

**DEPARTMENT OF LABOR, HEALTH AND
HUMAN SERVICES, AND EDUCATION, AND
RELATED AGENCIES APPROPRIATIONS FOR
FISCAL YEAR 2022**

WEDNESDAY, JUNE 9, 2021

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:02 a.m., in room SD-124, Dirksen Senate Office Building, Hon. Patty Murray (chairwoman) presiding.
Present: Senators Murray, Reed, Shaheen, Schatz, Baldwin, Murphy, Manchin, Blunt, Capito, Hyde-Smith, Braun, and Leahy.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE SECRETARY

STATEMENT OF HON. XAVIER BECERRA, SECRETARY

OPENING STATEMENT OF SENATOR PATTY MURRAY

Senator MURRAY. Good morning. The Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies will come to order. Today, we are having a hearing on the Biden administration's fiscal year 2022 budget request for the Department of Health and Human Services. Senator Blunt and I will each have an opening statement, then I will introduce our witness, Secretary Becerra. After his testimony, Senators will each have 5 minutes for a round of questions, and before we begin, I do want to walk through the COVID-19 safety protocols in place today, and I want to thank all of our clerks and everyone who has worked really hard to get this set up and help everyone stay safe and healthy.

As I mentioned before the break, with the change in guidance from the Office of the Attending Physician, the committee is now returning to requiring in-person attendance by witnesses and members who wish to make statements or ask questions. However, social distancing remains in effect, and those who have not been fully vaccinated are strongly encouraged to wear masks.

While we are unable to have the hearing fully open to the public or media for in-person attendance, live video is available on our committee website, and if you are in need of accommodations, including closed captioning, you can reach out to the committee or the Office of Congressional Accessibility Services.

Secretary Becerra, I am pleased to say this budget represents a world of change from the past few years on healthcare, and a road map on progress for years to come. It proposes increasing the Centers for Disease Control and Prevention's budget by nearly a quarter, which, as we discussed in our hearings with Director Walensky, will not only help see our Nation through this pandemic, but help us rebuild our public health system, and better prepare for the next one.

It also proposes serious investments to tackle other ongoing public health crises. Healthcare providers across my State have reported a sharp uptick in youth mental health emergencies during this pandemic, and the national suicide rate has been climbing for years. This budget builds on the resources we've provided for mental health and substance use services in our COVID-19 bills with an additional \$9.7 billion for the Substance Abuse and Mental Health Services Administration, and an increase of \$3.7 billion over fiscal year 2021 levels.

Washington State also saw drug overdoses increase by 38 percent over the first half of 2020, and our Nation saw a record-breaking number of overdose deaths last year. President Biden is proposing an historic investment of \$10.7 billion across HHS (Department of Health and Human Services) programs to end the opioid epidemic, and he is proposing we continue the progress we've seen towards ending another epidemic by investing \$670 million in the HIV/AIDS elimination initiative.

And to aid the fight against cancer, Alzheimer's, long-term COVID-19, and countless other diseases, President Biden is calling for the largest budget increase for the National Institutes of Health in the agency's history.

In the fight against systemic racism, he has proposed new investments across the department to reduce health disparities, and after years of relentless attacks on women's healthcare and reproductive rights, President Biden is charting a clear path in a new direction, one that puts women's health first, and puts patients, not politicians, in charge of their own healthcare decisions.

I am pleased to see this budget call for \$340 million for the Title X Family Planning Program, which helps so many patients, particularly women of color, get birth control, cancer screening, STD screenings, and other essential care. This funding will build on the administration's recent progress to restore the Title X Family Planning Program with a new proposed rule.

The budget would also eliminate the Hyde Amendment, which is a critical step towards ensuring every person is trusted to make their own individual choices about their life and future, based on their own values, no matter who they are, where they live, or how much money they make. I do recognize that is an area of strong disagreement among members of this committee, but for too long, Hyde has made abortion accessible only to those with means, while women of color and women who are paid low incomes struggle to get care.

This budget also takes other important steps to prioritize women's health. Our maternal death rate is the highest in the developed world, and two in three of those deaths is preventable. The death rate for rural mothers is 50 percent higher, and black and

native women are two to three times more likely to die from a pregnancy-related cause than white women. This budget will invest \$220 million to combat our maternal mortality crisis.

Domestic violence is another longstanding and urgent problem, and one made more challenging by a pandemic that makes it even harder for people to get away from their abusers. This budget proposes doubling Federal funding for programs that provide shelter and support for survivors of domestic violence.

We've also seen throughout this pandemic how the childcare crisis has grown worse, and been particularly hard on women, and hardest of all on women of color, and women who are paid low wages. This budget acknowledges the importance of investing in a bright future for every child in our Nation, and proposes to increase funding for childcare and development block grants by \$1.5 billion in addition to the bold investments proposed in the American Families Plan, and provide an increase of over \$1 billion for Head Start and pre-school development grants.

It also acknowledges our moral obligation to provide relief to some of the world's most vulnerable populations, including making sure the children in our Nation's custody are treated with decency, humanity, and kindness by calling for \$1 billion in funding for refugee programs, and \$3.3 billion for the unaccompanied children program, which has been stretched thin by this pandemic. These funds will help ensure children in HHS custody are quickly and safely placed in appropriate homes, provide care and services for them while they are in HHS custody, and provide social and legal services after they leave HHS custody.

Secretary Becerra, I look forward to hearing more from you on how the department is prioritizing the health and well-being of these children, and how this funding will help that work.

I always say a budget is a reflection of your values, and all-in-all, this budget paints a clear, encouraging picture of President Biden's values on healthcare. It shows he values public health, science, equity, women, children, families, and critically, the health and well-being of every single American, and that he believes healthcare must truly be a right in this country, not a privilege. I look forward to working with him and Secretary Becerra and my Senate colleagues to pass investments like those outlined in this budget into law to take bold steps to lower healthcare costs, and expand coverage, and apply lessons learned from the COVID-19 pandemic. With that, I will turn it over to Senator Blunt for his remarks.

STATEMENT OF SENATOR ROY BLUNT

Senator BLUNT. Thank you, Senator Murray. Appreciate Secretary Becerra being here today. We spent several years working together in the House before I came to the Senate, and you went home to become the Attorney General of California, and I look forward to what we can do together over the next couple of years.

Certainly, over the past year, we've faced a global pandemic that nobody would have anticipated, and nobody was trained for. You said in the House hearing in May that the fight against COVID-19 isn't over yet, and certainly, I agree with that. While the vac-

cination rates are going up, and the cases are going down, we still have a lot to finish to win this fight.

Many public experts have stated, and that includes those within the administration, that we really do have to achieve a certain vaccination level necessary to reach the kind of immunity where the virus ceases to spread, and we would hope, when it had no opportunity to spread, it would then cease to be something we need to be concerned about right now.

But we also are going to be looking carefully to see if a booster is going to be required, and, of course, if a booster is required to maintain that level of immunity, it's going to be a great obligation on you, and the administration, and the Congress to see that we have a plan that makes that work.

We also really need to have a clear strategy to provide vaccines to developing nations. We've seen in the past that outbreaks like Ebola, the one thing we know is that the next sick patient is only a plane ride away from here, and so, what we can do to help there ultimately protects us, as well.

I'm particularly concerned about what we're doing and the strategy we have for unaccompanied alien children. You and I have talked about that even yesterday, and I look forward to chances to talk about that more. Many people think that this unaccompanied children issue has nothing to do with COVID, but, of course, how you deal with individuals coming in from another country does have something to do with COVID, and it also has something to do with COVID when you're taking money from our COVID-19 funds to deal with this problem that has to be dealt with.

So far, the department's transferred \$2.98 billion to the unaccompanied children account to deal with the fallout of border policies that just simply aren't working. This includes funding specifically that came out of COVID-19 relief, out of the American Rescue Plan. I want to remind the committee that only a few short months ago, President Biden felt it was so imperative to pass a COVID-19 supplemental bill that the administration pushed a \$1.9 trillion bill through on a totally partisan vote, with no real input from my side of the aisle, and then, immediately, almost immediately, transferred \$850 million of that funding that was going to go for COVID-19 relief to this fund for unaccompanied children.

Just last week, the administration transferred another \$846 million to the unaccompanied children program from COVID-19 funding. That money in the bill was intended to fund community health centers, behavioral health centers, workforce training, public health workforce, and other programs. Well, you know, \$3 billion of that money won't be allowed to do that because we're having to deal with a policy at the border that has to be dealt with, with even the vice president, in the last week, trying to do things to tell people to stop coming to the border. We have to have a policy that works better there.

The supplemental passed in December that was written by this committee included, and it was a bipartisan vote, included critical resources for the Strategic National Stockpile. We saw the problems during the pandemic of what happened if the Stockpile wasn't there. The department already has taken \$850 million from the Stockpile fund to, again, the unaccompanied children program. I

will remind all of us that we've all had questions over the last year of why didn't we do a better job having the Stockpile money being used for the Stockpile. We don't want to see the Stockpile again become a fund that is easily transferred.

Finally, the department transferred \$426 million from fiscal year Labor/HHS funds for programs like—children's hospitals, graduate medical education, the Ryan White HIV/AIDS Program, medical research, childcare. One of the problems in this last bill that was passed—I hope we don't repeat this in a bill that comes through our committee.—I don't believe we will, but unlike language we had normally had, there was no real restraint on transfers, no restriction on those transfers, no requirement to justify to the committee the transfers, no notification of the transfers.

Those things were in every other bill we passed last year. They were not in the first bill that was passed this year, and so, the department hasn't given us notice on all of those transfers in a timely way, but the bill didn't require them to give us notice in a timely way. The members on my side of the aisle want to have discussions about how we deal with this ongoing in a better way.

Without a dialogue with this committee, I would hope again that we don't have the flexibility next year that we have insisted on, like reporting and things, in the past. While we may disagree, and I may disagree with the Department's transfers, or even the way the Unaccompanied Children Program has been managed, there are certainly significant areas where I do agree.

I support the National Institutes of Health increases. I think the new research institute at NIH (National Institutes of Health), ARPA-H (Advanced Research Projects Agency for Health), is in the right place at the right time with the right focus, and I announced in our hearing last week, you remember, Chair, that I intend to be supportive of that, and I believe we can make it work in a way we wouldn't have envisioned before the last couple of years, and the new things we did to step up to the pandemic.

I certainly agree with the expansion of the Certified Community Behavioral Health Clinics to help address the mental health crisis. I agree with efforts to end the HIV pandemic and bring additional resources to bear on the opioid epidemic. The devil's always in the details, but I hope we can move forward on those things and others, but the administration is obviously requesting a huge increase in nondefense discretionary funding. In the Department of Health and Human Services alone, a 23 percent increase, or an increase of \$23 billion. That's compared to a defense department budget that the increase of 1.6 percent doesn't even keep up with inflation.

For the last several years, our friends on the other side of this dais have pushed for parity between defense and nondefense when Republicans were in charge and were advocating defense spending. I hope we can have, and I expect, frankly, will have a similar discussion this year.

Finally, I wholeheartedly disagree with the administration's removal of the longstanding Hyde Amendment. One of things I've had a chance to do in both House and Senate is count, and I don't believe we can get a bill out of this committee without having the Hyde Amendment in that bill. It's been in the Appropriations Bill for 40 years. Every person on this committee who has ever voted

for a final Labor/HHS bill has voted for Hyde since it first appeared in 1976. I don't think this year should be or, frankly, at the end of the day, will be different, but it is clearly, as the chair's already pointed out, going to be an issue we're going to vigorously discuss.

This committee, Mr. Secretary and Chair, have been successful over the past 6 years with passing the bill, because we've really done things that, while they move things in a great direction, in the right direction, I think, didn't do it in a way that made drastic policy changes. I look forward to that same kind of incremental approach, and look forward to working with you, Mr. Secretary, as we move forward to continue to head your critically important department in the right direction, because it serves the American people, and in many ways, serves people all over the world. Thank you, Chairman.

[The statement follows:]

PREPARED STATEMENT OF SENATOR ROY BLUNT

Thank you, Chair Murray. I appreciate Secretary Becerra (pronounced: ba-serra) for being here today to discuss the Administration's fiscal year 2022 budget request.

Over the past year, we have faced the challenges of a global pandemic. At a hearing in the House in May, you testified that, "The fight against COVID-19 is not yet over." I agree. While vaccination rates are going up and cases are going down, we're still not finished with the fight. First, as many public health experts have stated, even those within the Administration, there is a certain vaccination level necessary to reach herd immunity and we're not there quite yet. Second, we may or may not need COVID-19 boosters at some point in the future and if we do, that will require further outreach and vaccination campaigns. Finally, we need to have a clear strategy to provide vaccines to developing nations. As we have seen with past infectious disease outbreaks like Ebola, the next sick patient is only a plane ride away.

That is why I have been particularly concerned with the Administration's strategy on Unaccompanied Alien Children. Many may think that one issue has nothing to do with the other. But when the Administration is robbing Peter to pay Paul, they become inextricably linked.

Mr. Secretary, over the past three months the Department has transferred \$2.98 billion to the Unaccompanied Children account to deal with the fallout of the Administration's failed border policies. This includes funding specifically for COVID-19 relief from the American Rescue Plan. I want to remind the Committee that only a few short months ago, President Biden felt it was so imperative to pass a COVID-19 supplemental bill that the Administration pushed through a \$1.9 trillion partisan bill, with no input from Republicans, and then almost immediately transferred \$850 million from funding that should have gone to additional COVID-19 testing to fund additional unlicensed shelter beds for Unaccompanied Alien Children. And just last week, the Administration transferred an additional \$846.5 million to the Unaccompanied Children program from their partisan COVID-19 bill intended to fund Community Health Centers, behavioral health workforce training, public health workforce, among other programs.

Second, the bipartisan COVID-19 supplemental passed in December that was written by this Committee included critical resources for the Strategic National Stockpile—which has proven essential during this pandemic, and for future crises. The Department took \$850 million from this vital stockpile under the guise that the Unaccompanied Children program needed money due to COVID-19 and not failed border policies.

Finally, the Department transferred \$426 million from fiscal year 2021 Labor/HHS funds, from programs like Children's Hospitals Graduate Medical Education, Ryan White HIV/AIDS, medical research, and child care. Prior to making these choices, none of these decisions were discussed with this Committee. In fact, Members on my side of the aisle have had no substantive discussions with you about the crisis at the border, even though the Administration has transferred or reprogrammed almost \$3 billion of funding to address it.

I understand that the Department is not in charge of our immigration laws and that the Department has to care for unaccompanied children that cross the border,

regardless of where they come from or how they arrive. But without a dialogue with this Committee on how to do so, I suspect you will not have the flexibility to run this program next year as you have had this year. The Appropriations Committee appropriates funding based on the budget request, through arduous negotiations between the Senate and House, between Republicans and Democrats. I do not think the Administration should simply ignore that.

While we may disagree on the Department's management of the Unaccompanied Children program, there are significant places where we agree. I support the increase to the National Institutes of Health and think that the new research Institute at NIH is coming at the right time with the right focus. I agree with expansion of Certified Community Behavioral Health Clinics to help address the mental health crisis, efforts to end the HIV epidemic, and bringing additional resources to bear to end the opioid epidemic.

However, this is going to be a difficult year and the devil is always in the details. For example, the Administration is requesting a 15.9% increase for non-defense discretionary funding, and the Department of Health and Human Services is requesting a 23% increase or an increase of \$23 billion. That is significant, especially when compared to the Defense Department's budget request doesn't even keep up with inflation. Over the last several years, the other side of the aisle has pushed for parity between defense and non-defense funding and that is where we have ended up. I would expect a similar outcome this year.

Finally, I wholeheartedly disagree with the Administration's removal of the long-standing Hyde Amendment. The Hyde Amendment prevents the Department from using federal taxpayer dollars to fund elective abortions. Hyde has been included in every government funding bill for more than 40 years. Every person on this Committee who has ever voted for a final Labor/HHS bill has voted for Hyde since its first appearance in 1976. And I do not think this year should be any different.

Mr. Secretary, this Committee has been successful over the last six years with passing a bill because we haven't made fundamental, drastic policy changes. That is the position I took as Chairman and it will continue to be my position this year. I hope the Department will set aside its partisan policies to support programs that benefit all Americans instead.

Thank you, again, for being here today.

Senator MURRAY. Thank you very much, Senator Blunt. I will now introduce our witness today. It's Xavier Becerra, the Secretary of the Department of Health and Human Services. Thank you for joining us today. And at this point, I'm going to turn the gavel over to Senator Reed. Thank you for being here. I have to go introduce three constituents at another committee meeting. I will return, but until that time, Senator Reed will hold the gavel, and Secretary Becerra, you can begin your testimony. Thank you.

SUMMARY STATEMENT OF HON. XAVIER BECERRA

Secretary BECERRA. Madam Chair, thank you. Ranking member Blunt, members of the committee, thank you again. The Department of Health and Human Services is at the center of many challenges facing our country today. The COVID-19 pandemic has shed light on how inequities and inefficient Federal funding can leave communities vulnerable to crisis. Now, more than ever, we must ensure that the Department has the resources to achieve its mission, and to build a strong public health system, and a healthier America.

For HHS, the budget proposes \$131 billion in discretionary budget authority, and \$1.5 trillion in mandatory funding. This budget underscores the administration's commitment to prepare the Nation for the next public health crisis, to expand access to affordable healthcare, to address health disparities, to tackle the opioid and other drug crises, and to invest in other priority areas, like maternal health, Tribal health, and early childhood education.

We know the fight against COVID-19 is not yet over, but even as HHS works to beat the pandemic, we must also prepare for the next public health challenge. To start, the budget makes significant investments in our preparedness and response capabilities, including by investing in the Strategic National Stockpile, and the public health workforce. It provides a new mandatory funding stream for the manufacture of medical countermeasures here at home, to protect Americans from future pandemics, and create U.S. jobs.

The budget includes the largest fiscal year investment in the CDC (Centers for Disease Control and Prevention) in almost two decades. The budget reflects the president's commitment to expand access to quality, affordable healthcare for all Americans. It builds on the groundbreaking reforms introduced in the American Rescue Plan by permanently extending the enhanced premium subsidies that put affordable healthcare coverage within reach for millions more Americans.

The budget also expands access to home and community-based services under Medicaid, critical services that allow older Americans and our loved ones with disabilities to live independently in their homes and communities. And the budget calls for Congress to take additional steps this year to lower the costs of prescription drugs, and further expand and improve health coverage through additional benefits and public coverage options.

Healthcare must be a right, not a privilege, and I will work hard to ensure that families across the Nation are able to secure the healthcare that they need. And as we work to expand access to affordable healthcare and address the challenges of COVID-19 and future pandemics, we need to address public health crises that are already here. Like violence in our communities and climate change.

