Control and Prevention, CDC's Youth Risk Behavior Survey in 2019, available at <https://www.cdc.gov/healthyyouth/data/yrbs/feature/index.htm>.

The CHAIR. Thank you. Thank you for your advocacy.

I think we all know and you just talked and you quoted "hope and empowerment." That really is key and critical to this effort, and it has been we have moved so far with regard to domestic violence. Again, the problem exacerbated by the pandemic, hearing more about that. And so that we need to, again, as I say, seize this moment to act on it and to provide you with the trained personnel, help you with the trained personnel because somebody on the end of that line has the ability to empower, to save a life, and someone who isn't trained, it can go in a different direction.

But we are there. I mean, our people are there. Again, it is a question of what the money is going to be. But overall, there really is a very basic understanding of what the circumstances are and how we have to deal with that hope and empowerment.

Congressman Cole.

Mr. COLE. Thank you very much, and I will try and be brief, Madam Chair.

Number 1, I want to thank our witness. Very effective, very powerful advocacy. I particularly want to thank you, as a Native American, for the work that you have done in that area. That is a community, as you know, that has been disproportionately suffering from this issue.

And I want to thank two other people, too. I want to thank the President of the United States, who, as a Senator, did Violence Against Women Act and has been probably the foremost champion in this area over the years. And I want to thank our chair because we wouldn't have gotten the Violence Against Women Act reauthorized if it hadn't been riding on the back of our bill when we finally got an omnibus bill done.

And we had struggled, my friends on both sides of the aisle that were supportive of that legislation, to try and work through some of the knotty issues because how anybody can be against that legislation is beyond me. But had not been for this committee and our chair, that would still be lingering out there, would not have gotten across the finish line in this most recent omnibus bill.

So even though we are not supposed to legislate on appropriations, sometimes we do, and it has to be with the consent of both sides, obviously. And in this case, we got that. But we wouldn't have it without the leadership of my friend the chair.

But thank you again for highlighting this. Thank you for the incredible work that your volunteers and advocates and professionals do, helping people in an incredibly traumatic and difficult and often isolated situation. And when they reach out and ask for help, as my friend the chair said, it needs to be there. And robustly and quickly, and we need to help people get out of these situations or through them in a way that protects them physically and emotionally and their children physically and emotionally and, hopefully, helps anybody engaged in this activity to find a different way to work through whatever their issues and problems are.

But again, Madam Chair, you have been a leader here. I appreciate it. I look forward to continuing to work with you on it.

Yield back.

The CHAIR. Thank you. Thank you very much, and we will work with you, Katie Ray.

Let me now introduce Rick Ginsberg, dean of the School of Education at the University of Kansas, the Learning and Education Academic Research Network of the LEARN Coalition.

Mr. Ginsberg.

**RICK GINSBERG, DEAN OF THE SCHOOL OF EDUCATION, UNIVERSITY OF KANSAS, THE LEARNING AND EDUCATION ACADEMIC RESEARCH NETWORK (LEARN) COALITION**

Mr. GINSBERG. Thank you, Chair DeLauro, Ranking Member Cole, and members of the subcommittee. We appreciate your work on all of our behalf.

I have been dean at the School of Education and Human Sciences at the University of Kansas for 17 years. But in my role as dean, I am also co-chair of the LEARN Coalition, a coalition of 41 leading research universities of education across the country, which supports critical investments in research aimed at advancing the scientific understanding and improving of learning and development.

We advocate for greater funding for these priorities across all Federal agencies, and today, I will be speaking on the need for increased funding towards IES and two institutes with NIH, the National Institute of Child Health and Human Development and the National Institute on Mental Health.

I want to start by noting that the LEARN Coalition is deeply appreciative of the increases provided to IES and NIH in fiscal year 2022, and we hope to build on this momentum to continue that strengthening in fiscal year 2023.

We are also grateful for the inclusion of the report language in fiscal year 2022 on the importance of the administration appointing members to the National Board of Education Sciences. Unfortunately, NBES has been unable to meet due to lack of a quorum since 2016. We encourage the subcommittee to continue urging the administration to fill these important roles.

Turning to the main purpose of my testimony, I am here today to request no less than \$815,000,000 for IES overall, with \$225,000,000 dedicated to the Research, Development and Dissemination line-item and \$70,000,000 for the National Center for Special Education Research, NCSEER.

IES is essential to developing a comprehensive, reliable evidence base, ensuring that teaching and learning practices in our country are grounded in evidence and research. While only 12 to 15 percent of NCER and NCSEER's applications have received awards over the past several years, the number of grant competitions offered by IES are currently severely limited due to chronic understaffing within the agency.

Furthermore, NCSEER was unable to fund all the grant applications rated outstanding or excellent in fiscal year 2021 due to a lack of sufficient funds. Such evidence displays how IES is currently too understaffed and too underfunded to support the Nation's education research infrastructure.

We believe that an appropriation of \$815,000,000 for IES overall, with \$225,000,000 designated for RD&D will support the continued examination of what works and what does not work to further our education system's curriculum, instructional techniques, and as-

sessments. This additional funding should also bolster IES's work towards COVID-19 recovery.

IES is also integral to the education research training pipeline by providing key training and grant opportunities to increase the number of education researchers who can successfully compete for IES-funded research. Making the case for more IES funding, the renowned National Academy of Sciences, Engineering, and Medicine just released a report in March called "The Future of Education Research in IES."

The Academy urged Congress to increase appropriations for IES, as it is severely underfunded despite an expanding workload. Indeed, the Academy report recognized—and I am quoting them here—that IES "does not appear to be on par with that of other scientific funding agencies," in terms of the amount of the dollars.

In addition to our request for IES overall, we urge Congress to provide \$70,000,000 for special education research through NCSE. NCSE currently has a budget that has remained relatively flat since 2014. That is a long time. This has negatively impacted the research that provides special educators and administrators the evidence-based resources needed to improve academic outcomes for students with or at risk of disabilities.

Last, I would like to emphasize the importance of increased NIH funding. The LEARN Coalition was disappointed that the President's fiscal year 2023 budget request did not include a healthy increase for the base NIH budget, but rather focused on increased ARPA-H funding. ARPA-H funding certainly is important, but that should supplement and not supplant NIH funding. Specifically, we believe the two programs require strong Federal funding.

This is why the LEARN Coalition is requesting \$2,020,000,000 for NICHD to examine brain functions and the impact of different educational services on learning and development. We also support an increase in funding for NIMH to \$2,570,000,000. This increase will help further understanding of the behavioral, biological, and environmental mechanisms necessary for developing interventions to reduce the burden of mental and behavioral disorders and optimize learning and development.

The LEARN Coalition believes that, collectively, these investments in education research will drive improvements in school, teacher, and student performance in the coming years.

Thank you again for considering these requests. I am certainly happy to answer any questions you may have.

[The information follows:]

Jahrom University  
College of Education

Boston University  
Wheelock College of Education and Human  
Development

Brown College  
Lynch School of Education

Florida State University  
College of Education

Georgia State University  
College of Education & Human Development

Indiana University  
School of Education

Iowa State University College  
of Human Sciences

Johns Hopkins University  
School of Education

Lehigh University  
College of Education

North Carolina State University  
College of Education

Oklahoma University  
Norman Marshall College of Education

Penn State University  
College of Education

Purdue University  
College of Education

Syracuse University  
School of Education

Texas A&M University  
College of Education and Human Development

The Ohio State University  
College of Education and Human Ecology

University of Arizona  
School of Education

University of California – Santa Barbara  
Gerstein Graduate School of Education

University of Central Florida  
College of Community Innovation and Education

University of Connecticut  
Hoop School of Education

University of Florida  
College of Education

University of Houston  
College of Education

University of Illinois-Chicago  
College of Education

University of Illinois-Urbana-Champaign  
College of Education

University of Kansas  
School of Education

University of Maryland College Park  
College of Education

University of Minnesota  
College of Education and Human Development

University of Missouri  
College of Education

University of Nevada-Las Vegas  
College of Education

University of Nevada-Reno  
College of Education

University of North Carolina  
School of Education

University of Oklahoma  
College of Education

University of Oregon  
College of Education

University of Pittsburgh  
School of Education

University of Southern California  
Rosser School of Education

University of Texas at Austin  
College of Education

University of Vermont  
College of Education and Social Services

University of Wisconsin – Madison  
School of Education

University of Wyoming  
College of Education

Yankton University  
Paulson College of Education and Human  
Development

Virginia Commonwealth University  
School of Education



Learning and Education Academic Research Network  
Advancing the Sciences of Teaching and Learning

**Written Testimony of the Learning and Education Academic Research  
Network (LEARN) as presented to the House Subcommittee on Labor,  
Health & Human Services, Education, and Related Agencies (LHHS) by  
Dean Rick Ginsberg of the University of Kansas regarding Education  
Research Programs at IES and NIH.**

**May 26, 2022**

Good Morning/Afternoon Chair DeLauro, Ranking Member Cole and members of the Labor, Health & Human Services, Education, and Related Agencies (LHHS) Subcommittee. Thank you for welcoming me to testify today on behalf of the Learning and Education Academic Research Network (LEARN) Coalition on the importance of investing in Federal Education Research programs at the Institute of Education Sciences (IES) and National Institutes of Health (NIH). I am here today to request no less than \$815 million for IES overall with \$225 million dedicated to the Research, Development and Dissemination (RD&D) line item and \$70 million for the National Center for Special Education Research (NCSE). The LEARN Coalition is also requesting \$2.02 billion for the National Institute of Child Health and Human Development (NICHD) and \$2.57 billion for the National Institute of Mental Health (NIMH).

My name is Rick Ginsberg, and I have been the Dean of the School of Education at the University of Kansas for 17 years. In addition to my role as Dean, I am a Co-Chair of the LEARN Coalition – a coalition of 41 leading research colleges of education across the country which supports critical investments in research aimed at advancing the scientific understanding of learning and development. We advocate for greater funding for these priorities across all Federal agencies and today I will be speaking on the need for increased funding towards IES, and two Institutes within NIH: NICHD and NIMH.

I want to start by noting that the LEARN coalition is deeply appreciative of the increases provided to IES and NIH in Fiscal Year 2022 and hope to build on this momentum in FY2023 to ensure that the nation's education research infrastructure continues to be strengthened.

In addition to these increases, we welcomed the creation of a program administration line item within IES in FY2022 and hope that strong funding in the long run for this line item will allow IES to fill critically needed staff positions, ensure their budget is further insulated and perhaps expand IES's capacity to provide two, rather than one, grant cycles a year. Prior to budget cuts in 2013, IES



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*Advancing the Sciences of Teaching and Learning*

was able to successfully run two grant cycles a year providing increased research opportunities to the field.

LEARN is also grateful for the inclusion of report language in FY2022 on the importance of the Administration appointing members to the National Board of Education Sciences (NBES). Unfortunately, NBES has been unable to meet due to a lack of quorum since 2016. It is evident that the lack of NBES members is a non-partisan issue as it spans across various Presidential Administrations and IES Directorships. While we understand that NBES can only be filled through Presidential appointment, we appreciate the Congressional desire to see NBES members appointed as soon as possible in order to support the IES Director in setting IES's agenda and research priorities. We encourage the Subcommittee to continue urging the Administration to fill these important roles.

Turning to the main purpose of my testimony, I am here today to request no less than \$815 million for IES overall with \$225 million dedicated to the Research, Development and Dissemination (RD&D) line item and \$70 million for the National Center for Special Education Research (NCSER).

As the primary Federal agency charged with supporting research for education practice and policy, IES is essential to developing a comprehensive, reliable, evidence base and ensuring that teaching and learning practices are grounded in this evidence base. While only 12-15 percent of NCER and NCSE's applications have received awards over the last several years, the number of grant competitions offered by IES are currently severely limited due to chronic understaffing within the agency. Furthermore, NCSE was unable to fund all the grant applications rated outstanding or excellent in FY2021 due to a lack of sufficient funds. Such evidence displays how IES is currently too understaffed and underfunded to support the nation's education infrastructure to its potential.

The LEARN Coalition believes that education research provides the bedrock of knowledge used by our principals, teachers, counselors and professors to help preK-12 students and those seeking a postsecondary education succeed. We believe that an appropriation of \$815 million for IES overall with \$225 million designated for RD&D will support the continued examination of what works and what does not work to further our education system's curricula, instructional techniques and assessments. This additional funding will bolster IES's work in relation to education research overall as well as provide support as the nation works towards COVID-19 recovery.

IES is also integral to the education research training pipeline by providing key training and grant opportunities to increase the number of education researchers who can successfully conduct IES funded research. We believe that increased funding for IES overall will help support these efforts, particularly in diversifying who leads and works in the education research field.



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*Advancing the Sciences of Teaching and Learning*

In addition to our request for IES overall, we urge Congress to provide \$70 million for special education research through NCSER. Despite being the only Federal agency specifically designated to develop and provide evaluations of programs aimed at students with disabilities, NCSER currently has a budget that has remained relatively flat since FY2014. This has negatively impacted the research that provides special educators and administrators the evidence-based resources needed to improve academic outcomes for students with or at risk of disabilities. With many special education students dramatically impacted by the change in schooling due to COVID-19, the LEARN Coalition finds that additional funding for NCSER is necessary to support data and evidence-based resources that will ensure a strong recovery for these students.

As the Subcommittee progresses through the FY2023 appropriations process, we want to highlight other prominent experts who have expressed concern over the relatively small amount of funding being provided to IES, especially in comparison to other Federal research agencies. The renowned National Academy of Sciences, Engineering and Medicine (NASEM) released a report in March titled "[The Future of Education Research at IES](#)." In this report, the Academy urged Congress to provide increased appropriations for IES as it is severely underfunded despite a continuously expanding workload. After hours of research and discussion, the Academy's committee recognized that IES funding "does not appear to be on par with that of other scientific funding agencies," such as NIH or NSF. This low level of funding makes it difficult for IES to accomplish its charge of leading the nation's education research agenda, collecting and evaluating education research and disseminating evidence-based resources to classrooms nationwide. The LEARN Coalition urges the Subcommittee to carefully evaluate this call for additional appropriations from this trusted outside report.

Lastly, I would like to emphasize the importance of increased NIH funding. The LEARN Coalition was disappointed that the President's FY2023 Budget Request did not include a healthy increase for the base NIH budget and rather focused on increasing ARPA-H. ARPA-H funding should supplement not supplant base NIH funding. Specifically, we believe two NIH programs – NICHD and NIMH – require strong Federal funding in FY2023. Both programs provide critical funding to investigate the science behind learning and development, particularly for vulnerable groups.

This is why the LEARN Coalition is requesting \$2.02 billion for NICHD to examine brain functions and the impact of different educational services on learning and development. This increase will ensure that researchers can build on the knowledge already gained, evaluate what works best in treating developmental disorders and develop new research-based strategies to improve student's learning and development. Additionally, it will support NICHD's efforts to understand the long-term effects of COVID-19 on key at-risk populations, including the cognitive development of children and adolescents.

LEARN also supports an increase in funding for NIMH to \$2.57 billion. This increase will help further understanding of the behavioral, biological and environmental mechanisms necessary for developing interventions to reduce the burden of mental and behavioral disorders and optimize learning and development. At a time when the mental health impact to children and adolescents remains dire following the COVID-19 pandemic, this research is needed more now than ever.



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The LEARN Coalition believes that collectively these key investments in education research will drive improvements in school, teacher and student performance in the coming years, strengthen the nation's education infrastructure and ensure a strong, educated workforce in the long run. Thank you again for considering these requests. I am happy to answer any questions.

Thank you,

Rick Ginsberg, Ph.D.

Co-Chair, Learning and Education Academic Research Network (LEARN)

Dean of the School of Education, University of Kansas

The CHAIR. Let me yield to the ranking member for comments or questions that he may have.

Mr. COLE. I will try to make two quick points. First of all, number one—well, three points. Thank you for your testimony. It is very helpful, very illuminating.