The President's budget increases funding to support domestic violence survivors. It addresses gun violence by doubling funding for firearm violence prevention research and allows HHS to play a major role in the administration's government-wide effort to tackle the climate crisis, by supporting research and programs identifying the human health impacts of the climate change and establishing an Office of Climate Change and Health Equity.

To ensure that HHS is equitably serving all Americans, the budget invests in reducing maternal mortality and morbidity that disproportionately impacts women of color. It builds on the American Rescue Plan's State option to extend Medicaid postpartum coverage, it funds a range of rural healthcare programs, and expands the pipeline for rural health providers. It includes a dramatic funding increase in advance appropriations for the Indian Health Services, and it invests in improving access to vital reproductive and preventative care services through Title X.

To support families and build the best possible future for our children, the budget makes major investments to ensure high quality childcare is affordable for low- and middle-income families, and to provide high-quality pre-K for all 3- and 4-year-olds. We know our experiences as children shape the adults we become. Support in childhood leads to success in the future.

To address COVID-19's unprecedented acceleration of substance use and mental health disorders, the budget makes historic investments in SAMHSA (Substance Abuse and Mental Health Services

Administration) to support research, prevention, treatment, and recovery services. To support innovation in research, the budget increases funding for NIH by \$9 billion, \$6.5 billion of which will go to establish the advanced research project agency for health, ARPA-H, with an initial focus on cancer and other diseases such as diabetes and Alzheimer's.

This major investment in Federal research and development will leverage ambitious ideas to build transformational innovation through health research and the application and implementation of health breakthroughs.

Finally, to ensure our funds are used appropriately, the budget invests in program integrity, including efforts to combat fraud, waste and abuse in Medicare, Medicaid, and private insurance.

Madam Chair, I'd like—and Mr. Chairman, I'd like to close by recognizing the women and men at HHS for their outstanding and tireless work fighting COVID-19 to protect the health of their fellow Americans. To build back a prosperous America, we need a healthy America. We've taken important steps over the past few months to expand access to quality, affordable healthcare, to lower healthcare premiums, and to protect women's health at home and abroad. President Biden's budget request builds on that progress. Thank you.

[The statement follows:]

PREPARED STATEMENT OF HON. XAVIER BECERRA

Chair Murray, Ranking Member Blunt, and Members of the Committee, thank you for the opportunity to discuss the President's Fiscal Year (FY) 2022 Budget for the Department of Health and Human Services (HHS). I am pleased to appear before you, and I look forward to continuing to work with you.

HHS is at the center of many challenges facing our country today—the COVID-19 pandemic, safely caring for unaccompanied children at our southern border, the overdose and the addiction epidemic gun violence, racial inequality, and more—and we are rising to meet those challenges. I am honored to be given the responsibility to lead HHS at this time.

COVID-19 has shed light on how health inequities and insufficient Federal funding can leave communities vulnerable to crises. The President's Budget invests in America, demonstrates a conscious effort to address racial disparities in health care, tackles the opioid and other drug crises, and puts us on a better footing to take on the next public health crisis.

Now more than ever, we must ensure that HHS has the resources to achieve its mission and tackle these challenges after years of underfunding. The President has put forward a budget that does just that. The FY 2022 budget proposes \$131.8 billion in discretionary budget authority and \$1.5 trillion in mandatory funding. The Labor-HHS total is \$119.5 billion, an increase of \$23 billion. Investments in the budget support families in areas such as behavioral health (mental health and substance use), maternal health, emerging health threats, science, data and research, tribal health, early child care and learning, and child welfare.

To build back a prosperous America, we need a healthy America, and President Biden's budget builds on that vision while investing in the many programs housed at HHS to save lives.

PREPARING FOR AND RESPONDING TO PUBLIC HEALTH CRISES

The fight against COVID-19 is not yet over. Even as HHS works to beat this pandemic, we are also preparing for the next public health crisis. The FY 2022 budget makes significant investments in our preparedness and response capabilities.

The Strategic National Stockpile, within the HHS Office of the Assistant Secretary for Preparedness and Response, has served a critical role in the COVID-19 response, permitting rapid deployment of personal protective equipment, ventilators, and medical supplies to states, cities, tribes, and territories across the country. The budget provides \$905 million for the stockpile, \$200 million above FY 2021, to ensure that the stockpile is ready to respond to future pandemic events and any other

public health threats while maintaining a robust inventory of critical medical supplies, enhancing visibility of the domestic supply chain, and modernizing the stockpile's distribution model. In addition, the budget provides \$823 million, \$227 million above FY 2021, for the Biomedical Advanced Research and Development Authority, which has supported the development of new vaccines, therapeutics, and diagnostics for the COVID-19 response. Additional resources will support improved medical countermeasure platforms that will enable quicker, more effective detection and public health and medical responses to health security threats. The budget also supports a strong public health workforce, and addresses gaps in the existing public health infrastructure, including at the state and local levels. In addition to discretionary investments, the budget includes \$30 billion over four years in mandatory funding for HHS, the Department of Defense, and the Department of Energy to protect Americans from future pandemics and create U.S. jobs through major new investments in medical countermeasures manufacturing; research and development; and related biopreparedness and biosecurity investments.

During this pandemic, we have seen the critical role of the Centers for Disease Control and Prevention (CDC). To ensure that CDC is well positioned to address current and emerging public health threats, the budget restores capacity to the world's preeminent public health agency by investing an additional \$1.6 billion over the FY 2021 level for a discretionary funding total of \$8.7 billion. This is the largest budget authority increase for CDC in almost two decades. A core function of CDC is partnering with state, tribal, local, and territorial entities, and this funding will enhance those partnerships. The budget will also provide CDC with additional resources to further develop and expand teams of highly trained and deployable public health experts to support preparedness at the local level.

The COVID-19 pandemic has also shown the importance of producing reliable data. Bad inputs lead to bad outputs, and without good data, CDC cannot effectively prepare for, or respond to, public health threats and make well-informed decisions to protect the American people. With funding provided in the FY 2022 budget, CDC will build upon previous investments in the data infrastructure to date and continue efforts to modernize public health data collection and analysis nationwide.

Public health threats know no borders, and CDC is working to prevent, detect, and respond to epidemic threats at home and abroad. With CDC experts embedded in countries around the world, CDC is supporting global COVID-19 response by leveraging core public health capacities and relationships built through decades of CDC global health activities. As we continue to confront new and emerging COVID-19 variants, as well as a surge of cases in India, support for CDC's work is even more important. CDC is working closely with U.S. government agencies, ministries of health, and other partners to assist countries in responding to COVID-19, while simultaneously developing and implementing adaptations to interventions for malaria, HIV, and vaccine-preventable diseases. With the President's proposed FY 2022 investments, CDC will not only address preparedness within the United States, but will also support core public health capacity improvements overseas and strengthen global health security by improving our ability to deploy experts internationally and support efforts to prevent, detect, and respond to emerging global biological threats. CDC will invest in global health security and continue to fight health threats worldwide while simultaneously enhancing domestic preparedness to address threats here at home. Domestic health is increasingly impacted by global factors and CDC's global health security efforts include conducting research to ensure efficient disease response.

The Assistant Secretary for Preparedness and Response (ASPR) and CDC investments complement preparedness activities across HHS including basic and clinical research within National Institutes of Health (NIH) and activities within the Food and Drug Administration (FDA) to advance regulatory science and mitigate potential supply or drug shortages.

While we prepare for future pandemic threats, we are also facing a public health crisis that is already here: violence in our communities. The current public health emergency has shone a light on the issue of domestic and gender-based violence. More than 1 in 4 women and more than 1 in 10 men have experienced contact sexual violence, physical violence, or stalking by an intimate partner and reported significant impacts. The budget provides \$489 million for the Administration for Children and Families (ACF) to support and protect domestic violence survivors, which is more than double the FY 2021 enacted levels. The budget also provides \$66 million for victims of human trafficking and survivors of torture, more than 45 percent above FY 2021 enacted levels.

We have also seen the devastating impact of gun violence in communities across the country. Almost 40,000 people die as a result of firearm injuries in the United States every year, while homicide is the third leading cause of death for people ages

10–24. This is a public health issue, and one that disproportionately impacts communities of color. The budget addresses this crisis by doubling CDC and NIH funding for firearm violence prevention research. The budget provides \$100 million in discretionary funding to CDC to start a new Community Violence Intervention initiative, in collaboration with the Department of Justice, to implement evidence-based community violence interventions at the local level. In addition to the discretionary investment for the Community Violence Intervention initiative, the budget includes a total of \$5 billion in mandatory funding for CDC and the Department of Justice, beginning in FY 2023 and continuing through FY 2029.

The climate crisis has real public health impacts, and the HHS’ mission depends on healthy and sustainable environments. HHS thus has a major role to play in the Administration’s government-wide effort to tackle this crisis. HHS’ investments to combat climate change in the FY 2022 Budget will advance health equity, lay the foundations for economic growth, and ensure that benefits from tackling the climate crisis accrue to tribal communities, communities of color, low-income households, and disadvantaged communities that have been marginalized or overburdened. The budget includes a \$100 million increase in NIH funding to support research aimed at understanding the health impacts of climate change, as well as an additional \$100 million investment in CDC’s Climate and Health program to support efforts to understand and identify potential health effects, including children’s environmental health considerations associated with climate change and implement plans to adapt to a changing environment. The American Jobs Plan also would invest \$1.5 billion to increase the resilience of hospitals and critical infrastructure, fund health emergency preparedness cooperative agreements, and build resilience including in relation to the effects of a changing climate.

CARING FOR ALL AMERICANS THROUGH HEALTH AND HUMAN SERVICES

Central to the HHS mission is the charge to enhance the health and well-being of all Americans. The budget invests in areas across HHS to ensure that we are equitably serving the American people. As Secretary, I will ensure that this focus is fundamental to all of our work.

A critical part of this is investing in civil rights enforcement to ensure that all people receiving services from HHS-conducted or HHS-funded programs, no matter who they are, or where they live, can receive health care free from discrimination.

The FY 2022 Budget makes expanding affordable health care access a priority across Centers for Medicare & Medicaid Services programs. A recently released report titled “Health Coverage Under the Affordable Care Act: Enrollment Trends and State Estimates” shows that the Affordable Care Act (ACA) has expanded health insurance coverage to millions of Americans, and the budget goes even further. It builds on the groundbreaking reforms introduced in the American Rescue Plan Act by extending the enhanced premium subsidies that put affordable health care coverage within reach of millions more Americans. These improvements in the American Rescue Plan Act are lowering premiums for more than nine million current enrollees by an average of \$50 per person per month. In addition, due to the COVID–19 pandemic, an ongoing opportunity to apply for enrollment in Marketplace health care coverage is available on HealthCare.gov through August 15. This extension provides individuals and families a desperately needed opportunity to get quality, affordable health insurance coverage. As of May 10, over 1 million additional Americans have signed up for health insurance through the Marketplace, and an additional 2 million obtained improved benefits through the Marketplace, benefitting from both reduced premiums and more affordable cost sharing.

The FY 2022 Budget also expands access to critical home- and community-based services (HCBS) under Medicaid, critical health care services that allow older people and people with disabilities to live independently in their homes and communities. The budget builds on the additional Medicaid funding included in the American Rescue Plan that not only expands access to these important services but also strengthens state HCBS programs by allowing states to use the additional money to, for example, provide additional benefits, like mental health and substance use services, to beneficiaries, as well as to raise wages and provide paid leave for home care workers.

I look forward to working with the Congress to achieve the Administration’s goal of lower costs and expanded and improved coverage for all Americans. This includes reforms to lower the costs of prescription drugs, such as allowing Medicare to negotiate payment for certain high-cost drugs, and requiring manufacturers to pay rebates when drug prices rise faster than inflation. We will also work to improve Medicare, Medicaid, CHIP, and private insurance coverage, by pursuing changes such as improving access to dental, hearing, and vision coverage in Medicare, mak-

ing it easier for eligible people to get and stay covered in Medicaid, promoting Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements for eligible youth, and reducing out-of-pocket costs for individuals in private insurance coverage obtained through the Marketplace. The Administration also supports additional public coverage options, including a public option that would be available through the insurance marketplaces. Health care is a right, not a privilege, and I will work to ensure that families across the nation are able to secure this right.

The United States has the highest maternal mortality rate among developed nations, with an unacceptably high mortality rate for Black and American Indian/Alaska Native women. Addressing this critical public health issue is a major priority of this Administration, as evidenced by the American Rescue Plan's state option to extend Medicaid postpartum coverage. Building on HHS's longstanding efforts to improve maternal health, including the Department's recent Medicaid postpartum waiver approvals, the budget provides more than \$220 million in discretionary funding to reduce maternal mortality and morbidity by implementing evidence-based interventions to address critical gaps in maternity care service delivery and improve maternal health outcomes. This includes increased funding to CDC's Maternal Mortality Review Committees and the Health Resources and Services Administration's (HRSA) Rural Maternity and Obstetrics Management Strategies program. HRSA also prioritizes maternal health through its Title V Maternal and Child Health Block Grant and Alliance for Innovation on Maternal Health programs. As with all our public health work, collecting good data will be critical. In addition to these discretionary resources, the budget includes \$3 billion in mandatory funding over five years, to invest in maternal health and reduce the maternal mortality rate and end race-based disparities in maternal mortality.

HRSA's work is central to our focus on serving all Americans, given their mission to improve health outcomes and address health disparities. HRSA-funded Health Centers provide access to care for low-income and marginalized populations, and they serve 1 in 11 people in the nation. The President's Budget increase to workforce diversity programs, highlights HRSA's commitment to supporting health care providers dedicated to working in underserved areas and building toward a workforce that reflects the communities it serves and is able to provide culturally relevant care.

The budget provides \$670 million across HHS to continue efforts to end the HIV epidemic in the United States by working closely with communities that have high rates of HIV transmission to implement effective prevention, diagnosis, and treatment strategies, including ones that address the disproportionate impact of HIV and Hepatitis C infections in Tribal communities. HHS programs have already made major progress in combating the HIV epidemic. HRSA ensures equitable access to services and supports for low-income people with HIV through Health Centers as well as the Ryan White HIV/AIDS Program. In 2019, 88.1 percent of those served under the Ryan White HIV/AIDS Program had achieved viral suppression, a record level that exceeds the national average of 64.7 percent. HHS will build on this work to end the epidemic once and for all.

Also, directly connected to the HHS mission is the need to provide access to high-quality care, no matter where you live. HHS will continue to focus on the unique needs of rural communities. HHS administers a range of programs that address rural health, from those that serve large populations such as Health Centers, to those serving targeted populations such as the Black Lung Clinics Program. The FY 2022 budget serves active, inactive, retired, and disabled coal miners and their families through high-quality medical, outreach, educational, and benefits counseling services. It also provides funding to increase the number of individuals receiving training and serving in health professions in rural communities, as research has shown that providers are likely to remain in the communities where they train as residents.

HHS will also address the stark health disparities that persist in Tribal communities by investing in the Indian Health Service (IHS), which serves over 2.6 million American Indians and Alaska Natives. The COVID-19 pandemic's devastating impact on Tribal communities has demonstrated the real human toll of these disparities. The budget provides a \$2.2 billion, or 36 percent, increase for IHS in order to take a historic step to address chronic underfunding, expand access to high-quality health care, and address critical facilities and information technology infrastructure deficiencies across Indian Country. For the first time, the budget also proposes advance appropriations for IHS to provide stability for the Indian Health system and parity with how other Federal health agencies are funded. I am committed to strengthening the Nation-to-Nation relationship between the United States and Indian Tribes. To this end, the budget supports self-determination through a consult-

ative process to consider long-term solutions, including mandatory funding, to ensure adequate and stable funding for IHS.

The budget also provides an 18.7 percent increase to the Title X Family Planning program to improve access to vital reproductive and preventive care and to advance gender equity. Over the last two years, nearly half of the programs supported by Title X lost providers as a result of the 2019 regulation which added burdensome restrictions inconsistent with quality care guidelines and ultimately resulted in many highly qualified, longstanding healthcare entities to exit Title X. The budget allows Title X to not only restore highly qualified providers, but also to expand its essential services to meet increased demand as a result of the global pandemic and resulting recession. In 2019, Title X-funded clinics served almost 3.1 million Americans, 66 percent of whom had incomes at or below the federal poverty level and 41 percent of whom were uninsured. This is nearly 1 million fewer people served than in 2018.

INVESTING IN CHILDREN'S FUTURES

Our experiences as children shape the adults we become, and support in childhood can mean success in the future. As Frederick Douglass wrote, "It is easier to build strong children than to repair broken men." High-quality early care and education lay a strong foundation so that children can take full advantage of education and training opportunities later in life. The American Jobs Plan and the American Families Plan invest in school and child care infrastructure and workforce training, and ensure that low and middle-income families pay no more than 7 percent of their income on high-quality child care. These investments include \$200 billion over ten years for a national partnership with states to offer free, high-quality, accessible, and inclusive preschool to all three- and four-year-olds, benefitting five million children. The budget also invests \$250 billion over ten years to make child care affordable.

The budget also provides \$19.8 billion in discretionary funding for the Department's early care and education programs in ACF, \$2.8 billion over FY 2021 enacted. This includes \$11.9 billion for Head Start, which helps young children enter kindergarten ready to learn. Head Start programs deliver services through 1,600 agencies in local communities, and they provide services to more than a million children and pregnant women every year, in every U.S. state and territory. In addition, the budget provides \$7.4 billion for the Child Care and Development Block Grant, \$1.5 billion over FY 2021 enacted, to expand access to high-quality child care for families in all corners of the country. Over a million children receive child care subsidies every month funded by the Child Care and Development Fund, and nearly half of the families receiving child care subsidies reported income below the Federal Poverty Level. These investments will improve outcomes for children across the country.

The budget also invests in improvements to the child welfare system, particularly to address its racial inequity. The budget provides \$100 million in new competitive grants for states and localities to advance reforms that would reduce the overrepresentation of children and families of color in the child welfare system and address the disparate experiences and outcomes of these families. This funding will also give more families the support they need to remain safely together. The budget also provides \$200 million for states and community-based organizations to respond to, and prevent, child abuse, over 30 percent above FY 2021 enacted.

COMBATING MENTAL HEALTH AND SUBSTANCE USE CRISES

HHS must address the public health crises associated with mental health and substance use disorders. This need is especially urgent given that both crises have accelerated during the COVID-19 pandemic. Calls to mental health helplines have increased across the country as Americans struggle with increased anxiety, depression, risk of suicide, and trauma-related disorders resulting from the pandemic. Younger adults, racial minorities, essential workers, and unpaid adult caregivers are particularly impacted. Similarly, preliminary data from 2020 suggests that overdose deaths, which were already increasing, accelerated at an unprecedented rate during the pandemic. Provisional data suggest that over 90,000 drug overdose deaths occurred in the United States in the 12 months ending in September 2020. That represents a year-over-year increase of close to 29 percent.¹ This crisis is also

¹Centers for Disease Control and Prevention. (2021). Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts. Retrieved May 6, 2021 at <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

evolving—overdose deaths involving substances other than opioids are also increasing. HHS will ensure that our work is responsive to the needs of communities across the country.

The budget addresses these crises through investments in the Substance Abuse and Mental Health Services Administration.

In a historic investment, the budget provides \$1.6 billion to the Community Mental Health Services Block Grant to respond to the systemic strain on our country's mental health care system—more than double the FY 2021 level. To address the undeniable connection between the criminal justice system and mental health, the discretionary request will also invest in programs for people involved in the criminal justice system. HHS will also focus on the behavioral impact of COVID-19, including on children. When children and young people face Adverse Childhood Experiences (ACEs) such as trauma, it can continue to affect them across their lifespan, so it is critical we intervene now to support their social, emotional, and mental well-being.

The budget also takes action to address addiction and the overdose epidemic, investing \$11.2 billion across HHS, \$3.9 billion more than in FY 2021, including \$3.5 billion for the Substance Abuse Prevention and Treatment Block Grant, which has historically failed to keep up with increases in the cost of providing substance use care to America's neediest citizens. For the first time, the budget includes a 10 percent set aside for recovery support services, a critical step for building and sustaining the nation's recovery support services infrastructure. The Block Grant remains a critical source of funding for states, tribes, and territories to provide prevention, treatment, and recovery support services to their citizens. The impact of this epidemic is felt in our communities, and the budget will direct funding to states and Tribes to increase community-level response. The budget will also increase access to medications for opioid use disorder and expand the behavioral health provider workforce, particularly in underserved areas. I greatly appreciate the investments the American Rescue Plan Act provided to the Substance Abuse Prevention and Treatment Block Grant, Mental Health Block Grant, and Certified Community Behavioral Health Centers, and HHS will continue to build on these efforts.

PROMOTING BIOMEDICAL RESEARCH

HHS' work is responsible for major scientific breakthroughs, and we are committed to supporting innovative science and research in order to advance the health and well-being of our nation. As the world's premier biomedical research agency, NIH will continue to be at the forefront of scientific advancements. The budget includes \$52 billion for NIH, a \$9 billion increase or 21 percent increase over FY 2021 enacted. Included in this increase is \$6.5 billion to establish the Advanced Research Projects Agency for Health (ARPA-H). With an initial focus on cancer and other diseases such as diabetes and Alzheimer's, this major investment in Federal research and development will leverage ambitious ideas to build transformational platforms, capabilities, and resources to speed the application and implementation of health breakthroughs and shape the future of health and medicine in the U.S.

This bold new approach will complement NIH's existing research portfolio, which is a vital contributor to longer and healthier lives, supports and trains world-class scientists, and drives economic growth. Outside of ARPA-H, the remaining \$2.5 billion increase will allow NIH to continue investing in basic research and translating research into clinical practice to address the most urgent challenges, such as HIV/AIDS and ending the opioid crisis.

RESTORING AMERICA'S PROMISE TO REFUGEES

HHS plays a critical role in promoting the wellbeing of those seeking refuge or relief in the U.S. The FY 2022 budget provides over \$4.4 billion to the Office of Refugee Resettlement (ORR)—an increase of over \$2.5 billion above FY 2021 enacted. This funding would allow ORR to support an increase in the refugee admissions ceiling to 62,500 this fiscal year and to continue to rebuild the resettlement infrastructure in order to resettle up to 125,000 refugees in FY 2022.

This funding increase also reflects a commitment to ensuring that unaccompanied children are provided with care and services that align with child welfare best practices while they are in ORR's custody, and unified with relatives and sponsors as safely and quickly as possible. Despite significant challenges posed by COVID-19 and policies from the previous administration, HHS is humanely caring for unaccompanied children while working to unite them with a vetted sponsor. Working across government and in close partnership with the Department of Homeland Security, we have substantially increased our ability to quickly facilitate the transfer of

children out of U.S. Customs and Border Patrol custody and into child-appropriate settings, including with fully vetted sponsors.

FUNDING CORE PROGRAM OPERATIONS

It is simply not possible to meet the HHS mission and address all these key changes without sufficient funding to cover our operational needs. The FY 2022 budget invests to bolster operations. It strengthens administrative and operational resources throughout the Department needed to ensure proper stewardship of resources entrusted to HHS by Congress.

PROVIDING OVERSIGHT AND PROGRAM INTEGRITY

Given the magnitude of HHS's work-and the taxpayer dollars used to fund it-it is critical that we ensure that our funds are used appropriately. The budget invests in program integrity, including efforts to combat fraud, waste, and abuse in Medicare, Medicaid, and Private Insurance.

CONCLUSION

I want to thank the Committee again for inviting me to discuss the President's FY 2022 Budget for HHS, which offers a comprehensive fiscal vision for the nation that reinvests in America's health, supports future growth and prosperity, and meets U.S. commitments in a fiscally sustainable way. I look forward to continuing to show how HHS helps fulfill that vision.

Senator REED [presiding]. Thank you very much, Mr. Secretary. Chairwoman Murray has allowed me to go first, and then I'll recognize Senator Blunt. Like Senator Blunt, one of the privileges of my life in public service is having served with you in the House of Representatives, and congratulations, Mr. Secretary, on your well-deserved position.

NATIONAL SUICIDE PREVENTION LIFELINE

One of the legislative initiatives that I was involved with was the National Suicide Prevention Lifeline. I worked together with Senators Gardner, Baldwin, and Moran. We've changed the ten-digit number to a three-digit number, and several States have already adopted the number. Everyone has to adopt it by next year, but the reality is we'll need more funding, because, as more people use this number, we'll need more counselors and more capacity.

We asked that SAMHSA provide a cost estimate to Congress on Lifeline in early April. Could you give us an update on the cost estimate, Mr. Secretary?

Secretary BECERRA. Senator, thank you for the question, because this one is important. Even though it's not one of the bigger items, it is crucial for a lot of people. Just as 911 has become indispensable, 988, I believe, will become indispensable for those who need some help in crisis.

And where we are right now, Senator, is we have had some briefings with members on the Hill. We're trying to follow up with those. We're hoping to move as quickly as possible. You may have seen in the budget, the President has quadrupled the amount of money that he would allocate for this particular 988 program and so, we would hope to receive funding for—about a year's worth of funding of about \$102 million over the 24 or so million that there was before.

We're hoping to move quickly, but I think you're right. To do this well, and to do it throughout the country, we may need to come back to you.

Senator REED. Well, thank you, Mr. Secretary, but I think we all recognize there's been an incredible increase in suicides, and particularly disturbing, among young people, also among service members, and so, I appreciate your efforts to get this thing done.

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

Turning to another issue, LIHEAP (Low Income Home Energy Assistance Program). It's a critical program, long supportive of it. The resources in the budget are impressive, and I appreciate it, but one of the issues we have is getting the word out, if you will. There are many individuals who could participate, but they're not aware of the program. Can you share the steps the agency is taking to conduct outreach and make sure that eligible individuals get their LIHEAP?

Secretary BECERRA. Senator, on top of increasing the budget for the LIHEAP program, because, like you, I have been a fighter for this program for quite some time, and we're also reaching out. We're reaching out to the utility companies, we're reaching out to local governments, we're trying to have them help us reach out to people who qualify for these services, and so, we don't want to just wait and believe that people will hear that we're increasing the funding for LIHEAP.

We're going to try to work with our local partners, private sector and public, to try to reach those families that really need this funding to help them survive, and make sure, monthly-wise they're covered.

Senator REED. Well, thank you, Mr. Secretary. One of the agencies that has been very effective are the community action agencies. They have roots in the community, so, I'm sure they're on your list, but I just wanted to mention that for the record.

PERSONAL PROTECTIVE EQUIPMENT MANUFACTURERS

We all are concerned about PPE (Personal Protective Equipment). We had a wake-up call during the pandemic, and we are concerned about how you're stockpiling it in terms of prioritizing U.S. manufacturers, or at least manufacturers that are consistent allies of the United States, and not potential competitors. But can you comment?

Secretary BECERRA. Here I have to thank you all for the work you did to help us stand up a sizeable pot of money, \$10 billion, that will help us make sure that we're doing all we can to increase domestic manufacturing of that. Not just the PPE, but the types of material, and the types of product that we need in the event of a future pandemic, or a future crisis.

And so, we're trying to adapt. The stockpile has to enter the 21st century. We have to make sure that what we do have stored actually will work once we need it, and we have to make sure that what we are storing is what we need to be equipped for the crises of the 21st century. But thank you for that support.

Senator REED. Well, thank you very much, Mr. Secretary, and again, thank you for your service, and I'm extremely pleased that you're the Secretary. Thank you.

Secretary BECERRA. Thank you, Senator.

Senator REED. Senator Blunt, please.

Senator BLUNT. Thank you, Senator. Secretary, the Congress has provided \$178 billion over the course of the last year for the Provider Relief Fund. There's another \$8.5 billion in addition to that for rural hospitals in the American Rescue Plan that passed in January. I think most of that money has to be spent by June 30.

You answered some questions on that at the Ways and Means Hearing yesterday. You said we're trying to make sure we don't make the mistakes of the past. What are a couple of those mistakes, and how are you trying to move forward without continuing what you think was a mistake?

Secretary BECERRA. Senator, I think we would all agree that we want to know where and why taxpayer dollars are going to particular item or cause, and I think most people will tell you—at least the comments that we're seeing are that there wasn't enough transparency in the process. How the money was allocated. Why was one provider provided dollars, in some cases, quite a bit of money, and in other cases, other providers who were also in need, didn't?

And so, what we want to do is provide that transparency. At the same time, we understand that there were a number of providers who were left behind because of the formula that was used to disperse the dollars, based on Medicare claims.

And in many cases, if you happened to be a provider that relied a lot on, say, Medicaid or other sources, or you provided a lot of charity care, you might not have had the same level of claims. That doesn't mean you didn't have the COVID patients. So, we're trying to provide the transparency, make sure we direct the money where it's needed, and with the money that's still left, we want to make sure that you all can look at this and say, we get it.

Senator BLUNT. So, I think there's approximately \$50 billion left. I also believe that money, most of it, needs to be spent by June 30. What are you doing to get that money out, and when you do get it out, what are you doing to make it more likely that the hospitals will be able to spend that money before the deadline?

Secretary BECERRA. Senator, there's a tranche of money that has not yet been allocated, and so the deadline for spending that has not yet been determined, but there is money that did go out that does have a deadline, and what we're trying to do is, over the next few weeks, make sure we provide some guidance so people understand how we can make sure that everyone fulfills their commitments in getting these dollars.

We want to make sure we provide some flexibility. We also want accountability. We want to make sure folks understand that when they got these taxpayers dollars to help Americans in need, that taxpayers expect that it went to help those families in need. And so, what we'll try to do is—understand that we can't change the process that began before, but what we can try to do is make sure we get the accountability while trying to provide some flexibility.

Senator BLUNT. So, advice I gave the previous administration on this in a letter I wrote last fall was, don't make it needlessly difficult by continuing to change the guidelines that you're giving hospitals on how they can spend the money. So, I hope as you allocate this last amount of money, or put out whatever guidance you need, that it doesn't suddenly restrict what they were earlier told they

could do, but more importantly, it does let them know that you're going to have guidelines out there that they can rely on if they spend the money that way, that it meets the guidelines.

UNACCOMPANIED CHILDREN

On the unaccompanied children issue, Secretary, I think you have an average of about 400 children coming in every day. You can verify that, if you know, and how many children do you have leaving the program every day?

Secretary BECERRA. It's a number, Senator, as you know, that fluctuates. A couple months ago, the average was probably closer to 600, maybe above that. Today, you're probably right. It hovers somewhere between 3 to 5 hundred a day, but we can't predict it.

Senator BLUNT. Well, the average is kind of what I'm wondering about, both on children coming in and then children leaving the program.

Secretary BECERRA. Yes, again, right now, and what we do at the department, my team, we try to use a week average. We go week by week to see the trends, but I'd say you're probably accurate. Somewhere between 3 to 5 hundred a day, over the last week, two weeks coming in.

Those that we are discharging to a responsible sponsor, after checking the background of those individuals, somewhere between, probably between 4 to 6 hundred, probably closer to the higher range of 600 than 400.

Senator BLUNT. And who checks the background on the individuals that these children are given responsibility for?

Secretary BECERRA. We have a dedicated team of people who've been trained to do background checks.

Senator BLUNT. And they work for you? HHS team, or a—

Secretary BECERRA. It's an HHS team. We pay for all the services that are provided. In many cases, we've been fortunate, the Department of Homeland Security has been very generous in providing us with some of their personnel who have been trained in doing intake work and processing. We have others within the Federal Government who have volunteered, and certainly we have folks from within HHS who are doing this.

We had to substantially increase the number of caseworkers that we use so we could make sure we process in a timely fashion those children's record to see if they could be discharged to a responsible custodian.

Senator BLUNT. Well, when 400 are coming in, or 500 or coming in, but more importantly, when say, 500–600 are going out, I know you don't want, and I don't want any of those children to go to a place where they're less safe, where they're going to be exploited or taken advantage of, and I would hope you're doing everything you can dealing with those big numbers to be sure that that does not happen.

Secretary BECERRA. Senator, I can assure you, the reason back in March and April we were looking at this and really seeing it as a major challenge in CBP, that's Customs and Border Protection, was having these large number of children in their adult detention facilities, where they should not be, is because we wanted to make

sure before we took that child, we could provide exactly what you just said.

The safety, the health requirements, wherever we are going to place that child. We ran out of the licensed care facilities that we typically would send these kids to a substantial time ago. We've had to stand up a number of emergency shelters to be able to properly house these children, and where possible, we try to move them as quickly as we can to a safe home once we've gone through the vetting process.

It is tough, it's challenging, and it's expensive, but we're going to do it right.

Senator BLUNT. Thank you, Mr. Secretary, thanks.

Senator REED. Thank you very much, Senator Blunt. And now, on behalf of Chairwoman Murray, let me recognize Senator Schatz.

TELEHEALTH

Senator SCHATZ. Thank you Mr. Chairman, Ranking Member. Thank you, Secretary. Last month, Mr. Secretary, you said that telehealth can be a godsend. I agree. 55 senators on a bipartisan basis who cosponsored my telehealth bill agree, but we're facing a telehealth cliff, because your current authority to expand Medicare's coverage of telehealth expires when the public health emergency ends.

Unless Congress acts, we will go back to the Dark Ages, with very limited access to telehealth. So, Secretary, do you believe that Medicare beneficiaries should have access to telehealth, no matter whether they live in rural or urban areas?

Secretary BECERRA. Absolutely. Telehealth is something that we have to move towards. We learned lessons from COVID, and I hope that you all are able to agree on legislation that gives us more authority.

Senator SCHATZ. Do you think that it's important that Medicare beneficiaries are able to use telehealth in their homes?

Secretary BECERRA. We want to make sure telehealth reaches every part of the beneficiaries' surroundings. I want to be careful here, because we want to make sure there's accountability, and there are some proposals that would show that accountability. But we want to make sure that, in fact, if we're going to provide reimbursement for that service, that those beneficiaries are receiving real service.

Senator SCHATZ. Are you satisfied that the current law that we're utilizing under this public health emergency is working, and that there's sufficient accountability?

Secretary BECERRA. Thank you for asking it that way. I think we need better authority.

Senator SCHATZ. Thank you. Do you believe that federally qualified health centers and rural health clinics should be able to provide telehealth services to their patients?

Secretary BECERRA. Again, with accountability, yes.

Senator SCHATZ. Do I have your commitment to work with Congress to provide the necessary data and technical assistance that we need to enact these telehealth policies this year?

Secretary BECERRA. You have me at hello on that one.

NATIVE HAWAIIAN HEALTH

Senator SCHATZ. All right. Great. Let me just talk to you a little bit about issues of native Hawaiian health. The U.S. shares a unique political relationship with the native Hawaiian community. Different Federal agencies within HHS are responsible for the administration of native healthcare programs, but the same Federal trust responsibility requires the provision of comprehensive, quality healthcare to native Hawaiians, Alaska natives, and American Indians.

But native Hawaiians are often overlooked or left out of HHS initiatives, and it does not always seem that HHS staff understand the Federal trust responsibility to native Hawaiians, and I don't think this is anybody's fault. We do oftentimes fall under a different statutory architecture because there's not a treaty relationship, there's a trust relationship, and so, what I'm really asking is if you would lay eyes on this particular relationship.

The way the statutory architecture works is sort of, in my view, immaterial to whether or not we're going to recognize this trust responsibility, and then in its implementation as we do native Hawaiian health programs, and other dollars that flow through HHS, we want to make sure that we are on equal footing with all native people. Do I have your commitment for that?

Secretary BECERRA. Absolutely.

PUBLIC HEALTH EMERGENCY FUND

Senator SCHATZ. Thank you very much. We have seen a—I want to talk to you about one final thing, and this is the Public Health Emergency Fund. We've seen a pattern where every few years, when an infectious disease outbreak or public health emergency occurs, we're taken by surprise, totally flat-footed. The Federal Government cobbles together funding, and then Congress appropriates.

But often, these are delayed, and they're delayed for idiosyncratic reasons, whether the particular disease resonates with the public, whether or not Congress is in session, and so, you know, the idea here is to establish a reserve fund so that you don't have to come back to Congress in order to respond to a public health emergency.

Do you think it would be helpful for Federal response agencies such as CDC, FDA (Food and Drug Administration), and NIH to be able to respond proactively and get ahead of these public health emergencies before they get out of control, and then you have to come to Congress and ask for not a few billion, but a few hundred billion?

Secretary BECERRA. Senator, I think I have to hire you, but yes, the answer is yes.

Senator SCHATZ. Well, I'm often told if this doesn't work out, I'd be an okay staffer.

[Laughter.]

Senator SCHATZ. Thanks very much.

Secretary BECERRA. Thank you.

Senator MURRAY [presiding]. Senator Manchin is next, I believe. He is not down there? Okay, we'll turn to Senator Baldwin.

SHORT TERM PLANS

Senator BALDWIN. Thank you, Madam Chair. A record 31 million Americans have obtained coverage through the Affordable Care Act, and that's in part thanks to this administration's efforts to stand up a special enrollment period, and increase funding for the Navigator Program, which assists people in searching for a plan that's right for them. These are two of my top priorities that I called for at the very beginning of the pandemic, but obviously didn't occur until this year.