Secondly, I think it is fair to say that the chair and I agree with you about the imbalance between NIH funding and ARPA-H, and we say that as joint supporters of ARPA-H. And I suspect you will see that addressed in the bill. We don't want to lose the record that we have built up of working together in a bipartisan fashion to steadily increase NIH funding. I think that has paid enormous dividends for the country.

And finally, I couldn't help but note looking behind you the very proud Kansas Jayhawk. As a fellow Big 12 guy, I want to take this opportunity to congratulate you on that amazing national title where you—where Coach Self and your Jayhawks pulled off one of the great games I have ever seen in an NCAA final. So, well done, Kansas.

So, with that, Madam Chair, yield back.

The CHAIR. Thank you. Thanks very, very much.

And the ranking member addressed the issue that we will try to create the balance in NIH and with ARPA-H in terms of basic research. But also I think it is fascinating in the testimony, we had a hearing, it may have been yesterday—you lose track of time around here. But where we heard that with regard to special education teachers, that there really is such a shortage, and they feel that grows bigger with the number of kids that we are trying to provide an education for.

So the role of being able to increase that number or understanding how it needs to be taught and, therefore, then the training of professionals in this area I think could really be helpful overall in terms of a quality education for our kids. But it is the data, you are a little bit like—this seems to be like the Bureau of Labor Statistics, the BLS for education with the information that you put together, but it is how you learn and how you teach. Basic fundamental questions of that underlie so much of what we do in the K through 12 space and then higher education.

So the function of your efforts are really critically important in underlying the kind of directions that we can go in in terms of our programming. So I thank you very, very much for this rich testimony about a vital area with regard to education, and thank you very much for being with us today.

Thank you.

Mr. GINSBERG. Thank you both.

The CHAIR. Let me introduce now Antonio Flores. Dr. Flores, president and CEO of the Hispanic Association of Colleges and Universities. Please, we recognize you for 5 minutes for your testimony.

**ANTONIO R. FLORES, PRESIDENT AND CEO, HISPANIC  
ASSOCIATION OF COLLEGES AND UNIVERSITIES**

Mr. FLORES. Chair DeLauro, Ranking Member Cole, and members of the subcommittee, thank you for the opportunity to testify

on the importance of investing equitably in Hispanic-Serving Institutions for fiscal year 2023.

The Hispanic Association of Colleges and Universities, HACU, was founded in 1986 and is the only national association that represents HSIs. These 559 institutions enroll over 5 million students in the United States, the District of Columbia, and Puerto Rico.

I urge you, respectfully, to fund Title V Parts A and B of the Higher Education Act as follows—\$250,000,000 for Developing Hispanic-Serving Institutions, Title V, Part A, or \$67,150,000 above fiscal year 2022, and \$100,000,000 for Promoting Postbaccalaureate Opportunities for Hispanic Americans under Title V, Part B, or \$80,340,000 above fiscal year 2022.

HSIs educate more than 5 million students annually, including two-thirds of the estimated 3.8 million Hispanic college students in American higher education. Most of them are first-generation college students and come from low-income families. They also, HSIs, enroll twice as many African Americans as all the Historically Black Colleges and Universities combined, more than 40 percent of all Asian Americans in college today, and twice as many Native Americans as all the tribal colleges and universities put together, as well as a sizable number of non-Hispanic Whites.

Additionally, while only accounting for 16 percent of all the colleges and universities in the country, HSIs enroll 31 percent of all the Pell recipients. Despite their great diversity and need, HSIs remain at the bottom of the Federal funding priorities, compared to other Minority-Serving Institutions and HBCUs.

Federal investments are essential to strengthen our workforce by enhancing educational attainment, especially in STEM and other fields of national priority. The U.S. Census Bureau reported that from 2010 to 2020, Hispanics accounted for more than half the total growth of our national population and are now over 63 million strong. And it has estimated that the Hispanic population will grow by 93.5 percent from 2016 to 2060. Therefore, from 2020 to 2030, three of every four new workers joining the American labor force will be Hispanic.

HSIs educate and train the most diverse and underserved communities and do so with fewer Federal resources per student than their peer institutions. As the Nation looks to rebuild the economy after the pandemic, it is critical that Federal investments strengthen our workforce by enhancing the educational capacity of HSIs to pave the path of success and opportunity for Hispanics and other underserved Americans.

As the Hispanic growth rate in K–12 enrollment continues to accelerate, the number of Hispanic high-school graduates is expected to increase by 49 percent between 2012 and 2028, compared to 23 percent for Asian/Pacific Islanders and to a net drop of 3 percent and 15 percent for blacks and whites, respectively.

The Bureau of Labor Statistics has projected that the Latino share of the workforce will increase dramatically from 1 in 10 in 2010 to 1 in 3 by 2050, while white workers will decrease in number considerably. Blacks will remain at 12 percent. Asian Americans will increase from 5 to 8 percent, and all others from 2 to 5 percent.

For America to remain competitive in the global economy, a much better educated and trained Hispanic labor force is required. HSIs must be placed at the top of Federal investment priorities without further delay.

HACU and its supporters wholeheartedly commend the U.S. Congress and the administration for funding generally HBCUs and other Minority-Serving Institutions, and we urge them to continue doing so. Likewise, we exhort Congress and the President to invest with equal commitment in HSIs and their underserved students. They truly are the future of the Nation.

On behalf of HACU and the Nation's 559 Hispanic-Serving Institutions it represents, I thank you most sincerely for your time and consideration of our request.

[The information follows:]

**Testimony of Antonio R. Flores, PhD, President & CEO, Hispanic Association of Colleges and Universities**

**Presented to the U.S. House of Representatives Committee on Appropriations  
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies**

Chairwoman DeLauro, Ranking Member Cole, and Members of the Subcommittee, thank you for the opportunity to testify in front of the Subcommittee to discuss the importance of investing in Hispanic-Serving Institutions (HSIs). My name is Antonio Flores and I am the President & CEO of the Hispanic Association Colleges and Universities (HACU). HACU was founded in 1986 and is the only national association that represents HSIs. These 559 HSIs enroll 5.1 million students in the United States, the District of Columbia, and Puerto Rico. I am here today to discuss HACU's Fiscal Year (FY) 2023 requests for Title V, Part A and Part B under the Department of Education. We urge you to fund our HSIs commensurate to their growth and student populations in a manner that would be fair and equitable by making the following historic investments in HSIs:

1. \$250,000,000 for Developing Hispanic-Serving Institutions (Title V, Part A): \$67,150,000 above FY2022; and
2. \$100,000,000 for Promoting Postbaccalaureate Opportunities for Hispanic Americans (Title V, Part B): \$80,340,000 above FY2022.

HACU commends the committee for increases to Title V Part A and Part B in recent years, including the \$34.12 million increase for Part A and \$5.81 million increase for Part B in FY2022. These funds are critical to HSIs as these are their main federal funding vehicles. Unfortunately, funding levels have not kept up with the number of HSIs. Since their codification in 1992 as part of the amendments to the Higher Education Act of 1965, as amended, HSIs have continued to grow exponentially from 311 in 2010 to 569 in 2019, for example. However, the pandemic saw the number of HSIs decrease, for the first time in 20 years, to 559, partly due to the economic and social impacts that disproportionately affected Hispanic students.

HSIs educate more than 5 million students, including two-thirds of the estimated 3.8 million Hispanic students in American higher education, most of whom are first-generation college students and come from low-income families. HSIs also enroll twice as many African American students as Historically Black Colleges and Universities (HBCUs), 41% of all Asian Americans, 21% of all Native Americans, and 16% non-Hispanic White students in U.S. higher education. Additionally, while only accounting for 16% of higher education institutions, HSIs enroll 31% of Pell recipients. Despite their great diversity and need, HSIs remain at the bottom of the federal funding priorities, compared to other Minority-Serving Institutions (MSIs) and HBCUs.

HSIs are consistently asked to do more with less. The first Congressional HSI appropriation in FY1995 was a meager \$12 million for more than 125 HSIs. As the number of HSIs has climbed rapidly, federal funding has been paltry over the years and amounted to a mere \$315.7 million in FY21, including \$221.6 in discretionary funds.

Coupled with persistent federal underfunding, COVID-19 has exacerbated the financial needs of HSIs: delayed deferred maintenance, access to broadband, classroom facilities enhancements, and much needed wrap-around student services, particularly health and psychological services. As the pandemic lingers on, the funding needs of HSIs will become more critical. In a report released by HACU in September 2021,<sup>1</sup> HACU surveyed HSIs and received 111 responses on their infrastructure needs that require capital financing. More than nine in every 10 HSIs need funding for construction of new buildings, facilities, and classrooms; eight of every 10 for deferred maintenance; three of every four for IT infrastructure; and more than two-thirds for repairs. Prior to the COVID-19 pandemic, HSIs already lacked sufficient funding and resources for up-to-date and “smart” technology equipped classrooms, state-of-the-art science laboratories, human patient simulators and skills labs, libraries, and other infrastructure needs. Currently, too many HSI classrooms are outdated and underequipped, libraries lack essential digital assets and holdings, and buildings are not equipped with the necessary broadband technology that has become a standardized part of the learning experience for all students.

Federal investments are essential to our HSIs in an effort to strengthen our workforce by enhancing educational attainment, especially in STEM and other fields of national priority. The U.S. Census Bureau reported that from 2010 to 2020 Hispanics, accounted for more than half the total growth of the national population and are now over 63 million, and it estimates that the Hispanic population will grow by 93.5% from 2016 to 2060.<sup>2</sup>

HSIs educate and train the most diverse and underserved communities and do so with fewer federal resources per student than their peer institutions. As the nation looks to rebuild the economy after the pandemic, it is critical that federal investments strengthen our workforce by enhancing the educational infrastructure of HSIs to pave the path of success and opportunity for Hispanic Americans for the FY2023.

As the Hispanic growth-rate in K-12 enrollment continues to accelerate, the number of Hispanic high-school graduates is expected to increase by 49% between 2012-13 and 2028-29, compared to 23% for Asian/Pacific Islanders, and to a net drop of 3% and 15% for Blacks and Whites, respectively. In fact, NCES projected in the same study an increase of 14% in Hispanic college enrollment between 2017 and 2028 from 3.5 million to over 4.0 million, but it may be under-projecting as in 2020 there were already 3.8 million Hispanics college students, 67% of them at HSIs.<sup>3</sup>

Investing in HSIs is an investment in a successful American workforce. Given the preceding demographic trends and projections, it is evident that the nation’s labor force is also becoming increasingly Hispanic. The U.S. Bureau of Labor Statistics (BLS) reports that Hispanics have the highest participation rate in the American labor force, which in 2019 was 66.8%, compared to 63.0% for Whites and 62.4% for Blacks.<sup>4</sup>

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<sup>1</sup> <https://www.hacu.net/NewsBot.asp?MODE=VIEW&ID=3424>

<sup>2</sup> <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf>

<sup>3</sup> <https://nces.ed.gov/pubs2020/2020024abbrev.pdf>

<sup>4</sup> <https://www.bls.gov/emp/tables/civilian-labor-force-participation-rate.htm>

A U.S. BLS study projected that the Latino share of the workforce will increase dramatically from 1 in 10 in 2010 to 1 in 3 by 2050, while Whites will decrease from 81% to 75%, Blacks will remain at 12%, Asian Americans will increase from 5% to 8% and all others from 2% to 5% during the same span of time.<sup>5</sup> Currently, more than half of all the new workers joining the nation's labor force are Hispanic. For America to remain competitive in the global economy, a much better educated and trained Hispanic labor force is required. As the backbone of Hispanic postsecondary education, HSIs must be placed at the top of federal investment priorities without any further delay.

HACU and its supporters wholeheartedly commend the U.S. Congress and the Administration for investing significantly in HBCUs and other MSIs and urge them to continue doing so. Likewise, we exhort Congress and the President to invest with equal commitment in HSIs and their underserved students; they truly are the future of the nation.

**Presented virtually on May 26, 2022.**

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<sup>5</sup> <https://www.bls.gov/opub/mlr/2012/10/art1full.pdf>

The CHAIR. Thank you so much. I really appreciate your testimony, Dr. Flores.

And really, you never sit back on what you have done, but always to move forward. But I was very excited that what we did in this conference committee in the 2022 bill, we increased the HSIs about 23 percent, and it was historic in terms of that. And I am just going to leave it with this, that it is my intention that we continue that historic climb with regard to HSIs.

Mr. FLORES. Thank you.

The CHAIR. So I thank you for what you do, and really, it is a pleasure to listen to you.

Thank you.

And with that, let me yield to Congressman Cole.

Mr. COLE. Thank you very much, Madam Chair.

And Dr. Flores, that was an excellent presentation. Really compelling, frankly. And the statistics that you laid out are, I think, more than informative. I think they are persuasive as well, and I agree with the chair. These are institutions that are doing an amazing job, and as your numbers suggest, they are only going to become more important in the future as this population becomes a larger percentage of our total population.

So this is an area that I know my friend and I will work on together. I was very pleased to see the increase in the appropriations in the 2022 bill, and I pledge to continue to work with her to see that we try to move forward in this area. But again, thank you for an excellent, excellent presentation.

With that, I yield back, Madam Chair.

The CHAIR. Thank you.

Let me recognize Janet Hamilton, the executive director of the Council of State and Territorial Epidemiologists.

**JANET HAMILTON, EXECUTIVE DIRECTOR, COUNCIL OF  
STATE AND TERRITORIAL EPIDEMIOLOGISTS**

Ms. HAMILTON. Chair DeLauro, Ranking Member Cole, and members of the subcommittee, thank you for the opportunity to testify today. I am Janet Hamilton, executive director of the Council of State and Territorial Epidemiologists, or CSTE. CSTE represents public health epidemiologists nationwide working to respond to emerging public health threats. For fiscal year 2023, CSTE asks that you provide at least \$250,000,000 for CDC's Data Modernization Initiative, or DMI.

Since I last testified in front of this committee 3 years ago, we have made progress in our public health data systems, delivering data faster to save lives, but we are not done yet. As we saw during COVID-19, our public health data systems were not prepared, nor is COVID-19 the last threat we will face. As we speak, a monkey pox outbreak is spreading globally, and a completely new threat is causing unexplained hepatitis in children. State and local public health departments are busy responding to these potential cases, but they cannot do this without the key data pieces to inform the investigation.

Public health response happens at the local level, and we must preserve the role that State, territorial, tribal, and local health departments play in our public health data infrastructure. Led by the

CDC, State and local health departments need a nationwide public health surveillance system to detect and respond to the threats. To build this infrastructure, we need the resources to support our existing laws. All States have laws that require the reporting of certain public health threats by physicians, hospitals, and laboratories. It is the process by which these data are reported that the DMI seeks to improve.

With our partners in the Data: Elemental to Health Campaign, CSTE called on Congress to provide the first-ever dedicated funding for public health data systems in fiscal year 2020. Thanks to this subcommittee, Congress has provided more than \$1,000,000,000 through annual and supplemental appropriations for DMI. Data: Elemental to Health estimates that the actual need for data modernization is at least \$7,840,000,000 over 5 years. Yes, we know that is a big number, but we also know how important it is to get this right.

There are five key pillars of the Data Modernization Initiative that are part of an enterprise-wide interoperable approach. More details are available in my written testimony, but to recap quickly, first, electronic case reporting, or ESR, assures that when providers see patients' demographic and clinical information, along with test results for reportable conditions, they are rapidly shared with State and local public health. ECR is closing health equity blind spots. Initial implementations demonstrate over 90 percent completeness of race and ethnicity data, far better than the 65 percent we had without this critical tool.

State, local, tribal, and territorial health department staff contact and interview cases and then provide the case investigation data to the National Notifiable Disease Surveillance System, NNDSS, the second pillar of DMI, but resources are lacking. With COVID-19, there are numerous examples where health department staff conduct outbreak investigations or identify clusters from genomic sequencing but are unable to electronically share those data with NNDSS due to agency infrastructure shortages.