I know that these actions have made a huge difference in people's lives. Unfortunately, under the previous administration, there were rules changes that allowed the proliferation of plans that I would refer to as junk insurance plans, that don't have to provide the same protections based on pre-existing conditions, et cetera.

Secretary Becerra, does the administration have any way of knowing how many Americans have signed up for these junk insurance plans?

Secretary BECERRA. Senator, I don't know if we can give a precise number, but we do know that the number of people who've signed up for these plans has increased, and it is very troublesome, because now we see the consequences when you think you have insurance, and you go and use services, and lo and behold, you're going to pay out-of-pocket a whole lot of money.

Senator BALDWIN. Yes. We also know that many of these plans engage in deceptive or misleading marketing practices kind of aimed at confusing customers during both special enrollment periods and open enrollment. At a time when comprehensive coverage is more affordable than ever, and the administration is working to get more Americans covered, why hasn't there been any sort of action taken to combat these junk plans and their practices?

Secretary BECERRA. Probably the best answer there, Senator, is stay tuned. We are looking to do some things. We want to make sure whatever we do withstands any legal challenge, but we are taking a close look at these plans that are really offering no real benefit or service to the people who are paying money. And so, I'd look forward to working with you on that, because it is a development that is alarming, especially during this time of pandemic when everyone needs to know what they actually have access to.

MEDICAID REENTRY ACT

Senator BALDWIN. Exactly. I look forward to working with you on that. Incarcerated and newly released individuals who have substance use disorder are at significant risk of overdose and death, as well as recidivism. And during the pandemic, these individuals have been at a substantially higher risk of contracting and dying from COVID-19. I was proud to introduce a bipartisan measure called the Medicaid Reentry Act, which would allow States to restart Medicaid coverage for eligible individuals 30 days prior to their release from a jail or prison. This coverage is really vital to facilitating what we might call a warm hand-off to addiction treatment and other healthcare services. Mr. Secretary, can you speak to the importance of providing comprehensive care for reentering

individuals, and will you commit to working with me to pass and implement the Medicaid Reentry Act?

Secretary BECERRA. Senator, not only do I want to be supportive, we want to help get this through quicker than you think, because so many people are falling through the cracks, and we know that there is a way to help many of these folks.

We just put out, about 2 or 3 weeks ago, we announced \$3 billion that we were putting out as a result of your good work on the American Rescue Plan. \$3 billion, half of which is going to go towards substance use disorder services, and the other half for mental health issues, and so, we want to get out there quickly, and so, we look forward to working with you on this, because this is a major endeavor.

We have money in the budget to help us deal with folks who are reintegrating back into the community, and so, very much prepared to do that work with you.

STRATEGIC NATIONAL STOCKPILE

Senator BALDWIN. Yes. I believe you've been asked some questions, significant questions, on the Strategic National Stockpile already in this hearing. I just wanted to note that I spent much of last year writing letters to the previous administration to ensure that my State, the State of Wisconsin, received the supplies that it needed from the Strategic National Stockpile to combat COVID-19. And unfortunately, it often took you know, public pleas from governors and Senators, and letters from congressional delegations as a whole for States to obtain the supplies that they needed during this crisis in its early days.

And that's unacceptable. The President's fiscal year 2022 budget calls for an increase of \$200 million for the Strategic National Stockpile, including for modernizing the Stockpile's distribution model, and increasing visibility of the domestic supply chain to improve our response capabilities.

So, can you describe how HHS has worked to increase the supplies available in the Stockpile? And why it's important for us to prioritize this funding for distribution and oversight improvements.

Secretary BECERRA. Senator, first I want to thank you for the good work that you've done here. This probably looks very familiar, what you see in the budget, because it really follows much of what you were proposing and calling for. And so, we do want to increase the transport of supplies, the capabilities. We want to refine and modernize our inventory. We want to be able to track our supplies better. We want to be able to expand domestic manufacturing. The \$10 billion that was made available for us to really focus on domestic manufacturing will be critical.

All that's going to get underway. More will be done if we get a budget that reflects those priorities. If we can move the budget from \$900 million to \$1.1 billion, that's significant. And if that is included, then we can really launch in ways that really let us make sure that we tell the American people we're stockpiling for what you need to get ready for in the future, and not say, "Oops, we didn't realize we'd need that," when it finally hits us.

Senator BALDWIN. Thank you.

Senator MURRAY. Thank you. Senator Shaheen.

Senator SHAHEEN. Thank you, Madam Chairman. Mr. Secretary, we're delighted to have you in front of us this morning, and congratulations on your new role. You are in a position that touches the lives of the majority of Americans, and so, we appreciate your good work.

EXCESS VACCINES

I wanted to first ask you about a news report I heard this morning on the number of States that have excess vaccines, coronavirus vaccines that are going to expire if we don't figure out some way to use them. Estimates I've seen say that as many as 500 million excess vaccines could be available by fall.

I just came back from a trip to Eastern Europe, where they are desperate for vaccines. While I was there, we were able to announce the decision to provide vaccines to the country of Georgia, and they were very pleased to hear that.

Are we considering doing more to make those excess vaccines available to countries that are really in need?

Secretary BECERRA. Senator, thank you for the question. Obviously troubling if we do see vaccines expire, but we are working with our state partners. The difficulty is we have to make sure there's a process that's orderly, that we could ensure the utility of the vaccine, and that people can have confidence that it is still a viable vaccine.

And so, there are a number of things that we have to do if we're going to move that vaccine, because you need to have that chain of custody in place. And so, we're absolutely working with our state partners on this.

We want to make sure our state partners understand that, as much as they may want to just get out there and help somebody, we have to do it the right way, because we have to have the confidence that the vaccines still work.

Senator SHAHEEN. Well, I appreciate that. I agree that's very important, but we know that China is doing this very well. In fact, when I was at a dinner in Georgia, I sat next to a woman who had just had her second vaccine from China. And so, if they can do it, we ought to be able to do it, and we should make this a priority. So, I hope you will agree to do your part to help make that happen.

Secretary BECERRA. We'll make it a priority, but we'll do it our way, not China's way.

STATE OPIOID RESPONSE GRANTS

Senator SHAHEEN. That's appropriate. New Hampshire's one of those States that's been very hard hit by the substance misuse, and the opioid epidemic has hit us very hard. The decision by the previous administration to provide set-aside funding to help the hardest hit States was very helpful to us, those State opioid response grants that came to us, and the support in so many other ways.

We have gotten much better at saving people's lives through Narcan and other means, but we're seeing people migrate to other substances, methamphetamines, cocaine, heroin, and I hope that you will commit to work with our office and some of those other States that have been so hard hit so that even though our overdose

death rate may be flat, we don't see a dramatic drop in funding because of that.

Secretary BECERRA. Senator, as you probably saw in our budget, we actually try to increase the amount of money there is—

Senator SHAHEEN. Which I appreciate.

Secretary BECERRA. Yes, the State opioid response grants that are out there. And so, we hope to work with New Hampshire and all the States. Quite honestly, there's not a State in the country that isn't being impacted by opioids. Some, however, like your State, more impacted than others.

And so, definitely looking forward to working with you. This is one issue where I did a lot of work as State AG (Attorney General). I would have thought by now we might have heard, but I know there is a settlement in the making that will help supplement what the Federal Government is doing, and I hope together, with what the States acquire through a settlement, and what we're able to do working with you, we can actually tackle this in a meaningful way.

Senator SHAHEEN. Well, now that we are seeing COVID in our rear-view mirror, it will really be important to get back to some of those programs so that we can reach people, so that we can make progress, and I appreciate the commitment that you have.

CHILDCARE PROVIDERS

One of the other areas that has been heavily impacted because of the coronavirus has been childcare. We've seen the reports of what's happened to women because they can't get childcare anymore. In meeting with childcare providers in New Hampshire, they have had a very difficult time, and continue to have, as people try and come back, and they try and provide coverage for families. But one challenge has been expediting the funds that are going out to States, and it's an issue for us at the State level, as well, because of the challenge of making sure people understand the guidance and are very clear.

What I heard from childcare providers is that they don't want to spend money and then find out later that they haven't complied with the rules and have to give it back. So, will you work with New Hampshire and other States to make sure that that guidance and assistance is there for our childcare providers, who are really struggling at this time?

Secretary BECERRA. Absolutely. Absolutely, and I look for your guidance, and any member who wishes to make sure that we are working closely with your state partners.

HEALTH INSURANCE SUBSIDIES

Senator SHAHEEN. Thank you. Finally, I've only got a few seconds left, but if I could, Madam Chair, just ask a final question about health insurance, because we have a chart here that shows what would happen if we are able to address deductibles in a way that does what the American Rescue Plan did to help expand coverage. And what this shows is—I have legislation that would tie the plans and deductibles to the Gold plan rather than the Silver plan. And so, this shows what happens for a family making \$25,000 or less, in terms of the impact of expanding the help so

that they could get additional assistance with their deductibles if we peg it to the Gold plan rather than the Silver plan.

And you can see the numbers behind me for medium cost-sharing assistance is \$800. For the highest cost-sharing assistance right now, it's \$177. So, it would be really helpful to families to be able to expand, thus, to help with those deductible costs, and I hope we can work with you to do that.

Secretary BECERRA. Senator, I'd only add—I know time has expired—I'd only add that President Biden made a very strong commitment here, and the fact that we are trying to extend permanently the increase in subsidies that families get would be tremendously important, because all those families who you're pointing to who fall off that cliff, that fiscal cliff, when they hit that point in their income, where they no longer get the subsidies.

Senator SHAHEEN. Right.

Secretary BECERRA. Wow. All of a sudden, they can't afford the care, and President Biden wants to extend the good work that you all did to provide additional subsidies for those middle-class families. So, we want to work with you.

Senator SHAHEEN. Thank you, I appreciate it. Thank you, Madam Chair.

Senator MURRAY. Thank you. Thank you. We have been honored to be joined by the Chair of the full committee, Senator Leahy. Thank you for being here. Turn to you.

Senator LEAHY. Thank you very, very much. Thank you and Senator Blunt for having this hearing. I appreciate having the Secretary here. I should note for the record, the Secretary and I have known each other for years. We've worked together at the Smithsonian as regents, and he knows that I'm a huge fan of his, and I look forward to working with him on this.

I was glad to see a large increase in funding to support research and prevention treatment. Recovery support services, as you can tell from Senator Shaheen's question and others, and your own experience, really concerns all of us. We see the fatalities in opioid overdoses going up. We tried a lot of innovative, community-based approaches in my State of Vermont, and with your own experience in the Congress, you know that it's not unusual for local issues to come up among the members of the Appropriations Committee.

ALTERNATIVES TO OPIOIDS FOR TREATMENT OF CHRONIC PAIN

But I think that research to addiction alternatives has lagged at the Federal level. I think we have to have more research on chronic pain management and treatment, other than through the use of opioid painkillers, and I think that is extremely important, because we're going to need to help people with the chronic pains. Will your budget support funding for alternatives to opioids for treatment of chronic pain?

Secretary BECERRA. Mr. Chairman, first, great to see you, and thank you for your concern and the work that you've done. We're going to try to be as flexible as we can, because the solutions to opioids will not come from Washington, D.C., the support will, and we can provide some resources, so there are any number of ways to tackle substance abuse disorders, and, quite honestly, and one

of the things I found when I was the attorney general of California is that even the medications differ in their utility State by State.

And so, we have to be able to provide our state partners, local partners the flexibility. They're the ones that are going to do the work. They're the ones who have the know-how. We want to provide the support and be a partner.

Senator LEAHY. I know that the University of Vermont, their Center of Rural Addiction helps rural counties, and the budget includes a request increase of \$55 million for rural communities' opioid response programs. And I hope we can use that to train, recruit, retain addiction specialists to serve in rural areas, because obviously, a State like mine, and actually every State here, has rural areas, and I would hope that you could look at what they're doing in the Center of Rural Addiction that we have. There could be similar ones in other States, and I just want you to think about how we can most effectively use that funding.

Secretary BECERRA. And Senator, again, having come from a position as a leader in my State of California, I want to now, as Secretary at the Federal level, make sure that I'm listening as closely as I can to the local leaders. And so, what we try to do should be to try to support the innovation, the best practices locally.

Opioids is going to be very difficult, and even with all the resources that we're providing, and that this future settlement may provide with the attorneys general, it's still a bear. And we've learned many things about how to deal with opioids, but it's still going to be a bear, and so, whether it's rural or inner city urban, there are people doing this on the ground, and we should go with the most effective best practices that are out there.

TELEHEALTH

Senator LEAHY. Well, and I will make sure I get to you some of the things that we're doing, because the rural health programs are much needed. Telehealth is very needed, but then you have the problem that many of us find in rural areas, broadband connectivity and all these others, it's not the medication, it's getting the telehealth there in the first place. So, I hope your budget will address some of these issues.

Secretary BECERRA. Yes. And Senator, we spoke a little earlier about telehealth, and one of the things you want to do with telehealth as you learn from what COVID has taught us is to make sure that we expand access to that Internet service, to that technology. And it would be a shame, especially in rural communities that you just mentioned, and its poor rural and urban communities, if we expand telehealth but forget them because they can't get it because they lack good broadband.

Senator LEAHY. Thank you. Thank you, Madam Chairman.

Senator MURRAY. Thank you, Mr. Chairman. Senator Capito.

Senator CAPITO. Thank you, Chair Murray. I appreciate the hearing, and thank you, Secretary Becerra, who we served together, and congratulations on your new position. Before I begin to ask questions, I just wanted to echo the theme that I know Ranking Member Blunt had conveyed, and I share.

I am the ranking member on Homeland Security, and so I have a particular interest in this, and I am, Mr. Secretary, I can't decide

if I'm frustrated or grateful, but you have overseen the transfer and reprogramming of almost \$3 billion within your department from COVID-related purposes. I believe testing and strategic reserve is where those dollars came from, to address the migrant crisis at the border.

So, I'm frustrated you ignored the intent of the funds, but I appreciate that your action signals to your own administration something that we have been calling for months, and that is that billions of unspent COVID funds can and should be used for a more pressing need.

My question is—I'm very interested, obviously, as a citizen and a representative from West Virginia, on the opioid and overdose issue, but I think you've answered that, and we certainly want to be a partner. When you mentioned that the answers are local, can be found locally, I think our State in many sections of our State, and Senator Manchin I think would agree here, have come forth with some tremendous ideas to be solutions to the problem that are community based, that are widespread within the community, and that lift those communities.

Unfortunately, the pandemic—there's a lot of backsliding, as you know, so we've got to get this right back on the screen. And we also have along with that an increase in my own home county of HIV, which is very concerning to me, and I'm hoping that the CDC, while they're in our State right now on this issue, can be a bit more aggressive there.

ALZHEIMER'S DISEASE

What I wanted to ask, then, I'll move to another area of passion for me, and that's the Alzheimer's disease. We saw most recently that a new treatment that emerged and was approved, tentatively, I think, is targeted for people at early stages of Alzheimer's disease. And it is the only drug on the market that aims to slow the brain's deterioration instead of just treating the symptoms.

But along with this comes an effort that we've had, bipartisan here in the Senate, which is this new—not new, but the existing welcome to Medicare initial exam, where we are empowering and trying to empower our medical professionals to begin asking questions early to try to meet the challenges that not just that particular Medicare patient could have, but also the family. As you know, caring for the folks afflicted with Alzheimer's is very intense, and very, very difficult for families. And expensive.

But in those visits, we encourage screen detection, diagnosis, and other things of related dementia. I think what we have here is, if we have this progression of a possibility of a drug that can help, we need to merge this with the welcome to Medicare exam so that we are expanding the possibilities that a welcome to Medicare exam could do, and sort of heading off what could be the later ravages of Alzheimer's.

I don't know if you all have thought about that, in terms of Medicare, what your perspectives might be there.

Secretary BECERRA. Senator, you've hit on something that's crucial as we continue to see innovation in new medicines, and that is how do we incorporate them, because these are not inexpensive medicines.

Senator CAPITO. Right.

Secretary BECERRA. And so, to your point, the earlier we start in the process of trying to detect conditions that a person might present with, the sooner we'll know if we have to provide these types of medicines. And it's going to save us a lot of money if we get them upfront versus later stages when it's extremely expensive to treat some of these very difficult, devastating diseases.

So, I think you're absolutely right. It's the preventative model. It's approaching folks early. It's trying to do the intervention while you can, and maybe have a chance to either slow, or maybe in some cases cure the condition. But certainly, we should not be waiting until it's at its worst point.

Senator CAPITO. Right. I agree with that. This one is a particular challenge, as you know, because it's not something that maybe is apparent in your blood count, or you know, you can physically see it. It's something that those of us who have experienced, and comes on very gradually in some cases, and before you know it, you can't ask that last question. So, I thank you for your dedication here. I want to work with your department to see if we can enhance that welcome to Medicare wellness check so we can prevent on the front end. Thank you.

Secretary BECERRA. Thank you.

Senator MURRAY. Senator Manchin.

DOMESTIC MANUFACTURING

Senator MANCHIN. Thank you, Madam Chairman. Secretary, the Food and Drug Administration reports that nearly 40 percent of finished drugs, and roughly 80 percent of active pharmaceutical ingredients are manufactured abroad. Widespread shortages of personal protective equipment, the PPEs as we know, and other medical equipment at the beginning of the COVID-19 had a disastrous impact on all of us, in hospitals and consumers especially.

While global shortages of semiconductors in recent months forced U.S. manufacturers to slow or halt production lines. Just yesterday, President Biden directed Federal agencies to institute whole of government efforts to strengthen domestic competitiveness, and supply chain resilience, important to supporting domestic manufacturing of generic essential medicines.

So, how is HHS responding to this directive to strengthen our domestic supply chain?

Secretary BECERRA. Senator, we've had conversations on this. And thank you, first, for providing us with some resources. The American Rescue Plan does provide us several billion dollars to try to move towards more domestic manufacturing. We've also seen as a result of COVID and the Strategic Stockpile how we lack the kinds of product and medicines that we needed.

And so, what we're trying to do is, working within ASPR, (Assistant Secretary for Preparedness and Response) the agency within HHS that would deal with this, we're trying to move as quickly as we can to start having a stockpile that really will have us ready for the 21st century. We know COVID's not the last pandemic, and so we want to be ready. This report that was just issued yesterday that speaks to these issues on domestic manufacturing will go a long way in directing all of us in how we do this. But, no doubt,

when it comes to anything related to health, HHS has to be on top of it.

Senator MANCHIN. Has HHS done any type of an inventory, looking at what manufacturing facilities might be able to be restarted if or if not, or basically put into production for the needs of our country?

Secretary BECERRA. I'd say that's underway—

Senator MANCHIN. Okay.

Secretary BECERRA [continuing]. Nowhere near completion.

Senator MANCHIN. If you can, whenever you can have your people working on that, or we can work with them or something—

Secretary BECERRA. Yes.

Senator MANCHIN [continuing]. Identifying those facilities.

Secretary BECERRA. Absolutely.

OPIOIDS

Senator MANCHIN. Sir, also, we had 90,000 Americans die from overdose last year. My State's been hit the hardest. We have an average of about 70 to 75 thousand every year. We had a spike because of the COVID. The problem that I have seen is that basically they're putting more and more products on the market. Manufacturers are producing larger and larger volumes. It just doesn't stop, and I've never seen any of us being able to stop that or thwart that, so, if we know that these opioids are causing the problem, we need treatment centers, and we have not enough.

I look at domestic shelters we have. When we identified domestic violence as really an epidemic in our country, we put domestic shelters in about every neighborhood. This is an epidemic. Overdose. So, I've had a piece of legislation called Lifeboat, and all we're doing is saying you will pay one penny per milligram production fee if you're going to make opioids.

We never had opioids when you and I were growing up in it, okay? So, if this is what they think that they need, and that's their model business model, then you're going to pay for one penny per milligram, and every penny of that goes into treatment centers. So, every part of our Nation, any part of our Nation will have treatment centers to help people. Is it something you all think you could support, or have you heard much about it, or can we set with yours?

Secretary BECERRA. We look forward to working with you on that because we agree. In fact, just two or three weeks ago—I already mentioned this earlier—we put out grant funding of \$3 billion, half of which—

Senator MANCHIN. You went \$3.7. I applaud you all on the three and a half billion.

Secretary BECERRA. Yes. We're still—

Senator MANCHIN. But still yet, it kind of goes you know, we hit these ebbs. This would be consistent. \$2 billion a year. One penny is \$2 billion a year.

Secretary BECERRA. Yes.

Senator MANCHIN. Unbelievable. It doesn't hurt anybody.

Secretary BECERRA. Go to it. We'll offer you whatever technical assistance and whatever else we can, because what we're putting in our budget and we've already done through the American Rescue

Plan, what you all have been working on, we're still not keeping pace with this epidemic.

340B

Senator MANCHIN. With the need. I agree with you. Thank you. And then also, my final question. The 340B program is essential for providing access to safe and affordable medications for low-income West Virginians, and low-income all over our country. Recently, HHS determined that six pharmaceutical companies have violated the program by restricting access to contract pharmacies.

The undermining of the 340B program by pharmaceutical companies and pharmacies' benefit managers has taken its toll on my West Virginia hospitals, community health centers, and their contract pharmacy partners, and I'm sure in every State every one of us have been hit with this. What are the next steps that you will take as the head of HHS to ensure the integrity of the 340B program?

Secretary BECERRA. Well, Senator, as you just said, we just put out, in writing, we didn't just say it verbally, we put out, in writing, a clear message to these six manufacturers that we believe that they're violating the law. You violate the law, you pay the consequences, and so——

Senator MANCHIN. Has it been turned over to DOJ (Department of Justice)?

Secretary BECERRA. We're waiting for responses.

Senator MANCHIN. Okay.

Secretary BECERRA. Some have responded, but we're waiting for full responses. By the way, our budget also does increase funding in this area. I think we provide almost a doubling, not quite a doubling of the money that is available to make sure that we can do the grant rule-making that we need. I hope what you'll do is you'll give us more authority to actually give clear guidance on what can be done and can't be done on 340B because——

Senator MANCHIN. And I really think we could do that in a bipartisan way, because I tell you, we're all being affected. Every one of us.

Secretary BECERRA. That would be helpful, because this way the manufacturers can't sort of play this shell game with us.

Senator MANCHIN. Okay.

Secretary BECERRA. They'd know what their responsibility is.

Senator MANCHIN. Well, I look forward to working with you, and thank you for your service, Secretary.

Secretary BECERRA. Thank you.

Senator MANCHIN. Thank you, Madam Chairman.

Senator MURRAY. Thank you. Senator Hyde-Smith.

Senator HYDE-SMITH. Thank you, Madam Chairman. Mr. Secretary, I recently visited the border with several of my colleagues a few months ago, and we just saw how many children were down there. The issue that's going on. The possibility of thousands of illegal immigrants crossing the Southern border and being transported to our State and housed in facilities in Mississippi is what the concern is.

UNACCOMPANIED CHILDREN

But I understand that your department reached out to many States, including Mississippi, to identify potential housing locations for these unaccompanied migrant children, and when Mississippi declined to participate, your office sidestepped State and local governments by asking private organizations and nonprofits to house the immigrant children.

And I've been getting several calls on this. I mean, from a friend who said the local caterer just had a called asking, "can you put in a bid of feeding 200 seven days a week, three times a day?" Where is this coming from, Mr. Secretary? What do you know about this? Do we need to get our local resources ramped up for these children coming in? And I said, I know nothing about this.

But this action, you know, just ignored the elected officials, who said that they were not going to participate, and they're not being notified or given up-to-date information. We just have to rely on these calls that we get. But you know, there's just no transparency whatsoever in the last few weeks, other than calls from my local sheriff saying, "I heard this is happening," because of the inquiries being made in the community.

It is of great concern to me and my constituents that HHS would send distressed children to States without the involvement or approval of those States and communities and without the resources and security that we would need to care for such a large influx of migrants.

But I firmly believe this administration's misguided actions have created a humanitarian crisis on the Southern border, and you know, they're looking for the States to pick up the pieces, to make this happen if those children get transported without our knowledge into our State.

Does your department plan to continue on this path and to circumvent the will of the State governments? Do they plan to continue that if we know best what the capabilities of us serving those children are, and how do you plan to improve communications with the States and provide up-to-date transparent information on the UC (unaccompanied children) program?

Secretary BECERRA. Senator, thank you for the question. Very important. And by the way, I hope in the future you feel comfortable reaching out to me. I'd like to develop that relationship with you so that your team and my team can work together on some of these issues. On this particular matter, my sense is that some of the information that you've been given is not only incorrect, but it's disturbing.

We never make any approach into a State without talking to the State's leadership, and local leadership. As you just mentioned yourself that some of the State officials said that they were approached and they rejected the opportunity to have some of these migrant kids go into their State.

We have an obligation to provide a safe place for these children. We typically look for licensed care facilities, people who are licensed and trained to do this. They're children. And so, we go wherever we can. We do reach out to the State leadership to see if they will help us, but if the State leadership doesn't want to help

us with children who are in distress, we still have an obligation to find a place for these kids.

We do nothing behind anyone's back, because all these facilities are licensed by the very State. And so, whoever is telling you that they don't know anything about this is either being disingenuous or they're not interested in helping us make sure we take care of children. We don't offer them luxury, we try to provide them with the basics. And we look for licensed care facilities. We're not going to put them in a facility where we don't have people who are trained to care for kids, and we have to search far and wide throughout the United States, because we don't just use facilities that are near the borders where these kids cross.

And so, I would hope to be able to work with you and your team to show you how we do this, because we're not hiding anything. What I can guarantee you is that we're going to provide a safe place for these kids while they're in our care. However temporary it is, while they're in our care, we're going to do this the right way. I suspect you have kids or grandkids. I have children. No grandkids yet. I would expect whoever has my child to take the best care they can with what they've got.

Senator HYDE-SMITH. But you do understand the concerns of the local medical facilities and law enforcement if we were to overnight get 200 children in a small area.

Secretary BECERRA. Certainly, if that were the case. But that never happens, because we don't do something overnight. You can't, not with 200 kids. There's nothing you can do with 200 kids that is just done overnight. We have to go through the process of establishing the relationship. Remember, most of these licensed facilities can't accommodate more than just a handful of kids.

The emergency intake sites that we have stood up, principally in places like Texas and in California, those are large. But those take months. In some cases, maybe weeks, but months to stand up. And there's no way to hide when you have a facility that's holding maybe three or 400 kids, or more from the sight of any official.

But the licensed care facilities are typically 10, 12, 20 kids, and the State knows about it because these folks, these facilities have to seek a license from the State in order to operate. These are facilities that operate for these migrant children, unaccompanied migrant children. We don't take money from the foster care program to do this. It is a separate stand-alone program, because there are special circumstances.

These kids are here under temporary—not even status—they are requesting asylum, and so we have to process them. That's done by DOJ and DHS (Department of Homeland Security), but we have the responsibility, HHS, to provide them with the care, either under our custody, or if we're able to find a responsible custodian, temporarily in that custodian's care.

And the only activity that might occur in your State is only the result of having worked with that licensed care facility to reach an arrangement to have some of these kids housed temporarily there.

Senator HYDE-SMITH. Well, we may be contacting you, because it was a large number of calls. It was a couple hundred all in one, and the locals—and, of course we called everybody we knew in Mis-

issippi, and no one knew anything about it. So, we may be contacting you on that, because——

Secretary BECERRA. Please do so.

Senator HYDE-SMITH [continuing]. You know, we just definitely want to be prepared and know those things.

Secretary BECERRA. Please, I invite you to.

FETAL TISSUE RESEARCH

Senator HYDE-SMITH. Another concern I have is funding research that uses fetal tissue from unborn children who have been aborted, I believe that science is best when it's ethical and respects the dignity of life. I also believe that the Americans who object to abortion should not have their taxpayer dollars going toward purchasing fetal tissue from abortionists like Planned Parenthood.

Furthermore, even the American Medical Association has raised concerns regarding the serious ethical problems created by the financial benefits to those involved in the sale of fetal tissue. And I'm over my time, but I just want to make a couple of points here. Is——

Senator MURRAY. If the Senator could be concise, we've got another Senator waiting quite a bit of time, and you are way over time.

Senator HYDE-SMITH [continuing]. We are concerned about that, and that the justification rule from 1995 is still being used, and we know that science has changed a lot since 1995, and so we may want to have another discussion about that. Thank you, Madam Chairman.

Secretary BECERRA. Look forward to it.

Senator MURRAY. Thank you. Senator Murphy.

Senator MURPHY. Thank you very much, Madam Chair. Let me just underscore the Secretary's remarks about these kids and the facilities they're in. These are State-licensed facilities, as the Secretary said repeatedly. These are not federally licensed facilities. And so every State knows where these kids are, and they all have the opportunity, if they want to, to pull the license, modify the license, do whatever they need to do.

But, let's be honest, these kids are not security concerns. I mean, I understand there's a logistical effort necessary to care for these kids, and I would hope that notwithstanding folks' political opposition to the President, we would all agree that if these kids are here applying for asylum, we should you know, all be in the business of trying to you know, make sure that they have a roof over their head. But they're not a security concern. These are you know, 13-, 14-, 15-year-old kids who you know, fled destitute poverty and violence to come to a better life, and are temporarily in our care until they get connected with a relative. So, I just don't want to overstate the danger or the impact that these young people have.

Let me just, Mr. Secretary, associate myself with the remarks of Senator Baldwin on the short-term, limited duration plans. I wasn't here for your answer, but I heard that you said we should wait and stay put for additional announcements. I hope that that is coming shortly. These plans you know, they're just frauds. They're sold a bill of goods, these folks who pick them up, and then

find out that they actually have no insurance, and I hope that we can get those out of the marketplace as quickly as possible.

My question to you is around the proposal for additional ACA (Affordable Care Act) premium subsidies, about \$60 billion in the President's budget over the next 4 years to continue the increased subsidies, and I thank Senator Shaheen for her advocacy and her leadership on this. I'm very supportive of that proposal, but I just want to point out that that is \$60 billion not necessarily going to consumers. That's \$60 billion that's going to the for-profit healthcare industry. That's \$60 billion that's going to end up in the pockets of insurance companies, and drug companies, medical device companies, for-profit hospitals. You know, all sorts of entities that are just making a king's ransom off of our healthcare system today.

I'm very glad that Senator Murray and Chairman Pallone have kicked off a process by which we're going to, I gather, start to come up with a path forward on a public option. The ability to put a Medicare, Medicare-like plan on these exchanges that does not have the kind of profit motive that private insurance plans do, and, if done right, will provide some real price pressure on the private sector.

PUBLIC OPTION

For instance, Senator Merkley and I have introduced what we believe to be the sort of most aggressive public option, and in it would be included bulk purchasing authority for you or for CMS (Centers for Medicare and Medicaid Services) that would result in a lower price for the Medicare-like plan. But it would also create pressure that would have benefits to private sector plans, as well.

What do you think of the process that has been announced in the Senate and the House to begin conversations about public option legislation? Do you see this as part of the answer on price moving forward? Because my only worry about a strategy on affordability that is predicated mostly on subsidy for the exchanges is that that ends up just feeding the for-profit health insurance and medical industry machine, which you know, ends up doing very well for them, ends up in increased coverage for Americans, but doesn't get at the price question.

Secretary BECERRA. So, Senator, having served with you as we were going through the process of passing the Affordable Care Act, and having pushed for many of the things that you're discussing, what I can tell is now, in this position, I just want you all to get something done, because, give me some authority to do something to lower costs, give me the ability to try to drive down the cost of those services, and to expand coverage.

Any number of good ideas, but I know that you all have to go through this process and figure out how to get to the right number to get something passed. The President has publicly stated he is supportive of the public option, we have dollars in this budget to try to support movement towards getting more Americans onto coverage, and I would simply tell you, we're ripe to get something done. The American public wants to see us do something, and so, it's almost—yes to all of the above. Just let's see something cross over the finish line.

Senator MURPHY. I appreciate that the administration and you have a lot on your plate right now, but at some point, some leadership to point us and others in the right direction on this question on how we construct a public option would probably be helpful, but I thank the Chair for her leadership on this. Thank you.

Senator MURRAY. Thank you. Senator Braun.

Senator BRAUN. Thank you, Madam Chair. Good to be talking to you again—

Secretary BECERRA. Thank you.

PARTIAL-BIRTH ABORTIONS

Senator BRAUN. February 23, in your nomination hearing, I asked will you follow the law, and it was in reference to the Hyde Amendment back then and some other things. Recently, you were testifying in a House committee, and the subject of partial-birth abortions came up, and I think there was some confusion as to whether there was a law on the books or not, and I assume that you of course now know there is.

I think what I'm interested in is not so much what you're going to do to enforce existing law, what you might be proposing or pushing when it comes to, you know, the issue of abortion, sanctity of life. So, is there any interest in your office pushing or trying to get legislation out there that would overturn the ban on partial-birth abortions?

Secretary BECERRA. Senator, thanks for the question, and thanks for following up from our previous discussion on this. I think the President has been fairly clear, and maybe if I wasn't so clear in my previous testimony, I could try to elaborate a bit. We're going to do what the law permits us to do. We're going to follow the law. This is a subject that, obviously, people differ on. These issues usually are premised on very deeply held beliefs. But what I can tell you is that if I'm doing my job, I'm following the law, and right now, *Roe v. Wade* is the law of the land.

We're going to do everything we can to protect a woman's reproductive rights, to have healthcare. We want everyone to have access equitably to healthcare, and so, we're going to do everything we can to make sure that whether you're rich, poor, young, old, tall, short, you're going to have access to the care you need.

HYDE AMENDMENT

Senator BRAUN. So, the current law incorporates the Hyde Amendment, and in the President's budget, that is a clear omission. So, does that mean that, and were you part of the formulation of the budget you know, that would have that not as part of it? And that's been around since 1977. So, when you hear statements that would be unclear about an existing law of partial-birth abortions, which you actually voted against that law, the one banning it, it would give many of us pause in terms of what might be done.

You're clear that you're going to respect the law, but I think I'm more interested in what you might be interested in doing to change the law. And the fact that the Hyde Amendment is not part of the budget, is that something more ominous on the horizon that it would be incorporated into law, at least it's reflected in the proposed budget, and were you part of crafting that omission?

Secretary BECERRA. Remember, Senator that President Biden, before he became president, said that he would be against maintaining the Hyde Amendment, and so, the budget is a reflection of what the President has said in the past. I have thousands of votes in my 24 years in the House of Representatives. I think my record's pretty clear where I stand on this issue, as well.

But, as you just said, my obligation is to respect the law, and the law is not established by the executive, it is established by Congress. And so, we will respect and follow whatever the law is that you all pass.

Senator BRAUN. Well, I'm glad to hear you're going to respect the law. I think that would be the minimum that we'd require out of anyone here in any capacity, and I think that what you're saying is that you may be trying to change the law, and President Biden has been clear, according to you, that he does not want the Hyde Amendment to be part of what ideally would be part of law in that area.

And then, what would worry some of us is that then the next step might be taken to where partial-birth abortions come into play, and I think it just good to be honest about what one's intentions are, and we're in a climate right now when it looks like there's a lot out there legislatively, and for any of us that are passionate about the sanctity of life, it is something—obviously, we would love to know clearly you know, what the intentions of the administration would be. Your intentions and lawmakers, as well. So, I think that we're not going to get any further on that topic here today, but I thought it was definitely worth mentioning.

Secretary BECERRA. Senator, I look forward to working with you. The art of compromise and the ability to come together is what makes this democracy work, and so, we don't have to have the exact same views to be able to get things done for the country.

Senator BRAUN. Thank you.

Secretary BECERRA. Thank you.

MATERNAL MORTALITY

Senator MURRAY. Thank you. Mr. Secretary, the U.S. is the only industrialized nation where the maternal death rate is rising. Each year, 700 women die due to pregnancy, childbirth, or subsequent complications, according to the CDC, and the vast majority of those deaths are preventable. Black, Tribal, and women who live in rural areas are at much greater risk, so we need to address the gaps in care for pregnant and postpartum women and root out bias and discrimination in maternity care settings.

So, I was really pleased to see your budget build on some of our bipartisan investments that we've been making in recent years to combat this crisis with \$220 million across several agencies within HHS. I want you to talk to us about how this new funding will address the problems driving these disparities for women of color and women who live in rural areas, and maybe what lessons you've learned from the committee's initial investments.

Secretary BECERRA. Senator, thank you. This one is important, not only because it's the right thing to do, but, as you said, we as a country, as a Nation, a leading Nation are doing something totally wrong when it comes to protecting women, women who are

going to help us move the next generation of leaders. And so, it's time, and I'm thrilled that the President saw the need to make a substantial investment here.

Not only is it the \$3 billion to improve the maternal health programs that we have under the American Families Plan that he has proposed, but it's the \$223 million that I hope we get in funding, that's in this budget for a program that he wants to start to help improve maternal health programs around the country.

It is the challenge to States to say, under Medicaid, we right now provide a woman 60 days of postpartum care after she's delivered. We're saying, guess what? You join in, and we'll give you—we'll help you pay for a full year's, 12 months' worth of care for that woman. Because it's not just the delivery and the recuperation from the delivery, it's making sure the woman is ready to move forward in that first year of life of that child.