The third pillar of DMI is electronic lab reporting where labs submit test results to public health as soon as they are available. Test results often serve as the first piece of information received by State and local public health to launch a rapid response. The fourth pillar is electronic vital records systems, which ensures real-time transmission of birth and death data for statistical and surveillance purposes. And the fifth pillar, the National Syndromic Surveillance Program, helps detect, monitor, control, and prevent emerging diseases.

These five pillars are interwoven, and each plays a key role in moving us from a sluggish, outdated, and burdensome patchwork system to a 21st century public health data infrastructure that provides complete, accurate, and instantaneous data. We do not have a science problem. We have a resource problem. To make our public health systems work now and in the future, we need regular, sustained annual funding for our public health surveillance systems and data workforce.

Again, we respectfully request the subcommittee provide at least \$250,000,000 for DMI in fiscal year 2023. Thank you.

[The information follows:]

**Janet Hamilton, MPH, Executive Director  
Council of State and Territorial Epidemiologists  
Appropriations Committee  
Subcommittee on Labor, Health and Human Services, Education and Related Agencies  
In Support of FY 2023 Funding for CDC's Data Modernization Initiative**

Chair DeLauro, Ranking Member Cole, and members of the Subcommittee, thank you for the opportunity to submit this testimony in support of at least \$250 million in Fiscal Year (FY) 2023 funding for the Data Modernization Initiative (DMI) and the Center for Forecasting and Outbreak Analytics (CFA) at the Centers for Disease Control and Prevention (CDC). I am Janet Hamilton, the Executive Director of the Council of State and Territorial Epidemiologists (CSTE). CSTE represents public health epidemiologists nationwide working on the front lines to respond to emerging public health threats—including, recognizing and identifying the very first introductions of COVID-19, and then responding daily during the COVID-19 pandemic.

As you know, COVID-19 exposed deadly gaps in our nation's public health data infrastructure. After years of neglect, our antiquated public health data systems were not prepared to handle the onslaught of a pandemic caused by a highly infectious virus. Instead, paper-based systems, phone calls, spreadsheets, and faxes requiring data entry by hand remain in widespread use and left us ill-equipped to combat the spread of the virus as it emerged and surged. Delayed detection and response had dire consequences. And, while COVID-19 is the most recent—and ongoing—threat that requires a robust public health response, it is not the only threat we face nor last public health threat we will face. As we submit this, an outbreak of Monkeypox in the US and other non-endemic countries is occurring and a new emerging threat leading to unexplained hepatitis in children is emerging – illnesses (potentially due to adenovirus) can be severe, associated with hospitalization and liver transplants in some children. Led by the CDC, state and local health departments across the country need a nationwide public health surveillance system to detect emerging threats and facilitate immediate response to keep our population safe.

Prior to the COVID-19 pandemic, CSTE initiated the call for improved public health surveillance systems. The pandemic only made it clear that this goal cannot wait. With our partners at the Data: Elemental to Health Campaign we called on Congress to provide the first ever dedicated funding for public health data systems and to build a 21<sup>st</sup> century public health data superhighway. Thanks to the work of this Subcommittee, Congress answered the call and has provided more than \$1 billion to date in annual funding as well as critical injections of supplemental funding through the CARES Act and the American Rescue Plan for CDC's public health DMI.

The DMI is a commitment to building the world-class data workforce and data systems that support daily operations and are 'response-ready' for the next public health emergency with capacity to surge and scale. We need far more resources to meet our nation's current and long-term public health surveillance needs, which Data: Elemental to Health estimates will cost at least \$7.84 billion over five years. In the immediate term, we need robust, sustained, annual funding for DMI to ensure we are providing resources for public health systems and infrastructure, including at state and local health departments, to keep pace with evolving technology.

DMI is an enterprise approach and there are five key interconnected pillars essential for public health data modernization. They are: Electronic Case Reporting, the National Notifiable Disease Surveillance System, the Electronic Vital Records System, Syndromic Surveillance, and Laboratory Information Systems.

We need electronic Case Reporting (eCR) to give health care providers a means to seamlessly communicate with public health. eCR will help guarantee that when providers see patients—in any setting—patient demographics, clinical information, and test results for reportable conditions (including, but by no means limited to COVID-19) are rapidly shared with state and local public health and then able to be seamlessly incorporated into CDC's National Notifiable Disease Surveillance System (NNDS). eCR also assists with data completeness and rapidly understanding health inequities. DMI investments in eCR are already paying off. For example, race and ethnicity

data received on case reports in pilot jurisdictions are over 90% complete which will support a more robust ability to appropriately address health disparities. All 50 states, DC, and Puerto Rico, as well as 13 jurisdictions have received initial electronic case reports for COVID-19 and more than 18 million COVID-19 case reports have been sent electronically to public health agencies.

Resources are needed to make improvements in NNDSS and rapid data submission from states to CDC. For example, state, territorial, local, and tribal health department staff serve as disease detectives contacting and interviewing cases gathering detailed information to learn how and where they may have become infected—are they part of a cluster or outbreak, or what co-factors may have led to a more severe illness? For example, during the Zika response, case investigations conducted by the local health department identified persons working on elevators were at increased risk of infection as standing water often collected in the bottoms of open-air elevator shafts serving as breeding location for mosquitos. After case investigations and interviews are conducted, resources are needed to provide those details to the CDC through NNDSS. Numerous similar examples exist for COVID-19 where health department staff conduct outbreak investigations or identify clusters from genomic sequencing but are unable to electronically share those data with CDC's NNDSS due to agency infrastructure shortages. Additionally, right now, there are multiple jurisdictions who have the desire to provide more detailed COVID-19 case information to CDC, but don't have the data work force and resources to update file structures and data processes to submit those data.

We need an electronic lab test ordering and result process that supports the collection of information to launch a rapid public health response. Seamless electronic communication is critical—a health department forced to sort through mailed or faxed lab reports will not be able to respond promptly or adequately to an emerging threat. Investments here have also shown early success. Electronic laboratory reporting (ELR), which has been expanded to have implementations across the country, formed the backbone of our case surveillance for COVID-19, enabling states, localities, territories, tribes and the federal government to have timely information to identify

potential cases, where those cases lived, and basic information about their age. Without ELR we would never have been able to conduct control measures and know what was happening in virtually every jurisdiction. While we still have many laboratories to incorporate into ELR, in many jurisdictions this information is automatically uploaded and ready for analysis within a day of the result. These digital roads must be maintained as new tests or test types are added and performed in the laboratory.

We need improvements to our electronic vital records systems to ensure real-time transmission of birth and death data for statistical and—critically during a pandemic—surveillance purposes. We must make sure systems are interoperable so physicians, coroners, medical examiners, and funeral directors can seamlessly report deaths through their existing electronic records systems—eliminating delays and reducing errors.

Standards-based interoperability will also help identify threats as they emerge. As it stands, nearly one third of all emergency department visits are not reported to the National Syndromic Surveillance Program, which helps detect, monitor, control and prevent emerging diseases.

These five pillars are interwoven, and each plays a key role in moving the United States from an outdated and burdensome patchwork of systems to a 21<sup>st</sup> Century public health data infrastructure that provides complete, accurate, and instantaneous data. Again, DMI is an enterprise-wide approach, which will support widespread and rapid access to public health data for all public health programs at all levels of government for all diseases and conditions. Currently, CDC has many siloed public health surveillance systems, many of which are not interoperable, which results in duplicated and redundant data entry or data submission. DMI will help break down those siloes and ensure all systems are integrated and interoperable.

Equally important is a skilled workforce that includes epidemiologists, public health informaticists, data scientists, and other experts—all of whom work together so that the public health surveillance system can detect and monitor current threats and ready for the next pandemic.

The Administration has committed to strengthening our nation's public health workforce, including epidemiologists and data scientists and we urge the committee to continue to provide resources towards this goal, an important step forward to grow and build the next-generation public health workforce and we hope to see the committee support continued funding to sustain this progress.

Working hand-in-hand with DMI, CDC's newly established CFA will facilitate the use of data, modeling, and analytics to improve pandemic preparedness and response. The CFA is already doing critical work, including helping to inform government response to the spread of the Omicron variant of COVID-19 in late 2021.

We do not have a science problem; we have a resource problem. The core data systems for a national infrastructure already exist they must be modernized and maintained so they can keep pace with new technology.

CSTE applauds President Biden for proposing an unprecedented investment in CDC through his discretionary budget request. The President requested \$10.675 billion for CDC. As part of this significant and well-warranted proposed increase, the President "prioritizes investments that will modernize public health data collection, increase capacity to forecast and analyze future outbreaks, and operationalize lessons learned from the COVID-19 response." We also support the President's proposal to invest \$81.7 billion in mandatory funding toward pandemic preparedness efforts, including \$28 billion for CDC to invest in critical efforts, including public health infrastructure and DMI. We encourage Congress to make this proposal a reality.

To make our public health systems work now, and in the future, we need regular, sustained annual funding for our public health surveillance. We respectfully request the Subcommittee provide funding of *at least* \$250 million for DMI and \$50 million for CFA at CDC in Fiscal Year 2023.

Thank you.

The CHAIR. Thank you very, very much. We put in, I guess, \$100,000,000 in the 2022 bill for data modernization. I think we have had enough hearings, and, again, that was done on a bipartisan basis. I think there is a recognition that we nearly had the collapse of the CDC during the pandemic because of a lack of public health infrastructure. So let me be succinct with you. We are committed to doing that. Again, I was at the CDC on Friday, and we had a report on data modernization, which is extraordinary, and progress has already been made. We are going to work to continue to move that forward.

And also, I want to try to take a look at introducing what are the kinds of authorities the CDC needs to have in order to be able to collect data on a uniform basis and have the data reported back to the CDC in real time, and not have a patchwork of data that is out there that is held back from the CDC. So I will leave it there but committed to increasing that opportunity. We have to come out of this pandemic with the public health infrastructure so that, in fact, this doesn't happen again with regard to the CDC. The CDC is too vital to our, you know, healthcare system.

Congressman Cole.

Mr. COLE. Thank you very much, Madam Chair. Dr. Hamilton, I remember the last time you testified because it was one of the very last hearings that we had—

Ms. HAMILTON. Yes.

Mr. COLE [continuing]. Before COVID hit us, and in that sense, prophetic in the warnings that you and others were issuing about the need to do exactly what you are here advocating for today. And I will reiterate the chairman's support. We think what you are doing is important. We think these investments are critical. We think they need to be sustained going forward, but it is always timely for you to come back and remind us, and I will be working with the chair so we can continue the progress we have made. I think it is absolutely essential to the public health and well-being of the American people going forward that we get out of this patchwork into a much more uniform, modern, and effective system that gives us the information we need to respond in a timely fashion to threats that genuinely, as we saw, can quickly get out of hand and be just devastating to our population and, honestly, people around the world.

So, again, I don't think this is an area of any debate between the chair and me. I think this is an area where we will have to scratch our heads and see how we find the resources for all these worthy causes, but there is just no question this investment needs to be made. But thanks for coming before the committee. Thank you for the work you and your colleagues in public health have done and for the extraordinary performance over the pandemic where, you know, I have just seen local public health people do amazing things. And the data has made a difference as Congress has tried to come together and figure out what to do during the pandemic to both minimize the loss of life and get us through this to the other side of it with our economy intact and our people damaged as little as possible. So thanks for your contributions.

I yield back, Madam Chair.

The CHAIR. Thank you. I recognize Ms.—let me see if I have this right—Szilagyi.

Ms. SZILAGYI. Very good.

The CHAIR. Okay. That is great. Thank you. President of the American Academy of Pediatrics. Wonderful to have you with us today. Thank you.

**MOIRA SZILAGYI, PRESIDENT, AMERICAN ACADEMY OF  
PEDIATRICS**

Dr. SZILAGYI. Thank you so much. To Chairwoman DeLauro and Ranking Member Cole, thank you so much for the opportunity to participate in today's public witness testimony. My name is Moira Szilagyi. I am a primary care pediatrician and president of the American Academy of Pediatrics. On behalf of AAP, I thank you for all of your efforts to fund programs that are essential for the optimal health and well-being of children.

While I address numerous programs that are important for children's health in my written testimony, my original plan today was to focus on three programs of particular importance: firearm injury and mortality prevention research, the Pediatric Subspecialty Loan Repayment Program, and the Pediatric Mental Health Care Access Program. I plan to talk about the need to address the serious gaps in the pediatric workforce by increasing funding for the Pediatric Specialty Loan Replacement Program to \$30,000,000 to improve access to care for children with special healthcare needs. This program is vital and very much needed. And I had planned to discuss increasing funding for the Pediatric Mental Health Care Access Grant Program to \$14,000,000 to help meet the mental health challenges facing young people and the rates of suicide, anxiety, and depression that have all been exacerbated by the COVID-19 pandemic, especially among people of color. We do need to increase mental health services for children and enhance the capacity of pediatric primary care providers to screen, treat, and refer children with mental health concerns.

But then we got the news about the school shooting at Robb Elementary School in Uvalde, Texas, on Tuesday, and that is what is at the top of my mind today: 19 students and two teachers killed by gunfire. Just like the 10 people shot at the Tops Supermarket in Buffalo and the one person killed and five injured at the Irvine Taiwanese Presbyterian Church in my home State of California just weeks ago, there is never any justification for this kind of violence anywhere, ever, and yet we as a Nation have been here before too many times. Columbine High School, Sandy Hook Elementary, Marjorie Stoneman-Douglas High School, and so many other schools have been sites of terror, violence, and death.

Many more daily acts of gun violence do not even make the headlines but also rob children of their childhood and families of their children. Just visit a hospital emergency department to see the daily toll of firearm injuries. In fact, a CDC report published just this month showed that the U.S. experienced a historic rise in gun deaths in 2020, and communities of color were disproportionately harmed. As a pediatrician, parent, and grandmother, and someone whose personal life has been effected by gun violence, I urge you to stand up for those killed or injured by gun violence.

The AAP was extremely grateful when this subcommittee agreed to provide Federal funding for gun violence prevention research in the 2020 fiscal year for the first time in 25 years, and we are tremendously appreciative of Congress providing \$25,000,000 to the CDC and NIH for firearm injury and mortality prevention research for the last 3 fiscal years. But if events from the past several weeks show anything, it is that we need to do more, and one thing we need to do is increase research on ways to reduce gun violence and disparities in gun-related deaths, and to prevent the next shooting at a school, a church, or another public setting.

Federally-funded public health research has a proven track record of reducing deaths, whether from motor vehicle accidents or smoking. The same approach should be applied to increasing gun safety and reducing firearm-related injuries and deaths, including suicides. Continuing and expanding CDC and NIH research is critical to that effort. We strongly urge Congress to increase the funding level for firearm injury and mortality prevention research to \$35,000,000 for the CDC and \$25,000,000 for NIH.

We should never become accustomed to acts of gun violence. We owe to the children in that classroom in Uvalde, the people shopping at Tops, and the parishioners at the Irvine Taiwanese Presbyterian Church to increase our efforts. Thank you so much for allowing me to testify today. I look forward to continuing this conversation.

[The information follows:]

**Testimony of Moira Szilagyi, MD, PhD, FAAP  
President, American Academy of Pediatrics**

**Before the House Appropriations Subcommittee on Labor, Health  
and Human Services, Education and Related Agencies**

**Public Witness Testimony  
May 26, 2022**

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Chairwoman DeLauro, Ranking Member Cole, and members of the subcommittee, thank you for the opportunity to testify before you today. My name is Dr. Moira Szilagyi and I am testifying today as the president of the American Academy of Pediatrics (AAP), a non-profit professional membership organization of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health and well-being of children. The AAP urges all Members of Congress to put children first when considering short and long-term federal spending decisions, and supports funding levels for the following programs: \$30 million for Pediatric Subspecialty Loan Repayment (HRSA), \$60 million for Firearm Injury and Mortality Prevention Research (CDC/NIH), \$14 million for Pediatric Mental Health Care Access Grants (HRSA), \$28.134 million for Emergency Medical Services for Children (HRSA), \$205 million for the National Center for Birth Defects and Developmental Disabilities (CDC), \$356 million for Global Immunizations (CDC), \$12 million for implementation of Scarlett's Sunshine Act (CDC/HRSA), \$26.2 million for the administrative component of the National Vaccine Injury Compensation Program (HRSA), and \$15 million for provisions in the Vaccine Awareness Campaign to Champion Immunization Nationally and Enhance Safety (VACCINES) Act (CDC).