And so, this one's critical, and, as I've always mentioned, this is something my wife, as an OBGYN has always talked so much about. How we don't really care too much except for making sure that we see the delivery go well. There's so much that goes on before the delivery, and so much that has to go on after. And to have in our own country, pockets of America where women are still dying, or their children are dying at birth, it's just incredible.

So, these are the investments that we need to make, and it's unacceptable to not do otherwise.

Senator MURRAY. Well, thank you. I look forward to working with you on that. Mr. Secretary, the number of migrant children referred to HHS's care began steadily increasing last year, including after courts enjoined the prior administration's policy of applying Title 42 restrictions to unaccompanied children. And at the same time, as you well know, COVID-related limitations significantly reduced HHS's capacity in its entire network of State licensed shelters.

UNACCOMPANIED CHILDREN EMERGENCY INTAKE SITES

And as a result of that, this administration inherited a system already approaching a breaking point, and the use of emergency intake sites has, thankfully, gotten a lot of our kids out of CBP facilities, and the department has made some progress in a very short period of time, I know, to reduce the number of kids at these emergency sites.

But those sites do not provide the same level of care or services that HHS's other facilities, and their extended use really raises concerns. I wanted to ask you what is HHS doing to phase out of these emergency sites as quickly as possible by placing more kids into these State licensed facilities, and with appropriate families and sponsors as soon and safely as possible?

Secretary BECERRA. Well, Senator, as you may have heard in my discussion with Senator Hyde-Smith, we reach out to every facility we can, in any part of the country. Because you're right, while these emergency intake sites have done the job of providing these kids with the care that you would expect, far more than the Custom and Border Protection Service could, we know that it's better to have them in a facility that is licensed to provide that care.

There are any number of licensed facilities, but very few of them we haven't already approached, and so, we're going everywhere we can, and we have been able to expand the number of licensed beds that have been available. There was a point where we had more kids in emergency intake centers than we had in licensed care facilities, when our census numbers were really high. But we have now flipped that, and there are more kids today in licensed care facilities than we have in these emergency intake sites.

Senator MURRAY. Okay, and are you addressing the emergency intake sites, and what are we doing there to improve the level of care? Because they still do exist and will for a time.

Secretary BECERRA. Substantial amount. Today, those intake sites offer behavioral health services to kids, which we know that is important for so many of these kids because they come—

Senator MURRAY. At all of the emergency intake sites?

Secretary BECERRA. I think we have it at all of the sites now. We do have behavioral health specialists who are there to provide for their needs. We've always provided the medical care. We were never sure when we first started standing up these sites how long they would be around, and so, we made sure we had the medical services. But getting behavioral health specialists is obviously a little bit extra. It's a tougher thing. But now, we do, because we've seen how we've had to open a number of them.

We also now do discharge work. We actually do the process of doing the intake, getting the information, doing the background checks on potential custodians, sponsors. And that wasn't done at the beginning either, because they were just emergency intake sites to help us deal with the overflow.

But we've seen that so many of these kids would end up staying in these sites for weeks, and so, we decided, no, let's start doing the work now of finding a responsible sponsor that can hold them, versus keeping them in one of these sites.

So, it's almost a full service—it is a full service. If you go to Long Beach, California, not only is it a full-service site, several hundred kids, but the community has so much gotten involved that they ended up getting, and this was about a month or so ago, 70,000 toys and books donated by the community. Several hundred kids, but they got 70,000 gifts from the community, which now is making it possible for us to send some of these things to some of the other kids in some of these other sites.

And so, it's a whole of agency approach, because we want to make sure that we provide the right service. Again, I have to acknowledge, this is expensive stuff. It is not easy. And we are not going to let a child go to someone unless we feel confident that they're going to be responsible caregivers. And so, it's very difficult, but these are kids.

Senator MURRAY. Yes. Okay, thank you. Senator Blunt.

COVID-19 VACCINE GOALS

Senator BLUNT. Thank you, Chair. Mr. Secretary, are we going to reach the White House goal of 70 percent of all U.S. adults with at least one shot by July 4, and for 160 million Americans to be fully vaccinated by that date?

Secretary BECERRA. I would not bet against this President, Senator, because he's so far done a pretty good job of hitting his marks, and I know he's determined, and we're working with him to get to that 70 percent. But, quite honestly, it shouldn't be just a goal of the President. It should be a goal of every American to try to help us get to that 70 percent threshold and beyond, because it's for the good of the people, not just for the President.

Senator BLUNT. Well, I agree with that. I guess we'll see if there are enough donuts, and enough cans of beer, and whatever else is being offered as the incentive to get people to take that vaccine. It's really important to get this done, and I hope we meet that goal. I'd be pleased if we exceeded it. Who's taking principal responsibility for that?

Secretary BECERRA. The President has thought it so important that he established, even before he came into office, this working group. Jeffrey Zients has been leading that group for some time, and over the course, it's gone mostly from trying to address to combat the pandemic and COVID-19, to now making sure folks are getting vaccinated.

We're still doing all of the other things. But the major focus has been now getting that vaccine out as best we can, and I'm waiting for the invite, Senator, so that we can go to your State and see the pockets that still have to get vaccinated, and we'll do what we can.

Senator BLUNT. Well, good. We'd be glad to have you, and we're trying to do that. I think one of the lessons we learned early on in this is you don't want to make it too complicated. Hopefully, we won't face this situation again in a hurry, but we might with the booster shots and, you know, the more people that can, without wondering if they qualify, can line up and get their vaccination, the better off we are, I think.

GRADUATE MEDICAL EDUCATION

I noticed in your budget submission that there is no increase in children's hospitals graduate medical education. As you know, that's the one part of medical education that's not funded out of Medicare. We've made an increase every year in the last 6 years. I hope you'll help us look at that again and find an increase. There are accounts really close to that that have increases. You know, if you don't have the opportunities to go into children's hospitals and get your specialty that way, you wind up going somewhere else, and I think we'd all agree that we don't benefit from having a lack of people focused on children's healthcare.

Secretary BECERRA. GME (graduate medical education) programs are critical. When I was in the House, I fought very hard. LA obviously has a number of facilities, and at one point, we almost lost MLK hospital in Los Angeles, which was one of the safety net providers, and we fought really hard to preserve the GME slots that we had for MLK, so that once it got back into business, we'd still be able to bring in graduate medical students, and so, I absolutely agree with you. We have to do everything we can to try to increase the number of, and supply of these doctors. Especially because, as you know, we lack those physicians and in those specialties for children.

Senator BLUNT. I'd like to figure out some way we could do with children's medical education what we've done with all other medical education for all other specialties. Maybe we can work together and figure out if there is a way in some other fund we could fund this like we fund everything else.

ACA/UNINSURED NUMBER

How many people—I know it was mentioned earlier that I think 31 million people have insurance through the Affordable Care Act. How many people do we believe don't have insurance now?

Secretary BECERRA. There are still probably tens of millions. I don't want to give you a number off the top of my head.

Senator BLUNT. Will you get back to us with a number on that?

Secretary BECERRA. Absolutely.

Senator BLUNT. I think when we started down this road a decade ago, it was 30 million we thought didn't have insurance. I'm afraid it's still about 30 million, but I'll let you take that for the record.

Secretary BECERRA. Will do, Senator.

Senator BLUNT. Okay. Thank you, Chair.

Secretary BECERRA. Thank you.

CHILDCARE

Senator MURRAY. Thank you. Mr. Secretary, the pandemic really exposed what many of us have known for a very long time that the childcare system in our country is really broken. And childcare is just such an essential of our infrastructure. It's really key to our economy, and during the pandemic, we saw four times as many women leave the labor force as men, in large part due to increased caregiving and distance learning responsibilities. And the problem was even worse for Black and Latina mothers.

So, I'm really glad to see your budget propose large investments in childcare, including a \$1.5 billion increase to the Child Care and Development Block Grant. Prior to the pandemic, CCDBG (Child Care and Development Block Grant) programs served just one in seven eligible children, and the need for the services is now expected to rise significantly given the economic turmoil that's been created by this pandemic.

So, talk to us about how this funding will improve access to childcare.

Secretary BECERRA. Madam Chair, you've said it. I mean, our economy will not fully recover until we address the childcare needs, especially for women, single women. And so, it is important for us to make these kinds of investments. But it still doesn't take us where we need to go. As you just mentioned, just for those who were eligible, we were only providing services to one in seven.

It's unfortunate that we look at it this way. Maybe it's our tradition that we think that we could take care of our kids ourselves, but today, that's not the reality. More often than not, even if it's a two-parent household, both parents have to work. And no one wants to see a scenario—I grew up being a latchkey kid. No one wants to see a scenario where we damage our future because we didn't think of investing in our kids.

The President's proposals to provide full-time pre-K for 3- and 4-year-olds would be a tremendous help for a lot of families. Pro-

viding the childcare tax credit that I know is before you, a tremendous help. But investments in these block grants that help those families is critical, especially for middle and low-income families.

Senator MURRAY. Well, you know, there's a recent report that showed nationwide the cost of childcare jumped, on average, 47 percent during the pandemic. We now have people trying to go back to work, and they're going, I couldn't afford this before, now what am I going to do?

And another problem we're seeing is the wages for childcare providers and early educators is abysmal, and yet these operators are now trying to operate on extremely thin margins, like everyone else. They can accept fewer kids, they have to have all of the sanitation equipment. It is much harder to run these businesses. So, I wanted to ask you how the budget requests address the funding gap that now exists between what parents can afford to pay and what high-quality childcare providers need so they can operate?

Secretary BECERRA. Madam Chair, probably the best way to say it is this is what happens when you fail to invest for a long time. It all starts to come at you, it hits you in your face, and what we're finding is that the costs will continue to increase, families will have a harder time, but quite honestly, we should not be paying the dirt low wages that so many of these childcare workers have been receiving. They deserve to be paid for the work they do. They're taking care of our most precious assets.

And so, we need to see them receive a decent wage and salary, which will cost more in terms of the service for the parents, but we have failed for so long to really invest in taking care of our kids and helping our brothers and sisters in America care for their kids that things are coming home to roost. We have to make the investments. Fortunately, President Biden wants to make those investments. I know that there's a great deal of support in the House and in the Senate to do something serious when it comes to childcare, whether it's the tax credit or major direct investments, we need to do it, because—

Senator MURRAY. Well, this is a top priority for me, and I know it is for pretty much every working parent out there so, we will work with you on that.

Secretary BECERRA. Amen.

HEALTH DISPARITIES

Senator MURRAY. I wanted to ask you one last question. The pandemic's deadly impact on communities of color really shows that we have a long way to go to address systemic racism and health inequities, and there's factors from housing to food deserts to access to health services that can really have an impact on somebody's health. So, I was really pleased to see the budget focus on addressing those problems, including an increase of \$150 million for CDC's social determinates of health activities. Can you talk a little bit about what those initiatives will do to reduce health disparities?

Secretary BECERRA. Madam Chair, the most important things is that we're now recognizing—the fact that we're using the words social determinants of health show how far we've come as a Nation and as a policy-making body that we recognize that, in so many

ways, your health is determined by your background, too often by your ZIP code, and we have to change those things, because there are people in America who are left out. There are places, the pockets in America where the services don't reach them, whether it's rural America or whether it's inner-city America.

And the President has made equity one of the prominent features of his administration, and we will do the same at HHS.

Senator MURRAY. Well, thank you very much, and that will end our hearing today. I do want to thank all of our fellow committee members and Secretary Becerra for a very thoughtful discussion today about the President's budget request and how we can work together to really address some of these really critical issues of lowering healthcare costs, and helping families across the country get covered, address inequities, respond to public health crisis, childcare. So much more that is within your jurisdiction. So, really appreciate your testimony today.

Secretary BECERRA. Thank you.

ADDITIONAL COMMITTEE QUESTIONS

Senator MURRAY. For any Senators who wish to ask additional questions, questions for the record will be due June 18 at 5 p.m. The hearing record will also remain open until then for members who wish to submit additional material for the record.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED TO SECRETARY XAVIER BECERRA

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. The past year has been particularly devastating for children and young adults' mental health. The CDC found the proportion of emergency room mental health visits increased by a quarter from April to October last year for children ages 5 and 11, and by nearly a third for those between ages 12 and 17. Suicide attempts and psychiatric help calls for children are also on the rise. Seattle Children's Hospital in Washington is seeing 170 children with mental health emergencies a week—compared to 50 before the pandemic. Sacred Heart Children's Hospital in Spokane saw admissions to its adolescent psychiatric unit and its pediatric floor for behavioral health issues both rise by around 70 percent.

How does the budget request target mental health services specifically to children and young adults?

How does the request address the ability for children to access mental health services within their communities?

Answer. HHS is committed to providing mental health services that address the needs of children and young adults. SAMHSA supports school-based programming in part through Project AWARE (Advancing Wellness and Resilience in Education). The purpose of this program is to build or expand the capacity of State Educational Agencies, in partnership with State Mental Health Agencies (SMHAs), to increase awareness, provide training and promote connection to services for youth with behavioral health needs. From October, 2016 to September, 2020, Project AWARE trained over 56,000 providers and ensured that more than half a million school-aged youth had access to and were referred to mental health services.

School-based health centers (SBHC) are typically funded by U.S. DHHS-Health Resources and Services Administration (HRSA; <https://www.hrsa.gov/our-stories/school-health-centers/index.html>) and/or by individual State Departments of Health. SBHCs provide students with a variety of age-appropriate health services, including, but not limited to, primary medical care, health education, and nutrition education. SBHCs are increasingly offering behavioral healthcare services such as mental health and substance use screening, counseling, and case management/referral services. SBHCs are often operated as a partnership between the school and a com-

munity health organization, such as a community health center (FQHC) or local health department; and for behavioral health services, SBHCs often partner with local community mental health centers.

SAMHSA has continued to expand the Certified Community Behavioral Health Clinics (CCBHCs) through expansion grants, awarding 134 grants in early 2021 through recent emergency funding, with up to 74 additional grants being awarded in summer of 2021 as part of the regular appropriations process. 166 CCBHC grantees were awarded in fiscal year 2020. SAMHSA is also planning a formal technical assistance arrangement to support organizations in implementation and sustainability. The CCBHC programs provide an array of critical, integrated services to meet the behavioral health needs of communities. CCBHCs provide a full continuum of timely, person and family-centered services, including access to crisis services 24/7, and are particularly focused on the needs of individuals with serious mental illness (SMI), serious emotional disturbance (SED) and/or substance use disorder (SUD). The program is designed to support individuals and families who are uninsured or underinsured and who may otherwise lack access to effective screening and treatment. The program encourages use of telehealth and other modalities to increase reach of services and to address barriers to care access.

Question. The fiscal year 2021 Labor-HHS bill included a new, 5 percent set aside in the Mental Health Block Grant for states to develop crisis systems to improve their ability to respond to individuals experiencing a mental health crisis. These systems are intended to connect people with appropriate services, rather than referring them to law enforcement or emergency rooms.

How does the request build on the crisis response set aside created in the fiscal year 2021 bill and how does HHS plan to work with states to ensure these systems are fully accessible with adequate coordination between mental health and law enforcement?

Answer. The Community Mental Health Services Block Grant received an increase of \$825 million in the fiscal year 2022 President's Budget, for a total of \$1.6 billion, to expand access to behavioral healthcare. Within the total, \$75 million is directed to the crisis services set-aside. This investment in crisis services will direct funding to states to build much needed crisis systems that will provide high quality, expeditious mental healthcare. This funding also will support the partnering of behavioral health providers with law enforcement.

SAMHSA has been actively engaging with states on the use of MHBG funds, including this crisis set-aside (\$75 million in fiscal year 2022 President's Budget). This coordination has included technical assistance on the use of funds, requests for information on specific allocations of funding across the crisis continuum of care, and recommended changes to the data reporting system. States are at different stages in their implementation of core crisis services and currently use the funds to expand existing core services or develop new services. Funding regional or statewide crisis centers is an allowable, but not required, use of the funds. There is significant variation in the degree to which states are using MHBG funds to support activities such as the Lifeline crisis call centers. The fiscal year 2022 President's Budget includes funds for SAMHSA to further expand the capacity of the call centers to ensure they can respond to the expected increase in call volume accompanying the transition to 988.

Beyond the current Lifeline functionality, it is critical that individuals experiencing a behavioral health emergency have access to a coordinated crisis system of care. Effectively responding to people in crisis who are experiencing a behavioral health emergency has three main components as outlined in SAMHSA's National Guidelines for Behavioral Health Crisis Care: providing someone to talk to, providing in-person response, and providing a place to go. Implementing 988 successfully will be a critical first step in the crisis response. Current research suggests that many crises can be effectively addressed through a call alone. In addition, call centers that have follow-along capacity and/or access to local outpatient treatment resources can provide enhanced crisis care. A robust crisis system, including 988 access through the Lifeline network, will decrease suicides, reduce arrests and criminal justice involvement for individuals with behavioral health needs, and will facilitate linkages to care to reduce unnecessary emergency department boarding and hospitalization. Implementation of the Lifeline, partnered with the development of a coordinated and comprehensive behavioral health crisis services system across the United States, will save lives.

The fiscal year 2022 President's Budget further supports local communities in meeting the mental health needs of people who are incarcerated by investing \$45 million more in these programs for a total of \$51 million to support the needs of those who are involved in the criminal and juvenile justice system(s) providing funding for partnerships between mental health providers and law enforcement.

SAMHSA will award a new cohort of grants to community-based behavioral health providers that focus specifically on the delivery of mental disorder treatment while in jail and provide linkages to care post-incarceration.

Question. The President's budget request includes a \$77.6 million increase for the National Suicide Prevention Lifeline in order to help build the infrastructure necessary to make a smooth transition to the new three-digit code (9-8-8) as required by the National Suicide Hotline Designation Act.

Please describe how this funding will strengthen the existing infrastructure of the Lifeline and better prepare local centers to respond to the increase in calls expected once the transition to 9-8-8 occurs.

Answer. The creation of 988 is a once-in-a-lifetime opportunity to strengthen and expand the Lifeline and transform America's behavioral health crisis care system to one that saves lives by serving anyone, at any time, from anywhere across the nation. Preparing the Lifeline for full 988 operational readiness will require a bold vision for a system that provides direct, life-saving services to all in need and links to community-based providers uniquely positioned to deliver a full range of crisis care services. SAMHSA sees 988 as the linchpin and catalyst for a transformed behavioral health crisis system in much the same way that, over time, 911 spurred the growth of emergency medical services in the United States.

SAMHSA envisions a multi-phase approach to making 988 operational and effective. SAMHSA is committed to using this investment to strengthen the existing infrastructure and prepare for the launch of 988. The first phase is focused on increasing the capacity and operational readiness for the National Suicide Prevention Lifeline to accept 988 calls, chats, and texts by July of 2022. This includes support to ensure a national back-up system or safety net. SAMHSA has reviewed modeling estimates to anticipate the expected call volumes with 988 rollout. The President's Budget includes funds to support the resources needed for network and telephony infrastructure expansion, training to harmonize protocols across all local centers, and staffing to increase the capacity of the Lifeline to respond to the anticipated increase in calls expected with the 988 transition.

An ideal crisis system would include state and regional crisis hubs, which can be fully integrated with mobile crisis response, crisis receiving facilities and follow up care. SAMHSA believes that the crisis system will be critical to make 988 optimally effective in addressing behavioral health crisis needs and reducing unnecessary hospitalizations and law enforcement involvement.

Question. The budget request notes that this funding will be used to increase the capacity to respond to text messages and to those who need specialized services. Does the Department plan on leveraging existing infrastructure rather than recreating these capabilities?

Answer. Yes, leveraging existing infrastructure will be instrumental in the success of 988. Initially established by Congress in 2005, the Lifeline is a national network of over 180 independently operated crisis call centers, three Spanish language centers, and the Veterans Crisis Line (VCL). The network is currently linked by the toll-free telephone number, 1-800-273-TALK, which is available 24 hours a day, 7 days a week. The Lifeline network also consists of 9 national backup and 38 chat/text centers. The backup and chat/text core network centers operate under contractual obligations through the Lifeline Administrator, who oversees the current Lifeline cooperative agreement from SAMHSA.

Until recently, funding for the National Suicide Prevention Lifeline was only \$7 million. This funding along with limited state investments has been insufficient to pay local centers to answer Lifeline calls. With the President's Budget request, as well current state investments in the answering of Lifeline calls, important progress is being made.

It is critical to invest in strengthening Lifeline network operations. While further system transformation will require additional capacities (e.g., substance use integration, coordination across the crisis continuum, etc.), the immediate priority is ensuring the Lifeline has sufficient resources to address the scope of contacts addressed directly in the National Suicide Hotline Designation Act, including individuals in suicidal or mental health crisis. In the near term, efforts should be made to map available local resources so that facilitated transfers and referrals can be made to support individuals with additional needs.

SAMHSA recognizes the need for a multi-pronged approach to address the needs of populations at higher risk of suicide. This includes both leveraging existing technologies as well as piloting and developing novel approaches to enhance access to crisis care.

Question. When does the Department intend to provide the Subcommittee with the report on the costs associated with a transition to 9-8-8?

Answer. SAMHSA has been working diligently on three important reports to Congress—the 988 Appropriations Report, the Report on Training and Access to 988 for High Risk Populations, and the Report on 988 Resources. SAMHSA worked collaboratively with the VA to develop the Resources report to Congress. All three reports are in the final stages and will be submitted to the respective Committees and your Subcommittee shortly.

Question. The pandemic's impact on child-care has been especially hard on communities of color, undermining parents' economic stability and children's school readiness. Virtually all child-care workers are women, disproportionately women of color and immigrant women who do not receive adequate wages or benefits. COVID has only made these inequities worse. Additionally, even before the pandemic, children of color were less likely to attend a high-quality early learning program than their white peers, and entered kindergarten 9 months behind their white non-Hispanic peers in math and almost 7 months behind in reading, on average. Furthermore, Center closures because of the pandemic have threatened an already limited supply of care for infants and toddlers and made it even harder for families of color to get quality, affordable child-care. I am concerned these closures will deepen racial and socioeconomic inequities in access to high-quality early learning opportunities that promote kindergarten readiness for children.

What role is HHS playing in addressing the racial inequities in child-care for families and providers?

Answer. The HHS Office of Child Care (OCC) is providing guidance, technical assistance, and oversight to assist states, tribes, and territories with administering the multiple rounds of COVID-19 child care supplemental funding, including the \$39 billion in child care funding provided by the American Rescue Plan Act consisting of \$24 billion in child care stabilization funds and \$15 billion in supplemental Child Care and Development Fund (CCDF) awards. This funding is helping to stabilize and improve the child care sector and improve access for all children and families, including addressing racial and ethnic inequities.

The American Rescue Plan Act child care stabilization funds are providing immediate financial relief to child care providers facing increased costs and declining revenue. Our guidance on these funds (Information Memorandum CCDF-ACF-IM-2021-02) indicates that applications, technical assistance, and written resources should be available in multiple languages, and that states are encouraged to work with culturally relevant organizations to meet the ongoing needs of providers receiving grants. We are also collecting data on the race, ethnicity, and location of child care providers to track the equitable distribution of resources.

The CCDF supplemental funds in the American Rescue Plan Act are an unprecedented opportunity to expand access to high-quality child care and move toward a more equitable child care system by assisting many families and providers who have not previously participated in the child care subsidy system—including families and providers from communities of color. Our guidance (Information Memorandum CCDF-ACF-IM-2021-03) strongly recommends that states prioritize increasing provider payment rates and workforce compensation so that child care providers can retain a skilled workforce and deliver higher-quality care to children receiving subsidies. These steps will advance equity for women, particularly women of color, lift families out of poverty, boost the broader economy, increase women's labor force participation, and improve outcomes for children. Our guidance also encourages states to pursue opportunities to build the supply of child care—including the use of grants and contracts—for historically-underserved populations. The guidance also encourages states to use some of the funds for outreach activities to underserved populations, including to disseminate materials in multiple languages, and to fund partners and organizations trusted by families and child care providers—including culturally relevant organizations.

OCC has developed a number of technical assistance (TA) resources to help state, territory, and tribal CCDF administrators and other systems-level professionals assess and ensure equitable child care service delivery to racially disadvantaged communities. These resources encompass all child care settings, e.g., center-based care, family child care, and family, friend, and neighbor care; as well as the range of age groups served by CCDF. Our TA system embeds racial equity considerations in the planning, development, and evaluation of new resources to ensure they are inclusive of diverse perspectives and responsive to disadvantaged community's needs.

—The National Center on Early Childhood Quality Assurance (ECQA) has developed resources on considerations for leadership in early childhood systems development and for child care licensing systems, as well as other health equity resources to help grantees develop integrated strategies to support the social and emotional wellness of children by highlighting promising strategies used by CCDF grantees. See for example Kickoff: Office of Child Care Initiative to Im-

prove the Social-Emotional Wellness of Children and A Resource Guide for Developing Integrated Strategies to Support the Social and Emotional Wellness of Children.

- Our TA Center for the Preschool Development Grants, Birth to Five (PDG B–5)—which supports early childhood systems development, including child care—recently delivered a webinar on building state capacity to consider equity in data collection, specifically administrative data, to improve equitable access and outcomes through data collection and analysis. The Center also developed a research to practice brief that highlights current research trends and implications for racial and ethnic disparities related to early childhood, including policy choices to reduce disparities and set children and families on more favorable trajectories. TA website users have demonstrated a strong interest in this equity content and it is among the PDG B–5 TA Center’s most popular links: <https://childcareta.acf.hhs.gov/improving-equity-services>.
- In recognition of the disproportionate impact of the COVID–19 pandemic on indigenous communities, OCC has made a focused effort over the last year to identify ways to support Tribal CCDF programs’ response and recovery. Understanding that cultural connection is a strength and resiliency factor in tribal children and families, the National Center on Tribal Early Childhood Development (NCTECD) has developed a number of resources to support grantees with culturally relevant quality improvement activities, including resources focused on CCDF quality requirements; ideas and innovations for quality improvement activities that meet community needs; support with planning, including prioritization and budgeting; and developing clear and strong policies and procedures. See <https://childcareta.acf.hhs.gov/quality-improvement-resource-page>.

In addition, our TA providers regularly refer states and other TA recipients to resources published by national organizations (such as the Annie Casey Foundation and Child Trends) that center racial equity in the development and implementation of child care policies and practices. These resources are used in the provision of intensive/individualized, targeted/group, and universal TA strategies depending on grantee need and readiness.

Looking ahead, the Biden-Harris Administration’s Build Back Better vision for early childhood would add substantial ongoing investments to early learning services and infrastructure and continue the momentum created by the American Rescue Plan Act—to benefit all children, families and providers—including in communities of color. The President’s fiscal year 2022 Budget includes \$250 billion over 10 years to make child care affordable and to modernize and expand child care facilities. High-quality early care and education opportunities lay a strong foundation so that children can take full advantage of education and training opportunities later in life. The President’s Build Back Better invests in child care infrastructure and workforce training and ensures that low and middle-income families pay no more than 7 percent of their income on high-quality child care. The Build Back Better also proposes \$200 billion for a national partnership with states to offer free, high-quality, accessible, and inclusive prekindergarten to all three- and four-year-olds. The proposed universal prekindergarten program is designed to give states incentives to build out their existing pre-k programs to reach more 3- and 4 -year-olds and to increase program quality by building on what has already been established in states. The Budget also proposes increased funding levels for existing early care and education programs, including nearly \$11 billion for CCDF and a total of \$11.9 billion for Head Start.

Question. Title X is the only Federal program dedicated to providing family planning services for people who are paid low incomes. It disproportionately serves communities of color, where the pandemic has hit the hardest and exposed sharp disparities in access to care. Sadly, this critical program has been chronically underfunded for too long. The President’s Budget proposes to increase the program by \$54 million, its first increase in nearly a decade. Yet, research shows Title X would need hundreds of millions more annually to provide family planning services to all women without insurance and who are paid low incomes in the United States.

Please explain how HHS plans to use this increase to help increase access for women of color and women who are paid low incomes?

Answer. HHS agrees the nation must take swift action to prevent and remedy stark racial and ethnic disparities in health and healthcare delivery in America, including advancing equity and reducing health disparities in all healthcare programs. As you noted, the budget provides a 19 percent increase to the Title X Family Planning program for a total of \$340 million to support family planning services for approximately 3.5 million persons, with approximately 90 percent having family incomes at or below 200 percent of the Federal poverty level and a disproportionate number of clients served identify as a person of color. The Office of Population Af-

fairs (OPA), part of the Office of the Assistant Secretary for Health (OASH), advises the HHS Secretary on a range of public health priorities including quality family planning and adolescent health and serves as a key stakeholder on HHS' effort to advance health equity.

OPA administers the Title X family planning program, the only Federal program devoted solely to the provision of family planning and related preventive healthcare. By law, under the Title X program, priority is given to individuals from low-income families, which include many communities of color. On January 28, 2021, President Biden issued a "Memorandum on Protecting Women's Health at Home and Abroad" directing the Department to review the 2019 Title X Final Rule and "consider, as soon as practicable, whether to suspend, revise, or rescind, or publish for notice and comment proposed rules suspending, revising, or rescinding, those regulations, consistent with applicable law, including the Administrative Procedure Act." The memorandum specifically directed the Department to ensure that undue restrictions are not put on the use of Federal funds or on women's access to medical information. After reviewing the 2019 rule, the Department went through notice-and-comment rulemaking and finalized a regulation to revoke the 2019 rules and restore the 2000s regulation that successfully guided the program for decades with several modifications needed to strengthen the program and ensure access to equitable, affordable, client-centered, quality family planning services for all clients.

Question. Chairman Pallone and I recently wrote a letter to interested parties requesting input on how best to write legislation establishing a public health insurance option. The objective is to create a strong Federal public option that makes healthcare more accessible, more affordable, and simpler for patients and families. In addition to policies like permanently extending the increased premium tax credits in the American Rescue Plan, a public option would go a long way towards ensuring every person has quality, affordable coverage regardless of income, age, race, disability, or zip code. We were pleased that the budget expressed the President's support for a public option available through the ACA marketplaces.

How would a public option help expand coverage, bring down healthcare costs, and make healthcare easier to access for patients and families?

Answer. The President supports providing Americans with additional, lower-cost coverage choices by creating a public option that would be available through the ACA marketplaces and giving people age 60 and older the option to enroll in the Medicare program with the same premiums and benefits as current beneficiaries, but with financing separate from the Medicare Trust Fund. President Biden has been clear that his goals for improving the American healthcare system begin with building on the successes of the Affordable Care Act, and HHS is committed to working toward that goal.

Question. The Affordable Care Act (ACA) authorized \$30 million for Consumer Assistance Programs (CAPs) to provide a dedicated Federal funding stream to help health insurance consumers effectively steer their way through our nation's complex health insurance system and to avail themselves of new consumer protections in the ACA. In 2010, HHS awarded nearly \$30 million in CAP grants to 40 states, territories, and the District of Columbia. Regrettably, efforts to overturn and then weaken the ACA resulted in blocking additional funding after the first year. Many states—including New York, Massachusetts, Maine, Connecticut, Rhode Island, Vermont, the District of Columbia, Maryland and more—maintained CAPs with limited state funds, but others closed altogether for lack of funding. These programs help consumers understand and use their insurance plans, resolve medical billing problems, and appeal insurance denials. As the Biden Administration joins Congress to provide support to individuals who are underinsured or who have lost their jobs and healthcare coverage due to the economic downturn caused by the COVID-19 pandemic, assistance is needed to help consumers navigate and understand their healthcare options.

Does the Administration support the resumption of the ACA CAP programs to sufficiently meet the demand for such assistance?

How does the Administration plan to prioritize the provision of services provided in the CAP programs to people across the nation?

Answer. HHS is committed to using all available tools to strengthen the ACA Marketplaces, making it easier for people to get and keep health insurance, and making sure more Americans know about their options and are supported in their enrollment.

Question. In December 2018, the bipartisan 21st Century IDEA (PL 115-336) was signed into law. It requires agencies to modernize their websites, intranets and digitize their paper-based forms with the goal of improving the Federal Government's customer experience and digital service delivery. Since Congress passed the 21st Century IDEA, the nature of how individuals engage with the government has

fundamentally changed—in large part because of the COVID-19 pandemic. These changes underscore an even stronger need to implement the 21st Century IDEA and allow Federal agencies to deliver an excellent customer experience from anywhere, to anyone, on any device.

Has CMS fully implemented the 21st Century IDEA Act (Public Law No: 115–336)? What barriers has CMS faced in implementing this law and modernizing its digital services?

The law required each executive agency to digitize and ensure any paper-based form was made available to the public in a fully usable mobile friendly option. Where does CMS stand in ensuring its forms can be filled out and submitted electronically on all digital devices?

Who is responsible inside CMS for ensuring the agency fully implements PL 115–336?

Answer. CMS is committed to making sure beneficiaries, enrollees, providers, and other stakeholders have access to the information they need to make important decisions about their healthcare. The 21st Century IDEA provided CMS with valuable resources and guidance that bolstered its ongoing efforts to modernize its websites. CMS has implemented the 21st Century IDEA for all of its public websites, and many CMS forms are available for beneficiaries, enrollees, providers, and other stakeholders to fill out and submit online. The CMS Office of Communications continues to make updates that make it easier to access and submit these forms from a mobile device.

Question. HRSA’s C.W. Bill Young Cell Transplantation Program, along with its nonprofit partner the National Marrow Donor Program (NMDP), provides support and access for patients who need lifesaving bone marrow transplants. The President’s budget request proposes to combine the Cell Transplantation/National Registry Program with the National Cord Blood Inventory (NCBI) Program. It also appears to request an increase of \$7 million for the Cell Transplantation/National Registry Program.

Please provide greater detail than what was included in the HRSA Congressional Justification (CJ) on the proposed consolidation and how HHS plans to spend the proposed increase.

Answer. In fiscal year 2022, HHS will use approximately \$49.2 million in consolidated funds from the C.W. Bill Young Cell Transplantation Program (CWBYCTP) and the National Cord Blood Inventory (NCBI) to support the common legislative and therapeutic functions of both programs (i.e. bone marrow functions, cord blood functions, single point of searching access, stem cell therapeutic outcomes database, and patient advocacy) outlined in the TRANSPLANT ACT of 2021.

In fiscal year 2022, HHS expects to award approximately \$10 million to licensed cord blood banks to continue banking high-quality, diverse cord blood units. HHS also plans to provide approximately \$7 million to examine ways to optimize cord blood utilization. The remaining \$32.2 million will support the five legislative functions described above through one or more contracts. HHS will obligate these funds primarily for contract-supported initiatives (i.e. adult donor recruitment and tissue typing, searches for stem cell sources through a single point of electronic access, patient education, case management, donor advocacy, public outreach, professional development, and data collection). HHS will use a small portion for administrative costs.

Question. In addition, this Committee provided increases for this program in both fiscal year 2020 and fiscal year 2021, yet the CJ includes little detail on how HRSA plans to use these resources. Please provide execution detail for each of these fiscal year increases and the total amount that was obligated and applied to HRSA’s partners who run the program.

Answer. In fiscal year 2020, HRSA provided an increase in funding to support new and existing activities under the Single Point of Access- Coordinating Center contract. The activities for the Office of Patient Advocacy and Stem Cell Therapeutic Outcomes Database contracts remained unchanged. The funding provided for each CWBYCTP contractor is outlined below:

—National Marrow Donor Program—

—Single Point of Access- Coordinating Center (SPA-CC)—\$21.8 million used to support the SPA-CC contract, which carries out three legislative functions (i.e., bone marrow, cord blood, single point of access);

—This funding included an additional \$5.4 million, which increased existing support for adult donor recruitment and tissue typing; high-resolution tissue typing of cord blood units and collaboration with cord blood banks to enhance cord blood operations. The funding also supported new activities under the contract, including: cytomegalovirus testing of adult donors;

- COVID-19 related increases including donor and courier costs; and cryopreservation of blood stem cell products.
 - Office of Patient Advocacy (OPA)—\$877,000 used to support the Office of Patient Advocacy; and
 - Medical College of Wisconsin’s Center for International Blood and Marrow Transplant Research—
 - Stem Cell Therapeutic Outcomes Database—\$4.6 million used to collect outcomes data on blood stem cell transplants using bone marrow and cord blood.
- In fiscal year 2021, HRSA plans to fund existing and enhanced activities carried out by the following CWBYCTP contractors:
- Single Point of Access-Coordinating Center (SPA-CC)—\$29.8 million used to support the SPA-CC contract.
 - HHS will fund many of the same activities, including adult donor recruitment and tissue typing, high-resolution tissue typing of cord blood units, and collaboration with cord blood banks. Also, HHS will fund donor advocacy and contingency planning activities.
 - The additional \$7 million will support existing NCBI cord blood banks; raise physician awareness of all cellular therapy treatment options, including cord blood; and support engagement with the cord blood community.
 - Office of Patient Advocacy (OPA)—\$903,000 used to support the patient advocacy and case management. The scope for this contract has not increased in recent years.
 - Stem Cell Therapeutic Outcomes Database—\$4.7 million used to collect outcomes data on blood stem cell transplants using bone marrow and cord blood. The scope for this contract has not increased in recent years.