In addition to my responsibilities as President of the Academy, I am a primary care pediatrician and Professor of Pediatrics at UCLA where I serve as the Division Chief of Developmental/Behavioral Pediatrics and the Peter Shapiro Term Chair for the Promotion of Child Developmental and Behavioral Health.

As pediatricians, we not only diagnose and treat our patients, we also promote preventive interventions to improve overall health. Likewise, as policymakers, you have an integral role in ensuring the health of future generations through adequate and sustained funding of vital federal programs. As such, we urge you to pass strong policies that invest in children in the earliest days of life. We implore you to take meaningful strides to address chronic poverty, homelessness, food insecurity, adverse childhood experiences and other social determinants of health that have long lasting impacts on the health and well-being of American children and their families.

As the last several years have taught us, we also need to make robust investments in preventive, primary, mental, and behavioral health care, workforce development, violence and injury prevention efforts, improving confidence in vaccines, and enhancing the quality of life across the lifespan for Americans with disabilities and other vulnerable citizens.

To achieve these ends, AAP supports robust funding of the Department of Health and Human Services (HHS) and its individual agencies which all combine to support important programs that ensure the health and safety of children. Federal funding through these agencies supports critical programs that address pressing public health challenges, and, therefore, the AAP urges the Subcommittee to support robust funding for the following programs detailed below.

**Firearm Injury and Mortality Prevention Research (CDC/NIH):** *FY 23 Request: \$60 million total; FY 22 Level: \$25 million total.*

The AAP is tremendously appreciative of and applauds Congress for continuing to provide \$25 million total, split evenly between CDC and NIH, for firearm injury and mortality prevention research in FY 22. Unfortunately, as we just witnessed at Tops Supermarket in Buffalo and the Irvine Taiwanese Presbyterian Church in California, gun violence remains a public health problem in the United States. In the midst of the COVID-19 pandemic, communities across the nation continue to suffer from increased levels of firearm-related injuries and death. In fact, a recent CDC report showed that the U.S. experienced a historic rise in gun deaths in 2020, affecting all age groups, and widening existing racial and ethnic disparities across the nation. Of particular concern, data showed that the gun death rate among young black men and boys, aged 10 to 24, was 21 times higher than the rate of young white men and boys in the same age group. Worse, the dearth of research on how best to prevent firearm-related morbidity and mortality makes it difficult to address it. Federally funded public health research has a proven track record of reducing public health-related deaths, whether from motor vehicle crashes or smoking. This same approach should be applied to increasing gun safety and reducing firearm-related injuries and deaths, including suicides, and continuing and expanding CDC and NIH research will be critical to that effort. As such, for FY23, the Academy urges Congress to allocate \$60 million for firearm injury and mortality prevention research, with \$35 million dedicated to CDC and \$25 million to NIH.

**Pediatric Subspecialty Loan Repayment Program (HRSA):** *FY 23 Request: \$30 million; FY 22 Level: \$5 million.*

The AAP appreciates first-time funding of \$5 million in FY22 for the Pediatric Subspecialty Loan Repayment Program, a Title VII health professions program designed to improve access to care for children with special health care needs by offering loan repayment to pediatric subspecialists and child mental health providers who agree to serve in an underserved area. To expand the number of beneficiaries of this program, the Academy respectfully requests \$30 million in FY23. The United States' current supply of pediatric subspecialists is inadequate to meet children's health needs. Many children must wait more than 3 months for an appointment with a pediatric subspecialist, and approximately 1 in 3 children must travel 40 miles or more to receive care from a pediatrician certified in certain subspecialties such as developmental behavioral pediatrics. Spotlighting the needs of children with autism spectrum disorder (ASD), as an example, there are approximately 1.5 million children with ASD but there are only about 700 practicing board-certified developmental-behavioral pediatricians. The national wait time for a pediatric developmental evaluation is 5.4 months. In terms of equity, ASD prevalence among Hispanic children is about 16% lower than among white and black children, which suggests that more Hispanic children with autism are not being identified. In

addition, black children with ASD are significantly less likely than white children to have a first evaluation by the age of three.

**Pediatric Mental Health Care Access Grants (HRSA):** *FY 23 Request: \$14 million; FY 22 Level: \$11 million.*

The AAP appreciates the support Congress has shown for Pediatric Mental Health Care Access Grants, with \$11 million in funding for the program in FY22, as well as robust funding in the American Rescue Plan in recognition of the impact of COVID-19 on child and adolescent mental health. The 45 states, tribal organizations, and territories who are receiving grants through this program are providing tele-consultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat and refer children with behavioral health conditions. Research shows pervasive shortages of child and adolescent mental/behavioral health specialists throughout the United States. Integrating mental health and primary care has been shown to substantially expand access to mental health care, improve health and functional outcomes, increase satisfaction with care, and achieve costs savings. In fact, a recent RAND study found that 12.3% of children in states with programs such as the ones funded under this HRSA program had received behavioral health services while only 9.5% of children in states without such programs received these services. In FY23, the AAP urges Congress to provide \$14 million in funding for Pediatric Mental Health Care Access Grants so that HRSA can maintain and expand this program to every state, tribal organization, and territory while also allowing programs to expand their services to schools and emergency departments.

**Emergency Medical Services for Children (HRSA):** *FY 2023 Request: \$28.134 million; FY 22 Level: \$22.334 million.*

The AAP urges the committee to increase funding for the Emergency Medical Services for Children (EMSC) Program to \$28.134 million in FY 23. EMSC is the only federal program that focuses specifically on improving the pediatric components of the emergency medical services (EMS) system. EMSC aims to ensure state of the art emergency medical care is available for the ill and injured child or adolescent, pediatric services are well integrated into an EMS system backed by optimal resources, and that the entire spectrum of emergency services is provided to all children and adolescents no matter where they live. An additional \$5.8 million in funding in FY23 will allow the program to provide increased funding to states to address gaps in children's access to high quality emergency and trauma care as well to support states building mental health capacity for children in emergency departments.

**National Center for Birth Defects and Developmental Disabilities (CDC):** *FY 23 Request: \$205 million; FY 22 Level: \$177.06 million*

The Academy requests \$205 million for FY23 for the National Center for Birth Defects and Developmental Disabilities (NCBDDD). According to the CDC, birth defects affect 1 in 33 babies and are a leading cause of infant death in the United States. NCBDDD conducts important research on fetal alcohol syndrome, infant health, autism, attention deficit and hyperactivity disorders, congenital heart defects, and other conditions like Tourette Syndrome, Fragile X, Spina Bifida and Hemophilia. NCBDDD supports extramural research in every State and has played a crucial role in the country's response to the Zika virus, as well as COVID-19. Increased FY23 funding would be used to build upon and expand work within the Center's priorities such as uniform data collection for

neonatal abstinence syndrome; supporting the Act Early: Children's Mental Health program, data collection around sickle cell disease, and expansion of the Surveillance for Emerging Threats to Mothers and Babies (SET-NET) program to allow more states to participate and gather needed information to protect pregnant individuals and infants from emerging public health threats.

**Global Immunization – Polio and Measles/Other (CDC):** *FY 23 Request: \$356 million (\$276 million for Polio and \$80 million for Measles/Other); FY 22 Level: \$228 million (\$178 million for Polio and \$50 million for Measles/Other).*

The CDC's global immunization program is one of the most cost-effective and successful public health solutions available and U.S. investments have driven remarkable results. The CDC was a founding member of the Measles and Rubella Initiative, which has vaccinated over 2 billion children and prevented 23.2 million deaths from measles since 2001. Since 1988, the CDC's global polio immunization work has reduced the number of polio cases globally by 99.9 percent, saving more than 10 million children from paralysis and bringing the disease close to eradication. Thanks to sustained funding by the U.S. government through the CDC and USAID and the coordinated efforts of the Global Polio Eradication Initiative (GPEI), the opportunity for a polio-free world is within reach. Unfortunately, the gains from global immunization are in jeopardy. Throughout the ongoing COVID-19 pandemic, many countries diverted resources set aside for polio and routine immunizations to fight the pandemic. While this was vital to many countries' ability to quickly respond to COVID-19, it has come at a terrible cost to polio eradication and routine child vaccination. In the first two months of 2022, measles cases were up 79% compared with the year prior. The World Health Organization and UNICEF warned of a "perfect storm" of conditions for measles outbreaks. Additionally, polio cases have increased, with Malawi experiencing its first wild polio case in three decades. To recover from pandemic-related disruptions, the Academy urges Congress to appropriate at least \$276 million for polio and \$80 million for measles vaccination programs.

**Activities Authorized under Scarlett's Sunshine Act (CDC/HRSA):** *FY 23 Request: \$12 million (\$8.5 million at CDC for the Safe Motherhood and Infant Health account and \$3.5 million at MCHB within the Special Projects of Regional and National Significance account); FY 22: Level: \$1 million at HRSA and \$2 million at CDC*

In passing the Scarlett's Sunshine Act in late 2020, Congress recognized the need for federal investments in research and prevention of sudden unexpected infant death (SUID) and sudden unexplained death in childhood (SUDC). The law authorized \$12 million for HHS to award grants and improve data and monitoring. Full funding for this initiative will strengthen efforts to better understand SUID and SUDC, facilitate data collection and analysis to improve prevention efforts, and support children and families. Requested CDC funding would improve communities' responses to infant and child death cases, inform prevention and clinical care, and help standardize data collection and reporting, as well as procedures and protocols for death scene investigations and autopsies. The grants can also fund safe sleep outreach efforts, which can reduce the risk of SUID. The funds at MCHB would support the expansion and use of the Case Reporting System to provide data summaries and dashboards on all SUIDs and making datasets available to researchers. These MCHB funds can also support bereavement services for affected families, which MCHB cannot currently provide.

**National Vaccine Injury Compensation Program Administration (HRSA):** *FY 23 Request: \$26.2 million; FY22 Level: \$13.2 million*

The Academy supports increased funding for the administrative component of the National Vaccine Injury Compensation Program (NVICP), which was established in 1988 to ensure an adequate supply of vaccines, stabilize vaccine costs, and establish and maintain an accessible and efficient forum for individuals found to be injured by certain vaccines. NVICP is an alternative to the traditional tort system for resolving vaccine injury claims and provides compensation to individuals found to be injured by certain vaccines. NVICP claims have increased more than fivefold from 402 claims filed in FY 2012 to 2,057 claims filed in FY 2021 while the administrative funding barely doubled from \$6.5 million to \$11.2 million during the same period. The steep increase in claims filed is due in large part to the flu vaccine being administered to adults. In fact, most of all petitions filed are now adult claims for alleged injuries from the flu vaccine. Though the number of petitions has risen, the number of staff to administer the claims has not risen at the same level. By hiring more staff and thereby expediting the processing of claims filed in the NVICP, the children and families who have been injured by a vaccine will be able to receive their due compensation in a timely manner. It will also help prepare HRSA to administer the NVICP program if the COVID-19 vaccine is eventually transferred from the Countermeasures Injury Compensation Program and included in NVICP program.

**Activities Authorized under the VACCINES Act (CDC):** *FY 23 Request: \$15 million; FY 22 Level: N/A*

The AAP is very appreciative that Congress specifically included the Vaccine Awareness Campaign to Champion Immunization Nationally and Enhance Safety (VACCINES) Act as part of Section 2302 of the American Rescue Plan that provided \$1 billion to improve vaccine confidence for both COVID-19 and routine immunizations. Much of this funding was distributed to state and local public health departments to help promote the uptake of COVID-19 vaccines and to provide Americans with accurate information about these vaccines. As we pass two years of living through the pandemic, it is more important than ever to bolster American's confidence in vaccines and debunk misinformation and disinformation about vaccines. The VACCINES Act authorizes the development of a national vaccination rate surveillance system at CDC and allows data collected to be used to identify communities with low vaccination utilization or where vaccine misinformation may be targeted. It also authorizes research grants to better understand vaccine hesitancy, attitudes towards vaccines, and develop strategies to address nonadherence to the recommended use of vaccines. Additionally, the VACCINES Act authorizes an evidence-based public awareness campaign on the importance of vaccinations to increase vaccination rates, including targeting communities that have particularly low vaccination levels. The AAP urges Congress to allocate the authorized \$15 million for CDC to ensure these activities take place to boost vaccine confidence in routine and COVID-19 immunizations and boost vaccination rates across the lifespan.

There are many ways Congress can help meet children's needs and protect their health and well-being. Adequate funding for children's health programs is one of them. The American Academy of Pediatrics looks forward to working with Members of Congress to prioritize the health of our nation's children in FY 2023 and beyond. Thank you for the opportunity to testify before the subcommittee today and I look forward to answering any question you may have.

The CHAIR. I am going to yield to Congressman Cole for any comments or questions.

Mr. COLE. Well, I want to thank the witness for her testimony. It is very powerful and certainly very compelling given the tragic events that we have had this week. And I want to compliment the chair. She is the one that started this pattern of investments in gun violence research and, I think, has been probably the leader in Congress on that, quite frankly. So, again, I don't know where we will end up, but despite what some people think, this has not been a matter where we have had any big differences, quite frankly. We signaled that, I think, maybe in 2019, Madam Chair, when we put language in there to try and let the CDC and the NIH know please go ahead if you decide that, and then my friend, the chair, followed up with an appropriation, I think, the very next year when the hint wasn't taken. So let's just put the money specifically there and give you an unmistakable signal.

So, you know, I don't think studying problems hurt. I think it helps, and, again, I tip my hat to the chair for having been a leader in this area, and I yield back.

The CHAIR. I thank the ranking member for really the cooperative effort. We had hearings on this, and this is an issue of public health, and that is how we want to try to, you know, to deal with it. And it is no way to restrict anybody's rights to own a firearm, but to understand, as well you pointed out, that, you know, we have done this with automobile safety, we have done with smoking, you know, and we have come out with some very, very good remedies here that have cut down automotive accidents and deaths, and the same with smoking.

There isn't any reason why not to do this. We are going to continue. We are going to continue to do this, and every time an event happens, like it happened 2 days ago, there is more and more need for us to understand. For me on the education side, I would put a mental health professional in every school in the United States, you know. That would be, you know, a way to help deal with our kids. But the aftermath of what happens, I really have got in my mind's eye this little boy that I heard this morning who survived. He is a 4th grader, and he was shaking while he was talking about what he saw around him, you know, with his pals, his friends, who were killed. And, you know, what happens in that beautiful little brain? What goes on? How can we prevent this? How can we do this?

So thank you. Thank you for your focus on this and so many other areas that you focus on. You really provide direction for us, and we rely on your data, your work, and your commitment, so thanks very much. I appreciate it. Thank you.

Let me introduce Mark Anthony Figueroa, A GEAR UP alumnus, and the National Council of Community and Education Partnerships. And I know how the ranking member feels about the GEAR UP Program. So, Mr. Figueroa, please, your testimony, and you are recognized for 5 minutes.

## **MARK ANTHONY FIGUEROA, GEAR UP ALUMNUS, AND NATIONAL COUNCIL FOR COMMUNITY AND EDUCATION PARTNERSHIPS**

Mr. FIGUEROA. Thank you. Madam Chair DeLauro, Ranking Member Cole, and distinguished members of the subcommittee, thank you for giving me the opportunity to provide testimony on the profound impact that the Gaining Early Awareness for Readiness for Undergraduate Programs Initiative, better known as GEAR UP, has had on my life. My name is Mark Anthony Figueroa, and it is my honor and pleasure to be sharing this testimony on behalf of the GEAR UP alumni and over 500,000 GEAR UP students across the country.

Given the program's return on investment, I respectfully urge the committee to appropriate \$435,000,000 for GEAR UP in fiscal year 2023 to support an additional 80,000 students across our country so that they, too, can have the support I received in GEAR UP.

As you may know, GEAR UP provides 6- to 7-year grants to States and partnerships comprised of K-12, higher education, and community-based organizations that strengthen pathways to college and careers in low-income communities. GEAR UP exposes students and their families, starting in the 7th grade, to comprehensive intervention that follow them through high school graduation and, ultimately, through the first year of postsecondary education. GEAR UP uses early and sustained interventions to ensure that students are successful in rigorous courses, are knowledgeable about the steps necessary to prepare for life beyond high school, and ultimately enroll in a high-quality certificate, associates, or bachelor's degree program that suits their goals. In the most recent year in which we had a large class of graduating seniors, the postsecondary enrollment rates of GEAR UP students were over 31 percent higher than low-income students nationally. Considering that GEAR UP achieves this critical goal at a cost of approximately \$645 per student per year, I strongly believe that the investment in GEAR UP pays significant dividends. GEAR UP is a powerful catalyst for sustained community improvement.

I grew up in the eastern part of Washington State in the city of Pasco. This part of the country is filled by passionate Latino, and Latino immigrant, and migrant families working in predominately agricultural fields. With long days and hard work, preparing for higher education can be challenging and a first for many. As a first-generation migrant student and the eldest of six in my family, postsecondary education seemed like a very distant, daunting, unknown land with no clear path towards it. However, participating in the GEAR UP Program helped me actualize my dreams of a postsecondary education through mentors, college and career fairs, FAFSA nights, and college admissions workshops.

Being the first in my family to pursue higher education, my parents and I had so many questions. It is a daunting process, especially if done alone. Nevertheless, GEAR UP was there to support and walk us the entire way. Because of GEAR UP, I was admitted and graduated from Washington State University. With these experiences and the competence that GEAR UP gave me, I was able to

develop strong leadership skills, community connections, and discovered all the ways to give back to my community.

During my time at Washington State University, I connected with other first-generation migrant students, and we encouraged one another to follow our dreams. I was elected and served student government and also helped lead a student ministry at the intersection of faith and culture. Having led the way with the support of GEAR UP, I am now there for my parents and five sisters as they navigate the college-going process. Currently, I work with local civic engagement organizations to encourage marginalized members of my community to elevate their voices and get involved.

As a current diversity advocate, a former high school history teacher, a soccer coach at the high school where GEAR UP supported me, and a graduate student pursuing a master's degree in theology, I can attest to the truth that GEAR UP does work. For me, none of this would have been possible without the guidance of the GEAR UP program. Through my own achievements in attending postsecondary education, I can see the generational barriers in my family have been removed for future generations, and they may find the same success that I have through education.

While the support that GEAR UP provided me was truly priceless, the only way that other students will be able to access the educational experiences I had because of GEAR UP will be to continue to increase funding. Acknowledging that I am just one of thousands of families GEAR UP has positively impacted highlights the impact of the GEAR UP Program. As you take on the work of preparing for the fiscal year 2023 appropriations, I respectfully urge you to consider increasing the investment in the GEAR UP Program to \$435,000,000 so that 80,000 more students just like me can benefit from the program as I did.

Thank you to the committee for taking time to hear my testimony.

[The information follows:]

**Mark Anthony Figueroa, GEAR UP Alumnus**

**National Council for Community and Education Partnerships**

***House Labor, Health and Human Services, Education, and Related Services Appropriations  
Subcommittee***

***U.S. Department of Education***

Distinguished members of the House Labor-Health and Human Services-Education Appropriations Subcommittee, thank you for the giving me the opportunity to provide testimony on the profound impact that the Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) initiative has had on my life. My name is Mark Anthony Figueroa, and it is my honor and pleasure to be sharing this testimonial on behalf of GEAR UP alumni and over half a million GEAR UP students across the country. Given the program's return on investment, I urge the committee to appropriate \$435,000,000 for GEAR UP in fiscal year 2023 to support an additional 80,000 students across our country so that they, too, can have the support I received in GEAR UP.

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postsecondary enrollment rates of GEAR UP students were over 31% higher than low-income students nationally<sup>i</sup>. Considering that GEAR UP achieves this critical goal at a cost of approximately \$645 per student, per year, I strongly believe that the investment in GEAR UP pays significant dividends. GEAR UP is a powerful catalyst for sustained community improvement.

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However, participating in the GEAR UP program helped me actualize my dreams of a post-secondary education through mentors, college & career fairs, FAFSA nights, and college admissions workshops. Being the first in my family to pursue a higher education, my parents and I had many questions. It is a daunting process, especially if done alone. Nevertheless, GEAR UP was there to support and walk with us all the way. Because of GEAR UP, I was admitted to and graduated from Washington State University. With these experiences, and the confidence that GEAR UP gave me, I was able to develop strong leadership skills, community connections, and discovered all the different ways to give back to my community. During my time at Washington State University, I connected with other first-generation migrant students we encouraged one another to follow our dreams. I joined the only Aztec-based brotherhood in the Pacific Northwest, I was elected and served in student government, and helped lead a student ministry at

the intersection of faith and culture. Having led the way, with the support of GEAR UP, I am now there for my parents and five sisters as they navigate the college-going process.

Additionally, I was inspired by my experiences and the experiences of others with stories like mine, and I was able to bring awareness to various issues affecting college students from all walks of life. I currently work with local civic engagement organizations to encourage marginalized members of my community to elevate their voices. As a former high school history teacher, a soccer coach at the same high school where GEAR UP supported me, a current graduate student pursuing a master's degree in theology. I can attest to the truth that GEAR UP does work.

For me, none of this would have been possible without the guidance of the GEAR UP program. Through my own achievements in attending postsecondary education, I can see that generational barriers in my family have been removed for future generations, and they may find the same successes that I have through education. While the support that GEAR UP provided me was truly priceless, the only way that other students will be able to access the educational experiences I had because of GEAR UP, will be to continue to increase funding. Acknowledging that I am just one of many thousands of families GEAR UP has positively impacted, highlights the impact of the GEAR UP program.

As you take on the work of preparing for the fiscal year 2023 appropriations, I urge you to consider increasing the investment in the GEAR UP program to \$435,000,000 so that 80,000 more students just like me can benefit from the program as I did. Thank you to the committee for taking the time to read my testimony.

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<sup>1</sup> U.S. Department of Education (2016). FY 2017 Department of Education Justifications of Appropriation Estimates to the Congress: Higher Education (Volume II). Retrieved from: <https://www2.ed.gov/about/overview/budget/budget17/justifications/index.html>

The CHAIR. Thank you for your testimony, and you are the face of the GEAR UP Program, and what a success story it is. And I am going to yield to a Congressman Cole, and then I will say something, but, Congressman Cole——

Mr. COLE. First of all, to our witness, Mr. Figueroa, I could not have done a better job. And to our friends at GEAR UP, you could not have had a better representative to come before this committee. This is a program, as the chair knows, that she and I have worked on together for 7 years. And I don't know what the final number will be, but for 7 years in a row, we have been able to increase this program, and you are a shining example of why these investments pay off.

I always tell people if we can get you to and through college, you know, you are, on average, going to make \$1,000,000 more in your lifetime. Don't worry, the Federal Government is going to get a share of that \$1,000,000. And so this is literally a program that pays for itself, in my view, and I often point that out in connection with TRIO, a companion program in many ways, but that has produced over 5,000,000 college graduates for this country that probably would not have had the opportunity to go or succeed at college. I feel the same way about GEAR UP.

My own State is full of first-generation college students. I am a first-generation college student, and the point you make about families wanting to do this, you know, but not knowing how to navigate the way, not necessarily knowing how do we prepare, what are the things that we need to make sure that our son or daughter does at the appropriate age so they are ready to go. We don't want to just get them to college. We want them to have the background to succeed, as you clearly are doing, in higher education.

So thank you for your eloquent advocacy for this program and for the personal example, and thanks for pointing out what a difference the program will make, not only for you, but for your brothers and sisters. And that is one of the big spillover impacts of this. I just think these programs are so wise and, again, such good investments for our country to make, not just individually for your future, but collectively in our own future. These things pay off big, big, big time for us, and, again, I salute the chair. She has always been a terrific partner in progress in this area, you know, whether she was chair or ranking member. I know how deeply she believes in the program, and we are going to continue to work together, and hopefully we can continue to come up with good results.

But thank you, Madam Chair. With that, I yield back to you.

The CHAIR. Thank you, and last year in 2022, it was \$378,000,000, I understand it, and obviously we will take a look at the money. But, you know, oftentimes people say, you know, is this Federal program working, is that Federal program working. GEAR UP works, and you are the poster child here for, you know, the success, and, as the ranking member pointed out, with the spillover effect. So GEAR UP will be front and center for us as we move forward. Thank you so much for your testimony. Thank you.

Mr. FIGUEROA. Thank you.

The CHAIR. And for your success. Thank you for what you are doing. An M.A. in theology. Okay. This is great.

Mr. FIGUEROA. Yes, thank you.

The CHAIR. Thank you. We now have Esther Lucero, president and CEO of the Seattle Indian Health Board. Esther, you are recognized for 5 minutes.

**ESTHER LUCERO, PRESIDENT & CEO, SEATTLE INDIAN  
HEALTH BOARD**

Ms. LUCERO. It is still morning time in the Seattle area, so I would just say [Speaking native language]. My name is Esther Lucero, Chair DeLauro, and it is a privilege to meet you at least in this virtual setting. And Ranking Member Cole, it is always a pleasure to work with you, and I am always honored to see another native person in such a prominent role but also with such longevity. So we are seeing each other in a different committee this time, and I am pretty excited about that.

So let me give you a little bit of perspective on the Seattle Indian Health Board. So we are a really unique organization in the sense that we are deemed an urban Indian health organization, and we were the very first urban Indian health organization to become a federally-qualified health center. So what that means is we see all people, but we see all people in the native way. Now, another thing that makes us unique is we operate the Urban Indian Health Institute, which is one of 12 tribal epidemiology centers in the Nation, and we are deemed a public health authority for the Indian Health Care Improvement Act and permanently reauthorized in the Affordable Care Act.

Now, these things are significant because what it allowed us to do was have an incredible response to COVID, and when I say “incredible,” it was truly community driven, and it was truly culturally attuned. And I want to make sure that this committee, in particular, recognizes the value of community health centers. And it doesn’t always place so much dependence upon county systems or State systems in regards to being a public health authority. The reason I say that is because we have an incredible relationship with our 29 federally-recognized tribes here in the State of Washington, and they advocated so that we could actually have a more community-centered response to COVID. And for that reason, we have 98 percent of all of our American Indians/Alaska Natives in Seattle in the King County region who are vaccinated, and I think that is a true testament to what we are capable of doing, especially with the public health arm where we were able to provide culturally-attuned education and awareness, and really develop trust with our communities.

So the reason I bring up COVID is because we were able to show one another what we are capable of, right? There were so many things that we said we couldn’t do, like telehealth, for example, but we did it, right? We were able to pivot on a dime to make sure that we could meet the needs of our people. Now, something else that occurred through COVID is that we have seen the most significant increase and investment in Indian Health Service in my entire history, probably in my lifetime. And when we think about this particular committee, Medicaid has been used to grossly supplement an underfunded system, right? And so when I think about that, we were actually successful at securing 100 percent FMAP in the 2-year pilot.

And how that resulted was, it resulted in an \$18,000,000 cost savings for the State of Washington, which was then allocated to an urban Indian line item. And now we are using it as a pilot to demonstrate the impact of traditional new medicine as a billable service. Now, obviously, if we can extend a 100 percent FMAP in perpetuity, then that would actually increase our ability to provide culturally-attuned services, which inevitably result in cost savings in the emergency centers, right, because culture actually is prevention and one of the best ways to overcome trauma.

Additionally, we operate a 65-bed residential treatment program in our treatment center, which we had to push pause on services because there was a lack of infrastructure dollars. Now, we are about to reinstate that facility and expand it to 92 beds for a couple of reasons. One is the opioid crisis reminded us that we have to actually adapt our environment to not only do the traditional abstinence-based recovery programs, but also to do medically-assisted treatment in an inpatient facility. We also have a desperate need to expand our services to support the needs of pregnant and parenting women, and so we have identified a site and will be purchasing that site and rebuilding to address those needs.

Now, the reason that is significant is because another thing we saw is finally we had investments in infrastructure related to behavioral health, right, build expansion through HRSA, and also, we are able to use our grant dollars to expand in other ways. And I would like to see that continued because the problem is that we don't have enough beds. The problem is we don't have enough housing. The problem is we just don't have enough resources to solve some of these things that are exacerbated by things like the pandemic.

And so when I think about, you know, things that are really challenges, I think about workforce development, and here we are in the age of the great resignation, and we need a significant investment, particularly in mental health services. If we are going to put a mental health provider into every single school system, like you said, Chair DeLauro, then we must invest in our workforce. And so we are asking for a \$1,000,000,000 investment in the Indian Health Care Workforce Development Program so that organizations like ours can continue to really add and build to that infrastructure.

So I just want to say thank you for your support, and it is an honor to be here with you today.

[The information follows:]



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Testimony of Esther Lucero, MPP  
 President & CEO, Seattle Indian Health Board  
 House Committee on Appropriations  
 Subcommittee on Labor, Health and Human Services, Education, and Related Agencies  
 Friday, May 13, 2022

Chair DeLauro, Ranking Member Cole, and members of the House Committee on Appropriations – Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, my name is Esther Lucero. I am Diné, of Latino descent, and third generation in my family living outside of our reservation, I strongly identify as an urban Indian. I serve as the President & CEO of the Seattle Indian Health Board (SIHB), one of 41 Urban Indian Organizations (UIO) nationwide. I have had the privilege of serving SIHB for six years and have been providing congressional testimonials for the past four years. I am honored to have the opportunity to submit my testimony today requesting: the permanent authorization of 100% Federal Medical Assistance Percentage (FMAP) for UIOs; encouraging behavioral health parity and integration through workforce development initiatives across the U.S. Department of Health and Human Services (HHS) and Health Resource and Services Administration (HRSA); modifying the Substance Abuse and Mental Health Services Administration (SAMHSA) Government Performance and Results Act (GPRA) tool; increasing access to traditional health services through the Centers for Medicare and Medicaid Services (CMS); and increasing administrative time under the Indian Health Service (IHS) Loan Repayment Program. Addressing these key issues can advance the health of urban American Indian and Alaska Native (AI/AN) population.

SIHB is an Indian Health Service (IHS)-designated UIO and a HRSA 330 Federally Qualified Health Center, which serves nearly 5,000 AI/AN living in the Greater Seattle Area in Washington state. Nationwide, UIOs operate 74 health facilities in 22 states and offer services to over 5.4 million AI/AN people in select urban areas. As a culturally attuned service provider, we offer direct medical, dental, traditional health, behavioral health services, and a variety of social support services on issues of gender-based violence, youth development, and homelessness. We are part of the Indian healthcare system and honor our responsibilities to work with our Tribal partners to serve all Tribal people, wherever they may reside.

We are home to a Tribal public health authority, Urban Indian Health Institute (UIHI), 1 of 12 Tribal Epidemiology Centers (TEC) in the country and the only TEC with a national purview- serving both rural and urban AI/AN's. For over 20 years, UIHI has managed public health information systems, managed disease prevention and control programs, communicated vital health information and resources, responded to public health emergencies, and coordinate these activities with other public health authorities and UIO's nationwide. Due to a lack of access to disease surveillance data, UIHI released the

only *AI/AN COVID-19 Data Dashboard*,<sup>1</sup> providing critical disease surveillance data to the 45 UIO service areas ensuring AI/AN communities have access to culturally informed data collection, research, and evaluation.

### **Extend 100% Federal Medical Assistance Percentage (FMAP)**

The American Rescue Plan Act of 2021 temporarily extended 100% Federal Medical Assistance Percentage (FMAP) to UIOs. For Washington state, the two-year temporary extension has resulted in \$18 million in federal cost savings that will be captured in the Indian Health Improvement Reinvestment Account. The investment account will be able to expand its funding to activities, programming, and initiatives that improve the health of AI/AN people across the state of Washington.

The permanent extension of 100% FMAP to UIOs upholds the political status of Tribal citizens to ensure federal dollars provide Medicaid-coverage to urban AI/AN Medicaid beneficiaries. Permanent extension of 100% FMAP reduces state Medicaid expenditures, honors federal trust and treaty responsibility to AI/AN people and creates innovative healthcare delivery and systems changes to address social determinants of health experienced in AI/AN communities.

### **Encourage Behavioral Health Parity and Integration**

We request HHS improve partnerships and invest resources with the Indian healthcare system to support recruitment and retention of health care professionals to support health integration, consumer demand, and identify need. A HRSA report found significant shortages of psychiatrists, psychologists, social workers, school counselors, and therapists across the country resulting in severe workforce deficits for Indian County.<sup>2</sup> For Washington state, HRSA has identified our area as having a Mental Health Professional Shortage Area, with only 16.8% of mental health needs being met.<sup>3</sup>

We ask that HHS encourage behavioral health parity and integration by supporting initiatives to dual credential our providers to support vacancies. We request HHS mirror the Veterans Benefits Administration (VBA) dual certification process to support our providers. As AI/AN people are disproportionately represented in poor behavioral health outcomes, including higher rates of behavioral health conditions such as mental health, substance use, or suicide,<sup>4</sup> it is necessary for HHS to invest in behavioral health parity through workforce developments for Indian healthcare clinics.

To address the workforce shortage of the Indian healthcare system as a whole, we support the National Tribal Budget Formulation Workgroup Recommendations, which includes \$1 billion to the Indian healthcare workforce development program to recruit and retain health professionals to address chronic and pervasive health care provider

<sup>1</sup> Urban Indian Health Institute (April 2022) COVID-19 Data Dashboard. Retrieved from: <https://www.uihl.org/covid-19-data-dashboard/>

<sup>2</sup> U.S. Department of Health and Human Services – Health Resources and Services Administration. (2016). National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025. Retrieved from: <https://www.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf>

<sup>3</sup> XPF. (2021). Mental Health Care Health Professional Shortage Areas (HPSA). Retrieved from: <https://www.xpf.org/other/state-indicator/mental-health-care-health-professional-shortage-areas?base7currentTimeframe=0&sortModel=%7B%22collId%22%3A%22location%22%22sort%22%3A%22asc%22%7D>

<sup>4</sup> U.S. Department of Health and Human Services – Office of Minority Health. (2021). Mental and Behavioral Health – American Indians/Alaska Natives. Retrieved from: <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=38>

shortages. In addition, we ask that HHS advocate for, prioritize, and support workforce development incentives at IHS, SAMHSA, and HRSA.

#### **Increase Partnerships and Resources to Address Provider Shortages**

As previously mentioned, we recommend HRSA support investments into the Indian healthcare system through workforce development and supporting dual credentialing of providers to address our workforce deficits and meet the needs of Indian Country.

In order to ameliorate the significant vacancy rates for the Indian healthcare system, and address challenges to filling the vacancies in our facilities, SIHB has a strong workforce development program which includes 6 family medicine residents, 6 public health interns, and 4 Master of Social Work program students. Of our 6 family residents, 4 identify as AI/AN and recent graduation rates show 80% of our previous residents go on to work in communities of color and 50% go on to work in Native communities. These types of training programs increase AI/AN representation in provider positions.

As we develop the next generation of Indian Health Care Providers, we must ensure that barriers for American Indian and Alaska Native providers are eliminated, and we must increase leadership and management opportunities for all Indian Health Care Providers in the LRP program. We recommend that IHS modify LRP program requirements to allow providers additional administrative time. Additionally, HRSA investments can support vacancies, salary comparison, incentives, training programs, and dual credentialing needed to support recruitment and retention of AI/AN representation in the healthcare workforce.

#### **Mandate CMS Reimbursement for Traditional Health Services**

We request CMS support the integration of Traditional health services as reimbursable services to improve access to quality health services for AI/AN populations. Improved access to Traditional health services support equity-based health care initiatives that are outcome-oriented, patient-centered, and support primary and preventative healthcare services.

In 2021, SIHB secured a SAMHSA grant to launch a Traditional Indian Medicine (TIM) pilot that will code Traditional health services into our Electronic Health Records (EHR) system and will replicate reimbursable services. UIHI will provide evaluation on the pilot to document the health benefits of integrating Traditional Practitioners as part of our wraparound services. SIHB has uniquely integrated our Traditional Practitioners into our clinical and social services teams to provide over 39,000 encounters through assessments, counseling, hospital visits, and group services. In March 2023, SIHB will release a report documenting our methods to credential Traditional Practitioners, code Traditional health services into EHR, replicate reimbursable billing, and health outcomes from this pilot.

The pilot will demonstrate how integrating traditional services in relatives' (patients) primary and preventative care can support and improve health outcomes of our relatives. Traditional health services can complement Western healthcare to support

culturally attuned care for AI/AN people and BIPOC communities across the nation. We will utilize our success story to advocate for Traditional health services being a standard practice across healthcare systems in the nation to advance health equity by supporting outcome-oriented, patient-centered, and primary and preventative healthcare services.

#### **Modify the GPRA Tools for Low-Barrier and Culturally Attuned Services**

The GPRA Modernization Act of 2010 modified the GPRA tool to better serve the needs of providers. Twelve years later, we desperately need the GPRA tool to be remodified to meet the modern needs of providers. The Administration, Congress, and local elected officials have all announced their efforts to address rising Substance Use Disorder (SUD) rates. However, the GPRA tool continues to be a burden to SUD access and treatment for our relatives due to the trauma triggering questionnaire. Additionally, the GPRA tool places a strain on our providers to meet required quotas. To ensure continued funding for our critical services, providers must commit their time and resources to fulfilling the requirements of the GPRA tool despite it not informing multidisciplinary teams of local clinics.

Today, the GPRA performance tool is burdensome to patients and providers. From providers in the Indian healthcare system, we have heard the GPRA tool is trauma triggering for patients, time intensive for patients and providers, and collects data that is solely beneficial for the federal government. The GPRA tool must be modified to be patient-centric, consider the time of our patients and providers, and avoid collecting unnecessary data that does not benefit local clinics. For example, UIHI and our medical division, are recipients of GRPA funds and certain questions related to behavioral health do not benefit our clinical team or research division.

We request HHS and SAMHSA modify the GPRA tool to be culturally attuned and low barrier to support the needs of our relatives. Additionally, we request HHS and SAMHSA modify the tool with the input of providers, patients, and Native experts to shorten the screening tool, ensure it is patient-centered, holds validity, administratively considerate, and informs providers of the immediate and long-term care of relatives.

#### **Increase Administrative Time under the IHS Loan Repayment Program (LRP)**

IHS has notified me amending the Loan Repayment Program (LRP) structure is a legislative fix that must be addressed by Congress. As the Indian healthcare system is severely understaffed, we must continue to implement unique initiatives to support our providers, which includes amending the IHS LPR to increase administrative time.

Under the current IHS LPR structure, medical providers are limited to 20 percent of FTE allocated to administrative time. While direct clinical care training is essential to the development of healthcare providers, we must acknowledge that administrative time is an opportunity to develop skillsets in leadership and operations management. I believe this amendment will support providers in the Indian healthcare system.

The CHAIR. Thank you so much, and thank you for the richness of the presentation, just real strong leadership in this effort. Really, it is more than encouraging, it really is, you know, and the ranking member can speak, you know, in a granular basis about the Indian Health Service. It has been a priority of his, you know. Really, I think it is historic. You know, it is all about who he is. But I am happy to hear you say that the increase that we did do for the IHS was historic. It doesn't end there, but what we need to do is to try to make sure that we don't have a separate healthcare system that is not functioning for, you know, for the Native-American population. It just shouldn't be. There should be parity in the kind of health opportunities that people should have.

If it is on its own, then, for gosh sakes, let's make sure it has the resources, it has the trained personnel, and everything that is needed to deal with a myriad of problems that occur, you know. We have talked about, you know, violence against women before. We know that that is there. We are talking about, you know, pediatric care and children. And so I want to ask you, and I want the ranking member to speak, what is your situation with infant formula, you know, and how you all are handling, you know, that effort. And telehealth, how can we help you, you know, with that? And I thank you for the work that you did through COVID, but we need many more conversations about the Indian Health Service and how we should be strengthening it, and what its direction is for the future, and where it should be. But so glad that you are there, and thank you for such a powerful, powerful testimony.

Congressman Cole.

Mr. COLE. Thank you very much, Madam Chair, and it was a terrific presentation. Thank you so much for making so many important points in such a brief presentation. And I want to thank my friend, the chair, who has been extraordinarily helpful on these issues. There are a lot of things, of course, and the witness and I would agree, that need to be done. Someday we will get forward funding, just like the Veterans Administration, with both our urban Indian health centers and for IHS. And I was very pleased to see Secretary Becerra bring up the idea of mandatory funding. I know that is controversial on both sides of the aisle with our budget hawk friends, but the reality is, this is the treaty and trust obligation that United States willingly assumed but has never fully funded, and we have made some progress.

I particularly want to echo what you had to say about the outstanding job that our urban Indian health centers did and, frankly, our tribal governments did with the resources we put at their disposal during COVID. In my home State of Oklahoma, the number one vaccination site was the health care center at the University of Oklahoma in the middle of Oklahoma City. The number two was run by the Chickasaw Nation in Ada, Oklahoma, a town of 25,000, and, I don't know, the last count I got, it was somewhere well over 75,000 vaccinations, and that is a while ago. And they set it up, ran it, made it available to everybody as most of our tribes did. You didn't have to be tribal. It was just another network.

And, frankly, in Oklahoma, as rural as we are, having the distribution of vaccination sites and, in many, cases given particularly the early vaccines that had to be stored in unusually, you know,

cold temperatures, honestly, if you didn't have Indian hospitals in these areas, there wasn't anybody else capable of actually housing the facilities. It is one of the reasons why, again, while they had a separate allocation, they opened up their allocations to anybody who would show up for a vaccination. So they became, for us, an alternative healthcare system that served every single Oklahoman, not just tribal members, and that gave us a lot more reach than we otherwise would have had.

And, again, this committee, you know, wrote the check and did great work under my friend's friends leadership, the chair, so we are going to continue working on these problems. Our colleague, Representative McCollum, is always a fighter on the forward appropriations front. She has got the legislation. I remember we both still offer it, but we would always co-sponsor one another's bill. So we never knew who was going to be in the majority, but we knew if we had one on both sides, we would have a chance of moving it forward. And she has been a great, great worker in these areas, you know, from her time as the chair of the Interior Subcommittee. She now chairs a much bigger committee obviously with Defense Subcommittee, but she hasn't lost her passion and her focus on Native issues.

So we have a lot of friends on these issues in this committee, and, again, it is an area where I am really proud to say the effort to move forward has been bipartisan because, again, trust and treaty obligations know no boundary on the basis of partisanship. These are agreements we have coming forward, and I want to thank you. You know, the job you have done in Seattle and, frankly, through the Northwest, some of our best, you know, urban health care centers are in the Northwest, and the tribes there are leaning forward. They are very, very advanced and sophisticated in the care that they offer, and, quite frankly, offer the additional resources beyond the Federal resources that tribes, if they are doing well economically, invest in these facilities. I mean, that is above and beyond.

I know certainly in the case of my own tribe, many of the tribes in Oklahoma—Cherokees and Choctaws—run amazing systems where they take the Federal dollars, Madam Chair, use that. They contract directly with the Federal Government, but then they put their own money on top of it to provide additional resources. And, again, they don't just do that for their tribes. If you are contracting, you know, any Native American can show up at any Native-American facility and be eligible for the care. You are not allowed to say, oh, we just take care of Chickasaws here. So when they are putting in extra money, they are putting in, quite often, to help members from tribes that might not be quite as blessed economically as they are.

And so, yeah, I just appreciate your great work, your great testimony. Madam Chair, thanks for indulging me on the time. I know it has been a long day—

The CHAIR. Oh no, no, this is important.

Mr. COLE [continuing]. On this particular panel, and thanks for all your help in this area. You have been spectacular.

The CHAIR. Thank you.

Mr. COLE. I yield back.

The CHAIR. Thank you. I just want to have a question. Infant formula. How have you fared, Esther?

Ms. LUCERO. It has been very challenging, but, you know, we do what we do, which is we reach out to community, and we try to identify where our rations are, and we try to do that through the groups that we actually serve. So that is how we have been able to respond is trying to pool our resources to be able to meet the needs of our most vulnerable people. So I wish I had a better answer but, you know, again—

The CHAIR. Well, we are going to keep at it. The issue at the moment is to deal with supply, but the safety issue is very, very critical. On that, we have to really be clear that the product on the shelf is safe for the babies to take. And I see my friends of the American Academy of Pediatrics, and I think that this is woefully underreported, the number of youngsters, babies who are going to emergency rooms with, you know, vomiting or diarrhea. And, you know, it is directly related to a recalled product that was contaminated.

So, again, thank you. Thank you, but keep in touch with us on that as we go forward. That would be very, very important information, if the distribution is getting to you, and, you know, to the tribes. So please, please do.

Ms. LUCERO. Absolutely. Thank you again so much.

The CHAIR. Thank you. Thank you.

Mr. COLE. Bye-bye.

Ms. LUCERO. Bye.

The CHAIR. And let me introduce Lodriguez Murray, senior vice president, public policy and government affairs, at the United Negro College Fund. Lodriguez, please, your testimony, and I recognize you for 5 minutes.

**LODRIGUEZ MURRAY, SENIOR VICE PRESIDENT, PUBLIC POLICY AND GOVERNMENT AFFAIRS, UNITED NEGRO COLLEGE FUND**

Mr. MURRAY. Chairwoman DeLauro, Ranking Member Cole, my name is Mr. Lodriguez Murray, senior vice president for public policy and government affairs for UNCF, United Negro College Fund. You may be familiar with our motto, "A mind is a terrible thing to waste."

UNCF has two functions. First, we raise funds on behalf of private historically black colleges universities, or HBCUs. Second, we also are a significant scholarship granting organization. Annually, UNCF awards over \$100,000,000 in scholarships to approximately 10,000 students at some 1,100 different colleges and universities. UNCF is the second-largest private provider of scholarships in the country overall. Additionally, we are the largest private provider of scholarships to minorities. That means UNCF doesn't just represent 37 member institutions or the 100-plus HBCUs, but we really represent the concerns of low- to moderate-income students wherever they are enrolled.

Personally, I am an HBCU and a UNCF product. When I arrived at Morehouse College, I was a first-generation college student and a first-generation high school graduate. Largely because of UNCF

support, I was able to graduate Morehouse nearly debt free. This is why my testimony today is a full circle moment.

HBCUs have received a great deal of attention recently. The coronavirus pandemic has brought much-needed attention to long persistent disparities. HBCUs have been at the forefront of improving education and health disparities long before the issues have recently become vogue. For over 150 years, HBCUs have been educating the progeny of slaves and now do more to educate and graduate underserved students than any other group of higher education institutions in the country.

Now, there has been an influx in funding to HBCUs. This subcommittee and, Madam Chair, your full committee have been responsible for funding that has stabilized many HBCUs and allowed us to successfully navigate the coronavirus pandemic. As much funding as has come our way, I want to be clear: as 2-year influx cannot reverse 150 years of systemic, persistent underfunding. Now, while we are thankful for President Biden's requested proposed investments in HBCUs, I do want to draw your attention to a few budget lines.

The Department of Education Strengthening HBCUs discretionary program should be funded at no less than \$500,000,000; the Strengthening Historically Black Graduate Institutions discretionary program, no less than \$100,000,000. We should forgive the remaining balances of institutions currently participating in the HBCU Capital Finance Program. We should double the Pell Grant, and we should strengthen the pipeline of training programs at the Department of Health and Human Services.

Now, the top funding request for HBCUs is \$500,000,000 for strengthening HBCUs, that program at the Department of Education. That program holds particular importance in our community because an institution can use the fund up to 17 different legislative ways, depending on the institution's needs. Currently funded at \$337,000,000, all 100 accredited HBCUs compete for this pool of very limited resources. This month, our institutions graduated nearly 50,000 students. Based on that fact that our institutions provide so much of the diverse workforce that our country values, it is our collective view that Congress should increase the program to reflect the value of our graduates. We recommend \$500,000,000 for the discretionary program. This is, again, HBCUs' top funding priority.

While the President's budget was funded at the authorized level, I must call the subcommittee's attention to one fact. There is one single HBCU that received a funding increase last fiscal year of \$100,000,000 all by themselves. All 100-plus HBCUs were forced to share in the collective, much smaller \$25,000,000 increase. This disparity in cap on the overall Strengthening HBCUs Program, it has to be done away with. We must invest \$500,000,000 in this program and an additional \$100,000,000 in the Strengthening Historically Black Graduate Institutions Program.

I want to reemphasize the HBCUs meet a national need: bright, capable graduates who tend to come from underserved backgrounds. However, the education they receive enables them to become productive citizens who contribute to our country in numerous ways, and I don't even have to mention the fact that well over

40 percent of the CBC members, your colleagues, are HBCU graduates. UNCF produced a report on the economic impact of HBCUs in November 2017. UNCF found that one single graduating class of HBCU students will earn a minimum \$130,000,000,000, collectively—one class—over their lifetime. HBCUs collectively hire and fire like a Fortune 50 company. Moreover, our institutions altogether have an annual economic impact of \$150,000,000,000.

HBCUs do what no other type of institution in this country does or attempts, and for that, we hope this panel will support us by implementing the funding requests I have made today. Thank you, and I am happy to answer any of your questions, and I want to commend you on such a long hearing and for your attentiveness.

[The information follows:]



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Good morning, Madam Chairwoman DeLauro; Ranking Member Cole; Full Committee Chairwoman Lowey; and a special greeting to Congresswoman Lee. My name is Mr. Lodriguez V. Murray, the Senior Vice President for Public Policy and Government Affairs for UNCF (United Negro College Fund). You may be familiar with our motto: “A mind is terrible thing to waste.”® That motto has been, and still is, a guiding light for us.

UNCF has two functions. First, we were formed in 1944 to represent and raise funds on behalf of private historically Black colleges and universities (HBCUs). UNCF is a unique membership organization. Unlike most organizations where members pay to join, at UNCF, we award the HBCUs, who constitute our membership, grants to further their mission and advance the education of the young people they serve.

Second, we are also a significant scholarship granting organization. Annually, UNCF awards over \$100 million in scholarships to approximately 10,000 students at 1,100 different colleges and universities. UNCF is the second largest private provider of scholarships in the country, overall. Additionally, UNCF is the largest private provider of scholarships to minorities. That means UNCF does not just represent the 37 membership-institutions or 100-plus HBCUs, but we really represent the concerns of low-to-moderate income students wherever they are enrolled.

Personally, I am an HBCU product. I was a TRiO student at Paine College in Augusta, Georgia. Without that experience there, I probably would not have been able to matriculate at Morehouse College in Atlanta, Georgia. I came to Morehouse a first-generation college student—and a first-generation high school graduate. Largely because of UNCF’s support I was able to graduate from Morehouse with little college debt. I was debt free from college prior to

age 30 because of my UNCF scholarship support. So, now, I have returned as a senior executive with UNCF and come full circle in this moment to ask Congress to stand for our requests today.

HBCUs have received a great deal of attention recently. The coronavirus pandemic has brought much needed attention to the long persistent issues of disparities, or the great societal differences, that have negatively impacted African Americans since the abolishment of slavery.

HBCUs have been at the forefront of improving education and health disparities long before the issues have recently become vogue. For 150 years or more, HBCUs have been educating the progeny of slaves and now do more to educate and graduate underserved students than any other group of higher education institutions in our country.

The more recent movement to respond to the death of George Floyd and others because of systemic issues has given new life to HBCUs, as our students are attracted to our institutions specifically because of the caring, nurturing environment we provide. We are unique. We originated wrap-around services. Our students know that their time on an HBCU campus will yield them a safe space to grow and learn.

Additionally, there has been an influx of funding to HBCUs. This subcommittee and the full House Appropriations Committee has been responsible for funding that has stabilized many HBCUs with the lifeblood that is allowing them the ability to successfully navigate the COVID-19 pandemic. As much funding as has come our way, I want to be clear: a 2-year influx cannot reverse 150 years of systemic, persistent underfunding. In other words, the funding that Congress has appropriated and the funding that has come from our philanthropic partners has not alleviated the lack of funding since our inception.

The lawsuits in the state of Maryland and Tennessee are just an example of how states have chosen to underfund HBCUs. Through the years, the federal government has underfunded these institutions. Philanthropic leaders have done the same. What Congress should do this coming fiscal year to solve that issue from the federal perspective is my focus today.

There has also been negative attention, and not because of anything that HBCUs have done. The hate of others has precipitated a large number of bomb threats levied at HBCUs. While that is not my focus today, UNCF does hope that the Commerce, Justice, Science Subcommittee of the House Appropriations Committee will take our recommendations.

With that said, please let me thank President Biden for his budget's support for HBCUs. While we are thankful for his proposed investments, I do want to draw your attention to a few budget lines. I will focus on the crucial funding needs and the national benefits of HBCUs, and I will implore the 117th Congress to fully fund the Department of Education's "Strengthening HBCUs" discretionary program at no less than \$500 million; fund the "Strengthening Historically Black Graduate Institutions" discretionary program at no less than \$100 million; forgive the remaining balances of institutions currently participating in the HBCU Capital Finance Program; double the Pell Grant; and strengthen pipeline training programming at the Department of Health and Human Services.

The top funding request for HBCUs is \$500 million for the "Strengthening HBCUs" program at the Department of Education. This program holds particular importance in our community because an institution can use the funds up to 17 different ways, depending on that institution's needs. How much each institution receives is based on a formula devised by the department. Currently funded at \$337 million, all 100 accredited HBCUs compete for this pool

of limited resources. Next month, our institutions will collectively graduate nearly 50,000 students.

Based on the fact that our institutions provide so much of the diverse workforce that our country values, it is our collective view that Congress increase this important program to reflect the value of our graduates. We recommend appropriating \$500 million for the discretionary portion of the “Strengthening HBCUs” program. This program, again, is the top funding priority for HBCUs.

While the President’s budget would seek to fund the program at its authorized level, I must call this subcommittee’s attention to one fact. There is one single HBCU that received a funding increase in fiscal year 2022 of \$100 million, all by themselves. All 100-plus HBCUs were forced to share in a collective much smaller \$25 million increase. This disparity and cap on overall Strengthening HBCUs funding must be improved. The HBCU community is depending on this subcommittee and the House overall to pass \$500 million for the Strengthening HBCUs program and an additional \$100 million total for the Strengthening Historically Black Graduate Institutions program.

The second most important priority of the HBCU community is for this subcommittee’s bill to contain language which will forgive the remaining balances of institutions under the HBCU Capital Finance Program. It was in December 2020, the grips of the pandemic, that Congress took steps to alleviate \$1.6 billion in debt which HBCUs owed the Department of Education. However, that was only for institutions which had executed the funding. For instance, Xavier University of Louisiana, the top HBCU feeder-institution to medical school, took out a loan for \$100 million but had not yet executed the funding. The result is that they

were not included in the debt forgiveness Congress passed. We need to make this correction, and this FY 2023 L-HHS bill is the right place to make that impact.

This need coincides with the need for new construction on our campuses. This funding was included in both the President's plans for infrastructure and Build Back Better; however, when the bipartisan infrastructure bill was passed, the funding was not included. HBCUs have aging facilities and few, if any, resources to rebuild. That is why the HBCUs IGNITE Excellence bill must become law before we turn our calendars to 2023.

To explain why the HBCU Capital Finance program exists and why these institutions take out these loans from the Department of Education, the program is a recognition that HBCUs—like African Americans in general—have a harder time accessing capital at reasonable terms than other institutions. HBCUs have taken advantage of the program to build new buildings and refinance existing debt. However, the economic downturn in 2008 and the crushing blow dealt by the administrative changes to Parent Plus Loans in 2010 left the HBCU community reeling. Prior to Parent Plus Loan changes, our institutions collectively enrolled 330,000 students. Following those administrative changes, changes implemented without the prior knowledge of our community, we collectively enrolled 290,000 students. A decline in student population by 40,000 significantly impacted tuition and revenue at HBCUs. The result is that our institutions faced difficulties meeting the terms and conditions of our HBCU Capital Finance loans.

In the March 2018 and September 2018 spending bills, Congress inserted language which allowed 13 private HBCUs to defer those HBCU Capital Finance loans for a minimum of 3 years—but up to 6 years—while the principal and interest amounts were both frozen. That

deferment authority was a life preserver for private HBCUs. Now, as we still experience this pandemic, the remaining relief for HBCUs is necessary.

Pell Grants used to be able to cover most college expenses for the neediest students. That purchasing power has dwindled considerably. I encourage this panel to do all it can to double the Pell Grant for the most underserved students, which will reduce student reliance on costly loans.

Lastly, the programs at the Department of Health and Human Services which help HBCUs produce minority health professionals—housed at the Health Resources and Services Administration (HRSA)—should not just receive level funding, but rather an increase in FY 2023. It is time to invest in programs that help us increase the number of doctors and researchers, especially doctors and researchers of color. To that end, the National Institutes of Health (NIH) should grant more funds to HBCUs.

In 2011, the NIH's internally-funded Ginther study stated that NIH's peer review system has implicit biases which allow fewer minorities—and even fewer African Americans—to receive the basic building blocks of support to begin a career in research. If NIH is to seriously increase the number of African American researchers, and if the agency acknowledges its own bias, then more of their budget should be invested in African American students through the institutions that serve them in large numbers: HBCUs. I also encourage this Subcommittee to take its oversight role seriously. Agencies, like NIH, will only prioritize HBCUs, researchers of color, African American researchers, and the needs of those communities if Congress shows they are, indeed, a priority.

To close my testimony, I will re-emphasize that HBCUs meet a national need: bright, capable graduates who tend to come from underserved backgrounds. However, the education

they receive enables them to become productive citizens who contribute to our country in numerous ways. UNCF produced a report on the economic impact of HBCUs in November of 2017. UNCF found that one single graduating class of HBCU students will earn a minimum of \$130 billion, collectively, over their lifetime. HBCUs, collectively, hire and fire like a Fortune 50 company. Moreover, our institutions together have an annual economic impact of \$15 billion. HBCUs do what no other type of institution does or attempts, and for that, we hope this panel will support us by implementing the funding requests made today.

Thank you, and I am happy to answer any questions.

The CHAIR. Thank you so much, Lodriguez, and it is great to see you again. I was pleased to be with you. We did that by Zoom—I lose track these days—but with Congresswoman Alma Adams where we all gathered and so forth. Thank you for your strong presentation, and I think we are very, very attuned to the role that HBCUs play in our Nation and in our education, and very, very, you know, proud that so many of our members are graduates of HBCUs.

So what we did do in the last go-round, as you talked about, the \$363,000,000, it was about a 7-and-a-half percent increase, and understanding we want to strengthen the HBCUs and the number to \$500,000,000. I am going to be upfront with you. We need to know what our numbers are, you know, clearly. We went up last year in doing this, and we made an increase. We are committed to maintaining the strength of the HBCUs. We just need to know where our numbers are going to come out, and how we are going to allocate the funding. But there is, you know, the commitment to continue to support HBCUs, you know, in the most robust way that we possibly can. And, again, thank you for the clarity of your testimony, and the strength of the testimony, you know, and the strength in the last meeting we had a well. It was a great gathering, so thank you.

And let me yield to the ranking member.

Mr. COLE. Well, thank you very much, and thank our witness. That was an excellent and very powerful presentation, and, frankly, quite compelling. And obviously, we have had several representatives of different minority-serving institutions that have testified before us today, and there is a common theme that runs through them all, which is the disproportionate contribution that these institutions make, and how high a percent of, whether it is medical professionals, and I am sure if we were talking lawyers, and obviously politicians, people might think we have too many of those. I don't know. But it is capped by law, so, you know, you don't have to worry about that.

But really, these institutions are tremendous value and have historically overperformed on limited resources. So, again, I know that I associate with the chair's remarks. It gets down to the numbers and what we can do, and we don't know that yet, but, again, this is not an area where we tend to disagree or debate. It is an area where we put our heads together and see what can we find in common. And obviously, there are a lot of our colleagues on both sides of the aisle that are enormous supporters of HBCUs, and weigh in as well, not just on the committee, but from other committees as well.

So thank you for the presentation. Thank you for your great work for the institutions that you represent, and we look forward to working with you going forward. I yield back, Madam Chair.

The CHAIR. Thank you. Thank you very, very much. And now let me introduce Nancy Gonzales, owner of Lil' Bears Family Daycare, and a member of the American Federation of State, County, and Municipal Employees, to talk about childcare and development of block grants. And, Nancy, don't take it in any negative way. You are the last witness today, and we are sorry you got to wait so

long, but we are delighted to hear from you, and thank you because of the importance of the Child Care Development Block Grant.

Ms. GONZALES. Okay.

The CHAIR. You are recognized for 5 minutes.

**NANCY GONZALES, OWNER, LIL' BEARS FAMILY DAY CARE;  
AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES**

Ms. GONZALES. Good morning to my congressman, Representative Josh Harder, Chairwoman DeLauro, Ranking Member Cole, and members of subcommittee. Thank you for the opportunity to talk about childcare investments and the need to double funding levels for the Department of Health and Human Services Childcare and Development Block Grant—CCDBG—and provide \$12,300,000,000 for fiscal year 2023.

I am Nancy Gonzales. I am a State-licensed family childcare provider in Modesto, California, and the owner of Lil' Bears Family Day Care. I am a proud union member of the 20,000-member strong United Domestic Workers Childcare Providers United, American Federation of State, County, and Municipal Employees. I have been providing childcare services out of my home for the past 16 years and have worked as a childcare provider for the past 29 years. I care for babies and children as young as 4 months old and up to 12 years old, weekdays from 4:30 am to 6:00 p.m. I open early to help families that have long commutes to work. Modesto is a rural area, and sometimes long commutes are required to get to work.

It pains me to say this, but our country takes childcare for granted. It really does. Our childcare system is broken for families who need childcare for the underpaid, mostly black and brown women like me, who are the majority of childcare providers. Emergency funding has been helpful in raising rates in some States and helping to keep childcare programs open, but it is only a band aid for the immediate health crisis. We need sustainable care that comprehensively fixes childcare to make it accessible and affordable for families and to pay providers living wages. That will require much larger investments.

Doubling CCDBG will make a down payment on a real childcare system. Investments in CCDBG will help families and address fairness and equity for providers. One of the biggest problems for providers and why programs are closing is low pay. Childcare providers are paid poverty-level wages. Family childcare providers generally charge less and earn less. Family childcare providers report that they earn \$23,000 or less in a year. Private pay is inadequate to ensure living wages. Adequate government funding is essential to ensure providers can earn living wages and make childcare affordable for families.

Childcare providers like me are faced with the dilemma of raising rates, knowing families will leave our care and be forced to place the young children in less safe arrangements, so I keep my rates low, but it just enough to cover everything my own family needs. And because CCDBG funding is not enough, the rate the State pays us does not cover the full cost of care so we can earn a living wage. Many childcare providers are forced to rely on public

assistance. We work multiple jobs. We can't afford health insurance or save for retirement, and we are struggling to deal with increasing costs. In some places, expenses are at 40 percent, while reimbursement rates have not increased to keep up.

Supporting worthy wages for home-based childcare providers is also an issue of equity for low-income parents, especially those who work jobs outside of the traditional 9:00 to 5:00 hours. Most center-based childcare doesn't offer care during these hours, and these parents depend on in-home based childcare. And finally, family childcare is often the choice in communities of color. After everything we endured during the pandemic as frontline workers, childcare providers can't take much more. Thousands of providers closed their doors during the pandemic. Many never returned. Employers all over California and the country are hiring for jobs that pay better and have better benefits than being a childcare provider. That means less childcare.

Access to care is a big problem right now. More than half the people in the U.S. are in childcare deserts where childcare is either unavailable or very limited. In California, the problem is even worse, especially for low-income and Latino families. I want to thank Congressman Harder for introducing legislation to address the shortage of childcare providers in these key areas.

After all the problems I described, why do I still work in childcare? Simple: I love this work and the children I care for. So do my fellow childcare providers, but we do have futures and families to take care of, too. I urge you to double CCDBG's budget to begin to create a childcare system that pays childcare providers living wages, entices providers to join the field and stay in, fixes childcare deserts, expands the program to cover more families, and makes high-quality care affordable and accessible to all families.

I appreciate Chairwoman DeLauro's leadership and others on this committee to work on these and other ways to fund and fix childcare. Thank you so much for your time, and have a great day.

[The information follows:]

Testimony of Nancy Gonzales

Family Child Care Provider, Owner of Lil' Bears Family Day Care, Modesto, CA

Member, United Domestic Workers (UDW)/Child Care Providers United (CCPU),  
American Federation of State, County and Municipal Employees (AFSCME)

Appropriations Subcommittee on Labor, Health and Human Services,  
Education and Related Agencies

U.S. House of Representatives

for the

Public Witness Testimony

May 26, 2022

Good morning to my congressman, Representative Josh Harder, Chairwoman DeLauro, Ranking Member Cole and members of subcommittee. Thank you for the opportunity to talk about child care investments and the need to double the funding level for the Department of Health and Human Services' Child Care and Development Block Grant (CCDBG) program and provide \$12.3 billion for FY 2023.

I'm Nancy Gonzales. I am a state-licensed, family child care provider in Modesto, California and the owner of Lil' Bears Family Day Care. I am also a proud union member of the 20,000-member strong United Domestic Workers (UDW)/Child Care Providers United (CCPU), American Federation of State, County and Municipal Employees (AFSCME). I've been providing child care services out of my home for the past 16 years and have worked as a child care provider for the past 29 years. I take care of babies and children as young as 4 months old and up to 12 years old, Mondays through Fridays from 4:30 am to 6pm in my home. I open early to help families that have long commutes for work. Modesto is a rural area, and sometimes long commutes are required to get to work.

I am honored to have this opportunity to talk to you about child care – what's needed to help families and providers like me. But I was worried that I could not make the time work. I cannot find substitutes willing to work for what I can afford to pay. So, I do everything myself with my husband. Every day I wake up very early so I can be ready for the first children to arrive at 4:30 am. Then I take children to school. While I drop children off at school, my husband takes care of the children in day care. I join him as soon as I can until I have to return to pick up children at school and then go back to our child care until parents pick everyone up at 6pm.

It pains me to say that our country takes child care for granted. Our child care system is broken – for families who need care and for the underpaid, mostly Black and Brown women, like me, who are the majority of child care providers. COVID-19 has exposed and deepened cracks in

the patchwork of our child care “system.” Even with emergency aid, at least 16,000 child care programs have closed over the last two years, and those that remain open, like mine, are operating on razor-thin margins.<sup>1</sup> Child care workers are overwhelmingly women (94%) and disproportionately Black (15.6%, compared with 12.1% in the overall workforce) and Hispanic (23.6%, compared with 17.5% in the overall workforce).

Child care is in crisis, with the loss of providers in the workforce, rising inflation that is hurting providers and families, and the lack of sustained federal investments that are needed year in and year out. Families and child care providers in California and across the country are relying on Congress to invest more in child care so parents can work knowing that their children are safe and learning, and so providers can earn living wages. I want to acknowledge that recent emergency funding has been enormously helpful, raising rates in some states and enabling many child care programs to remain open. But these funds were not intended to solve the complex challenges of our broken child care system. This funding is a band-aid for the immediate health crisis, and we need a sustainable cure. Fixing child care systemically to make it universally accessible and affordable for families and paying providers living wages requires much larger investments. I respectfully urge you to increase funding for the Child Care and Development Block Grant (CCDBG) to a total of \$12.3 billion in FY 2023, an increase of \$6.2 billion. That would be a good start and a helpful down payment.

Investments in CCDBG will help families and address fairness and equity for providers like me. One of the biggest problems for us is provider pay. Across the country, child care providers are paid poverty-level wages – roughly \$12.24 an hour on average. That’s below minimum wage in many states, and nowhere in this country is that a livable wage, especially not in California.<sup>2</sup> And family child care providers generally charge less and earn less. According to 2016 National Survey of Early Care and Education (NSECE) reports, half of family child care providers report that they earn \$22,978 or less in a year.

Despite the high costs of child care, providers like me are paid very low wages. Private pay is inadequate to ensure living wages. Adequate government funding is essential to make investments to ensure providers can earn living wages and to make child care affordable to families. I am faced with the dilemma of raising my rates, knowing families will leave my care and be forced to place their young children in less safe arrangements. So, I keep my rates low, but it is just not enough to cover everything my own family needs. And because CCDBG funding is not enough, the rates the state pays us do not cover the full costs of our care so we can earn a living wage.

Family child care providers like me are small business owners who must pay out of pocket for expenses and payroll for assistants. Because subsidy reimbursement rates are so low, many providers earn less than minimum wage after expenses. Until my union secured our first-ever contract with the state of California last year, they were paying providers based on 2016 average market rates. We are now at 2018 rates, an improvement, but far from what we need. I

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<sup>1</sup> [https://info.childcareaware.org/hubfs/2022-03-FallReport-FINAL%20\(1\).pdf?utm\\_campaign=Budget%20Reconciliation%20Fall%202021&utm\\_source=website&utm\\_content=22\\_demandingchange\\_pdf\\_update332022](https://info.childcareaware.org/hubfs/2022-03-FallReport-FINAL%20(1).pdf?utm_campaign=Budget%20Reconciliation%20Fall%202021&utm_source=website&utm_content=22_demandingchange_pdf_update332022)

<sup>2</sup> <https://www.bls.gov/ooh/personal-care-and-service/childcare-workers.htm>

think we can all appreciate that the cost of living has changed dramatically since 2018. And the market rate surveys that states base reimbursement on are too low. We need states to implement cost estimation models to capture the actual cost of providing quality care and not just the current going rate which is too low to sustain child care.

Since 2021, several states have increased their payment rates to levels at or above what CCDBG recommends, including Kansas, Maine, Montana, North Carolina, South Carolina, Utah, Washington and Wisconsin. We're still not there in California even though we have made progress. But these increases are supported with federal child care relief and recovery funds that have an expiration date that is approaching. Without huge, reliable increases in CCDBG, or even better – a permanent source of funding – these increases will likely be temporary.

Consider the impact of these very low wages. Over 53% of child care workers receive public assistance, compared to the 21% of K-12 teachers.<sup>3</sup> This year, one-third of child care providers report experiences of hunger. This is the highest rate on record, and even higher than of families with young children during the same period (23%).<sup>4</sup> One in four child care providers reports having to work at least one other job, and over 40% report that child care earnings are less than half of their income.<sup>5</sup> Many of us work multiple jobs and still can't make ends meet.

More than 60% of providers report that low wages is the number one challenge for hiring and retaining staff. I'm lucky that my husband is retired and works with me, because I could not afford to hire additional help. Without him, I would not be able to comply with state ratios. With costs soaring but pay stagnant, it's so hard to hire the help that is needed to allow child care programs to care for more children. Inflation is increasing expenses while income is stagnant. Child care providers like me are shouldering the increased costs of food to provide meals for the children we care for and gas for transporting school-aged children to our programs. In some places, expenses are up as much as 40%, while federal child care reimbursement rates have remained the same.

If this problem is not fixed, I know we will continue to lose more child care providers. I am not going anywhere. I love what I do, but I have seen people take jobs at Starbucks and Target and earn more money instead of coming to work with me.

The loss of more than 12% of the child care workforce since before the pandemic began has left nearly half of a million families scrambling to find reliable child care, as Wells Fargo estimates. Right now, more than half of people in the U.S. are in a child care desert where child care is either unavailable or very limited. In California, the problem is even worse. Before the pandemic, 60% of Californians lived in child care deserts, and now it's worse, especially for low-income and Latino families. Thank you Congressman Harder for introducing legislation to address the shortage of child care providers to address the problem of child care deserts. And because of inadequate funding, only 1 in 9 eligible children have access to subsidized child care.

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<sup>3</sup> 2020 Center for the Study of Child Care Employment's Early Childhood Workforce Index

<sup>4</sup>

[https://static1.squarespace.com/static/5e7cf2f62c45da32f3c6065e/t/624f309010d33b6d1a8e4518/1649356944399/Facing+hunger+factsheet\\_April+2022+.pdf](https://static1.squarespace.com/static/5e7cf2f62c45da32f3c6065e/t/624f309010d33b6d1a8e4518/1649356944399/Facing+hunger+factsheet_April+2022+.pdf)

<sup>5</sup> November 21, 2021 RAPID EC Survey data

Increased investments will serve more families, enabling more parents to work and more children to be in settings that will prepare them for school.

Supporting worthy wages for home-based child care providers is also an issue of equity for children and families. More than 6 million children ages 0-5 are in home-based care, including licensed Family Child Care (FCC) and license-exempt Family, Friend and Neighbor Care (FFN). Home-based child care providers like me disproportionately care for children from low-income families, infants and toddlers compared to child care centers. Children whose parents work non-traditional hours, approximately 40% of working parents, depend on home-based child care. Only 8% of center-based programs offer non-traditional hour care.

After everything we endured during the pandemic as front-line workers, child care providers can't take much more. Thousands of providers closed their doors during the pandemic. Many never returned. I'm sure you've read the news that it's a great market for job seekers. Employers all over California and the country are hiring for jobs that pay better and have better benefits than providing child care. Would you blame us if we took other work? Can you imagine what that would mean for California's economy if child care became even more difficult? And for our country? We are seeing the beginnings of the potential impact with the loss of women in the work place. There are 1.1 million fewer women in the labor force now than in February 2020 with child care obligations likely playing a large role.<sup>6</sup>

In addition to low pay, it's the lack of health coverage and retirement security that makes it truly impossible to stay in child care. Twenty percent of us don't have health coverage. I was one of those until recently. I'm so grateful now that I have access to health care, but my premiums are expensive. Half of my fellow child care providers are putting off important medical procedures because we can't afford it. We also worry about when—and if—we can retire. Ninety percent of us don't have a retirement plan. A lot of providers simply work until we drop. It's difficult to keep providers in the profession—much less recruit new providers—if we must gamble with our health and our futures to continue providing care.

After all the problems I described why do I still work in child care? Simple, because I love this work. It fills my heart with joy. My fellow providers and I, we love your children. We love caring for children and guiding the next generation to a strong and healthy future. But we have futures and families of our own to take care of. In closing, I urge you to double CCDBG's budget to begin to create a child care system that pays child care providers living wages, entices providers to join the field and stay in it, fixes child care deserts, expands the program to cover more families, and makes high quality child care affordable and accessible to all families. I appreciate Chairwoman DeLauro's leadership and that of others on this committee to focus on other ways to fund and fix child care comprehensively for all families and providers.

Thank you.

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<sup>6</sup> <https://nwic.org/wp-content/uploads/2022/03/February-Jobs-Day.pdf>

The CHAIR. Thank you so much, and I just will, you know, quote what you said in your testimony. It pains me as well because our country has taken childcare for granted, and it was demonstrated during the pandemic that it is an industry, if you will, that nearly collapsed, you know. And as we have dealt with an automobile industry, or hospitals, and anything else, when that kind of thing happens, it is the role, in my view, of the Federal Government to step in and to do something about it.

And the piece of this is that, given what happened, women were pushed out of the workforce because, you know, their jobs went away. There was no paid family and medical leave, so people were staying home. Their kids were at home. We had the childcare centers that went out of business. They just shuttered. And so the entire childcare crisis, you know, it was a perfect storm for understanding what was going on because the issue of low wages has been there for childcare workers for so long, and it is one that we need to address. But the other piece of this is, if this economy is going to recover and women are going to go back to work, we have got to have affordable, accessible childcare for families. Otherwise, they are going to stay home because you are not just going to, you know, abandon your children. It needs to be viewed as not taking it for granted, but it is being viewed as a cornerstone of a thriving economy and how this economy succeeds.

And so my hope would have been, and don't know what the vestiges of Build Back Better would be if we ever get a Build Back Better piece of legislation. Maybe we get something, but my hope is that, as was the case earlier, that childcare would be the central portion of that. That is on that side of it, but in terms of the Child Care Development Block Grant, I think we did a \$254,000,000 increase last year. I know what you are asking for is to double the amount of money. I am not going to lie to you. That is hard given that we don't know yet what our numbers are going to be, but I want you to be assured that childcare is now front and center. And as we have been saying in a number of the presentations today, we need to seize this opportunity. We saw what happened in this emergency, and we cannot let that happen. We cannot let the childcare industry be destroyed. Families rely on it. It has got to be affordable.

In the State of Connecticut, it is between \$15,000 and \$18,000 per child. How many people can afford to do that, you know? And so we have got to make it affordable. It has got to be accessible. We have to pay wages. We trust our most precious resource, our children, with the childcare workers, and yet we are not willing to pay them a livable wage. So big issues that you have brought to light. It is critical, but I am going to just say that the advocacy on your part, you know, you need to continue that advocacy because it is so palpable. It is there. There are so many examples all over the country of what has happened with childcare in the United States, and we have to address it and address it in a very substantial way.

You know, just this last note. My mother worked in the old sweatshops in the City of New Haven, but I went to my grandmother's store, you know, and that was my childcare. The fact of

the matter is grandmothers, grandfathers, aunts, uncles, everyone is in the workforce. Those days are gone.

Ms. GONZALES. Yes.

The CHAIR. Those days are gone, and we need to have a very substantial childcare system in the United States. Let me yield to the ranking member.

Mr. COLE. I don't know that I have much to add. I think our witness can understand how passionate our chair is about this and how knowledgeable. Look, this is something she knows a great deal about and has made sure our committee has had robust hearing and discussion about throughout her entire tenure as chair, and then rose up and responded, I think, magnificently during the coronavirus crisis when she understood what was happening to this industry and how critical it would be to our recovery to have it up and operational, help through a difficult time.

So I, like the chair, don't know where we are going to end up. If you have had the opportunity, and since you were last, I am sure you have waited a long time. [Laughter.]

You have gotten to hear some of the requests that our chair and our subcommittee have to deal with, and they are pretty compelling, but we really do take this seriously. We do try and take care of the needs really as well as we possibly can with the resources that are entrusted to us by our colleagues. So I don't think you need to worry that your voice won't be heard at the table. I think your voice is sitting at the head of the table. [Laughter.]

But thank you so much for the work that you do, and thank you for taking the time to testify, and thanks for being so patient with us. This is an important day for us, a big day for us, and I am sorry you were at the very end of the line. But, again, thank you for not being at the end of the line in terms of what this committee does, and thank you for being patient with us and allowing us to get through our other witnesses.

So with that, Madam Chair, I yield back.

The CHAIR. You know, listen, and again, we are in sync. Thank you so much, the Ranking Member. Thank you so much, Nancy, for your patience. And it is a long day, but as I said at the outset, as did the ranking member, we get so much out of this day with public witnesses, and there are a number of areas that, you know, are new information, you know, for us, and that gives us, you know, the opportunity to think about these areas when we are putting the bill together. And I can commit this to you. I cannot commit dollar amounts. We just don't know where we are, but that there is a thoughtful process and one that incorporates, you know, the testimony of the people who testified here today. And with that, I am going to call this hearing to a close.

The hearing is adjourned. Thank you.

Mr. COLE. You bet.

The CHAIR. Thank you, Tom.

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