Question. The Committee included language in the fiscal year 2021 Conference Agreement that encouraged HHS to “review the accreditation and eligibility requirements for the Public Health Service Corps and behavioral health workforce programs to allow access to the best qualified applicants, including those who graduate from Psychological Clinical Science Accreditation System (PCSAS) programs”. This review and these changes are necessary to update Department policy that was adopted prior to the establishment of PCSAS to permit the graduates of the current 44 PCSAS University accredited doctoral programs in psychological clinical science to be eligible to compete.

Please provide an update on progress to update these Department policy and regulation.

Answer. As of December 2020, the Public Health Service Commissioned Corps includes the Psychological Clinical Science Accreditation System programs in the Category Specific Appointment Standards. This means that individuals with such accreditation are permitted into the Corps.

HRSA is currently exploring options to include PCSAS doctoral programs as eligible entities in the upcoming fiscal year 2022 Graduate Psychology Education competition. HRSA will continue to explore options to include such programs in other future competitions, including, but not limited to, the Behavioral Health Workforce Education and Training program, and the Geriatric Academic Career Awards. HRSA currently anticipates posting the Notice of Funding Opportunity for the Graduate Psychology Education program in November 2021.

Question. The Centers for Medicare & Medicaid Services (CMS) posted a final rule for Medicare’s radiation oncology alternative payment model (RO APM) on September 18, 2020. Implementation of the model has been delayed by Congress until January 2022.

Is the Biden Administration reviewing and planning to issue an updated RO APM?

Will HHS commit to working with both Congress and stakeholders to improve the RO APM and ensure that a transition to new value-based models does not result in reduced patient access to innovative cancer treatments?

Answer. Since 2014, CMS has explored potential ways to test an episode-based payment model for radiotherapy (RT) services. In December 2015, Congress passed the Patient Access and Medicare Protection Act, which required the Secretary of Health and Human Services to submit to Congress a report on “the development of an episodic alternative payment model” for RT services. The report was published in 2017 and identified three key reasons why RT is ready for payment and service delivery reform: the lack of site neutrality for payments; incentives that encourage volume of services over the value of services; and coding and payment challenges.

The Radiation Oncology (RO) Model, implemented through the CMS Innovation Center, aims to improve the quality of care for cancer patients receiving RT and move toward a simplified and predictable payment system. The RO Model tests whether prospective, site neutral, modality agnostic, episode-based payments to phy-

sician group practices, hospital outpatient departments, and freestanding radiation therapy centers for RT episodes of care reduces Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. I am happy to work with Congress and other stakeholders to address any concerns about this model.

The Consolidated Appropriations Act, 2021 enacted on December 27, 2020 included a provision that prohibits implementation of the Radiation Oncology Model prior to January 1, 2022, effectively delaying the start date by at least 6 months. CMS intends to address the delay and make other modifications to the RO Model through notice and comment rulemaking.

Question. Analysis of CDC data and other reports indicate a reduction in routinely recommended vaccination of children and youth last year resulting from the disruption to routine healthcare caused by the COVID-19 pandemic. Lack of proper vaccinations could provide an additional challenge to the return to in-person learning in the fall.

How is HHS working with the Department of Education to support the vaccination of children and youth needed for school enrollment for in-person learning?

Answer. CDC issued a Call to Action in April 2021 encouraging healthcare providers to identify and follow up with families whose children have missed doses, and to schedule appointments for those children. CDC encouraged schools and state and local government agencies to use the state's immunization information system's reminder-recall capacity to notify families whose children have fallen behind on routine vaccines and encourage compliance with vaccination requirements. In June 2021, CDC issued an MMWR article describing the decrease in routine childhood and adolescent immunizations in 10 U.S. jurisdictions during March–September 2020 as compared with the same period in 2018 and in 2019.

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

Question. Secretary Becerra, the budget proposes \$767 billion for Medicare. One of the greatest drivers of outlays by the Medicare program is the cost of chronic conditions, including tobacco-related costs. By some estimates, 10 percent of Medicare spending is attributable to smoking and the health harms it causes. So it would seem that the Department would want to be doing everything it can to prevent tobacco use, especially among youth. As you know, youth e-cigarette use has skyrocketed over the past decade. Four million kids are now vaping—one in every five high school students.

And for years, the Federal Government failed to regulate these addictive, kid-friendly products. Nine months ago, e-cigarette companies were required to submit applications to the FDA in order to stay on the market. This is a momentous time for the FDA, as it will evaluate whether these e-cigarettes are “appropriate for the protection of public health.” That is a high bar. But the FDA's priority should be protecting our youth and preventing a lifetime of addiction. I am deeply concerned that the FDA will let a product such as JUUL—which has partnered with Marlboro-maker Altria and had a years-long documented campaign of hooking our kids on nicotine—to remain on the market. In particular, I am worried that FDA will allow flavored products—which we know are meant to target kids—to proliferate.

Can you commit to me that HHS and FDA will not authorize any vaping products that will lead to more youth use, including flavored products?

Answer. FDA has a very important responsibility to review new tobacco products before they can be legally marketed. FDA determines if a new tobacco product may be legally marketed by assessing whether the marketing of the product meets the applicable standard Congress set in the law to protect the public health.

As required by statute, a key consideration in our review of premarket tobacco product applications submitted for products like e-cigarettes is to determine whether permitting the marketing of the product would be “appropriate for the protection of the public health,” taking into account the risks and benefits to the population as a whole. This determination includes consideration of how the products may impact youth use of tobacco products and the potential for the products to completely move adult smokers away from use of combustible cigarettes. Importantly, we know that flavored tobacco products are very appealing to young people. Therefore, assessing the impact of potential or actual youth use is a critical factor in our determination as to whether the statutory standard for marketing is met.

Looking forward, FDA continues to work expeditiously to complete review of the remaining pending applications. While the Agency cannot prejudge applications or categorically deny marketing authorization based on certain characteristics, such as flavors, be assured that HHS and FDA share your concern about youth initiation

and use of tobacco products, and we will continue to keep you updated as reviews continue.

Question. Two decades ago, a CDC study came out that changed the way we think about public health. It was called the Adverse Childhood Experiences or “ACEs” study, and it established the link between exposure to trauma—things like witnessing violence or an overdose—and our long-term health, education, and economic outlook. We now understand how trauma and ACEs harm brain development, and how these emotional scars can lead to lower life expectancy, and a higher likelihood of suicide or drug use.

When you look at the public health crisis of gun violence—along with the mental health and addiction—it’s clear we must focus on the root issue of trauma. So Senator Capito and I teamed up in 2018 to pass legislation that created an ACEs program at CDC, and I am pleased to have secured \$10 million over the past 2 years for this work. We also passed provisions creating the Interagency Task Force on Trauma-Informed Care that brings our Federal agencies around the table to promote this understanding of trauma in every Federal grant program, increasing the authorization for the National Child Traumatic Stress Network, and authorizing a \$50 million trauma and mental health services grant program for schools, which we have not yet been able to fund. This grant program—Section 7134 of the SUPPORT for Families and Communities Act—would assist schools in adopting trauma-informed practices, training more staff, engaging families, and forging partnerships with clinical mental health professionals.

Now, the 2022 budget proposes a \$61 million increase to SAMHSA’s Project AWARE mental health funding, and a \$100 million investment at CDC in community-based violence interventions, working with neighborhood organizations and hospitals to deliver services. Chicago is home to many of these programs—including street outreach efforts, trauma programming in schools, and hospital programs that pair victims of violence with social workers to address their trauma and reduce the current 50 percent re-injury rate.

Secretary Becerra, can you explain how this new CDC community-violence proposal can support programs like those in Chicago, and how you envision this constellation of programs working together?

Secretary Becerra, in addition to, or as part of, the proposed increase to Project AWARE, would you also support appropriations for this already-authorized Sec. 7132 program to address the breadth of trauma needs in schools—setting up comprehensive plans, trainings, and partnerships?

Answer. The Community Violence Initiative (CVI) proposal would help CDC address the root causes of community violence and support systemic approaches to violence prevention. CDC would prioritize implementing evidence-based, community strategies to reduce rates of violence; expand our prevention data surveillance, conduct research to address critical gaps; and enhance what is known about what works to prevent community violence. This approach includes prevention strategies that address the structural determinants of health that contribute to violence inequities within and across communities, such as those currently implemented in Chicago. In addition, Hospital-Community Partnerships, such as HEAL, represent an important type of strategy to prevent and reduce community violence and could be supported under the proposed Community Violence Initiative.

A comprehensive approach is critically important to achieving and sustaining long-term reductions in community violence. A strong and growing research base demonstrates that there are multiple prevention strategies that are scientifically proven to reduce violence victimization and perpetration. Many of these strategies are upstream approaches that have yielded community savings that far outweigh implementation costs. These upstream approaches, coupled with programs like hospital-community partnerships, can create safe, healthier, and more resilient communities.

In addition to funding 25 cities with the highest overall number of homicides and the 25 cities with the highest number of homicides per capita, the CVI proposal would also fund up to five non-governmental organizations that have expertise in partnering with communities most impacted by community violence. Doing so will build a network of violence prevention efforts, from local health departments to community organizations. The CVI proposal will also help modernize data systems like the National Violent Death Reporting System (NVDRS) to provide more timely data on causes of violence in communities.

SAMHSA is also committed to effective school based mental health services that address the needs of children and families. Project AWARE grantees have established mechanisms to provide tiered services in school settings. This tiered system has three main components. One pays attention to the overall school climate and promotes social and emotional learning opportunities and supports for all children.

The next tier has special programming for children at risk for the development of behavioral health conditions. The third and final tier is comprehensive services for children and their family with serious emotional disturbance (SED). A comprehensive approach to behavioral healthcare in schools is critical to build resilience in our children and youth include building trauma-informed school systems and providing training and community partnerships in trauma-informed care. Building in trauma-informed care to AWARE projects and augment that work with additional partnerships to address the breadth of need in schools is critical to meet the mental health needs of our children and youth.

Several programs funded by HRSA are focused on measuring and addressing the impact of ACEs, as well as providing trauma-informed care in schools.

NATIONAL COORDINATING COMMITTEE ON SCHOOL HEALTH AND SAFETY

HRSA in collaboration with CDC leads the National Coordinating Committee on School Health and Safety (NCCSHS) to support student well-being and ensure school facilities are healthy and safe environments. Since its inception in 1996, NCCSHS aims to support communication among governmental agencies and national non-governmental organizations in order to share resources and disseminate information about school health and safety to local and state partners. NCCSHS members are working to coordinate communication and encourage uptake at the state/local levels of school-based approaches that protect student's mental health and well-being through expanding comprehensive, trauma-informed mental health services in schools and the Whole School, Whole Community, Whole Child model (WSCC). NCCSHS includes 170 members including eight Federal agencies and non-governmental organizations such as the American Academy of Pediatrics, American Psychological Association, and Council of Chief State School Officers.

COLLABORATIVE IMPROVEMENT AND INNOVATION NETWORK FOR SCHOOL-BASED HEALTH SERVICES

The Collaborative Improvement and Innovation Network for School-Based Health Services (CoIIN-SBHS) provides trauma-informed, behavioral health technical assistance to state partners (e.g., Title V Maternal and Child Health programs, state Medicaid programs, child mental health agencies, education agencies, state-level non-profit organizations), school districts, comprehensive school mental health systems and school-based health centers. This program is in its fifth of 5 years of funding and is administered by the School Based Health Alliance in partnership with the National Center for School Mental Health.

ADVERSE CHILDHOOD EXPERIENCES (ACEs) IN PRIMARY CARE SETTINGS DEMONSTRATION PROJECT

The newly awarded Adverse Childhood Experiences (ACEs) in Primary Care Settings Demonstration Project will study how best to implement, in primary care settings, screening protocols and evidence-based interventions for children and adolescents who have experienced ACEs. The goal of this program is to yield a model for integrating ACEs screening and strength-based, trauma-informed services into primary care settings. This three-year demonstration project aims to:

- Study how primary care settings can best screen and provide care to children impacted by ACEs, including strengths, limitations, and implementation challenges; and
- Produce a scalable model that can help pediatric providers effectively integrate screening with strength-based, trauma-informed care and services in primary care settings.

National Survey of Children's Health:

The National Survey of Children's Health (NSCH), funded and directed by HRSA's Maternal and Child Health Bureau, is the nation's largest annual survey of children's health at the state and national levels.

This parent-reported survey includes questions to assess a range of Adverse Childhood Experiences (ACEs) among U.S. children.

Data from 2019–2020, show that 21.7 percent of U.S. children ages 0–17 had experienced one ACE in their lifetime, while 18.1 percent had experienced two or more ACEs. Data from the 2021 NSCH will be released on October 3rd, 2022.

Question. Secretary Becerra, the United States is world's largest importer of personal protective equipment. Three-quarters of N95 masks in the U.S. are produced overseas, the majority from China. And from 2019 to 2020, American imports of PPE from China skyrocketed from \$2 billion to \$14 billion. This created shortages and price spikes—resulting in those horrific images of our health heroes wearing

garbage bags to stay safe. 80 percent of nurses reported re-using masks meant for single use. When it came to our prized Federal backstop—the Strategic National Stockpile—the supply was inadequate. 5 million N95 masks in the Stockpile were expired. Governors only got a fraction of the masks, gowns, and gloves they asked for.

Senator Cassidy and I have introduced the PPE in America Act to boost domestic manufacturing of PPE and medical supplies so we no longer have to rely on China and others to keep our health workers safe. Our bill would use the purchasing power of the Stockpile as an engine to sustain domestic PPE manufacturers. And it would enable a replenishable, churning mechanism for the Stockpile to routinely sell supplies to other agencies, states, and the commercial market . . . and re-stock equipment from domestic producers. This arrangement will provide predictability that domestic PPE manufacturers can depend on . . . and will improve their coordination with the Stockpile to avoid expiration of supplies.

Secretary Becerra, I'm pleased to see the budget proposes a \$200 million increase for the Stockpile. Do you support policies that boost domestic PPE production, mitigate risk for expiration, and provide sustainability for manufacturers, including through replenishing mechanisms for the SNS?

Answer. The global pandemic has highlighted the vulnerabilities of the global supply chain. It is critical that steps are taken to invest in expansion of U.S. domestic manufacturing capacity. To that end, the Office of the Assistant Secretary for Preparedness and Response (ASPR) is leveraging the authorities delegated to the Secretary under the Defense Production Act (DPA) to ensure that private sector partners making life-saving products are able to acquire raw materials, retool their machinery, scale their production facilities, train their workforces, and ultimately deliver their product. Throughout the COVID-19 response, ASPR has used the DPA authority to issue 46 priority ratings for United States Government (USG) contracts for health resources, eight priority ratings for USG contracts for industrial expansion, and 3 priority ratings for non-USG contracts to indirectly support COVID-19 and/or mitigate the potential stockout of critical lifesaving therapies. Going forward, ASPR will continue to build capacity and partnerships with private industry toward the shared goal of ending the COVID-19 pandemic and preparing for future pandemics.

ASPR is also working to support efforts in expanding the domestic industrial base. These industrial base expansion (IBx) efforts seek to reduce supply chain vulnerabilities and generate a domestic “warm-base” for manufacturing that can be leveraged in a crisis. During the COVID-19 pandemic, all contracts—competitive and sole-sourced—awarded by the Department of Health and Human Services for N95 respirators were for U.S.-produced supplies. A total of approximately 800 million domestically produced N95 respirators were procured for the Strategic National Stockpile. Contracting actions executed in March 2020 were intended to encourage manufacturers to immediately increase production of N95 respirators, and these manufacturers with domestic production capabilities stepped up to support the nation with quality products at the best prices for the USG. Furthermore, with \$10 billion received for emergency medical supplies enhancement, ASPR has been establishing and maintaining domestic capacity for critical supplies.

Lastly, ASPR's Hospital Preparedness Program (HPP) included two requirements in the fiscal year 2019–2023 funding opportunity announcement to help address supply chain vulnerabilities. First, HPP recipients and their healthcare coalitions must conduct a supply chain integrity assessment to evaluate equipment and supplies that will be in demand during emergencies and develop mitigation strategies to address potential shortfalls. Second, each healthcare coalition must update and maintain a regional resource inventory assessment.

ASPR will continue to assess and monitor domestic manufacturing capabilities going forward. As the COVID-19 pandemic continues, we will modify and refine efforts, as needed, to ensure they do not interfere with the private sector but support efforts to maintain and build a robust domestic capability.

Question. One of the major lessons learned from the pandemic was the need to bolster our healthcare workforce. But this is not a new problem. Even before COVID-19, our nation faced a shortfall of 120,000 doctors and a quarter-million nurses, with many rural and urban areas facing recruitment challenges. Across Illinois, 5 million people live in shortage areas for mental health providers, 3 million with too few primary care doctors. The problem starts with medical education in America. We take promising students, put them through years of rigorous education and training, and license them on one condition: student loan debt that can average more than \$200,000. The burden of paying off these loans steers our brightest minds into higher-paying specialties and more affluent communities. This is especially true for healthcare providers of color. You may be aware there are fewer Black men

entering medical school today than there were in the 1970s. Black and Latinx Americans make up 31 percent of the nation's population, yet just 6 percent of doctors. We know that this discrepancy leads to worse care and outcomes for patients of color.

Thankfully, the National Health Service Corps helps to address these gaps by providing scholarship or loan repayment for healthcare workers who commit to serve in urban and rural areas with shortages. President Biden's American Rescue Plan included a provision I authored with Senator Rubio to provide \$1 billion in loan repayment and new scholarship awards to the National Health Service and Nurse Corps. It will help surge tens of thousands of new clinicians into under-served areas, representing the largest single-year appropriation to our healthcare pipeline in history. We know that scholarship-based awards can make a particularly meaningful difference when it comes to emphasizing recruitment from under-represented populations.

The pandemic has also magnified acute workforce shortages in communities facing natural disasters or other public health emergencies. The GAO has recently reported on how the National Disaster Medical Service—which activates health personnel from private practices for deployment intermittent Federal employees—does not have the planning in place to ensure a workforce capable of responding to nationwide or multiple concurrent health events, and that its workforce is only a fraction of its target level. I have introduced legislation with Senator Rubio (S.54, the Strengthening America's Health Care Readiness Act), to test a pilot program that provides supplemental loan repayment for NHSC alumni who continue to practice in a shortage area, and current NHSC clinicians, who concurrently serve in the NDMS and are available for rapid, short-term deployment for health emergencies. Under this pilot program, HRSA and ASPR would have the authorities and directive to coordinate to ensure adherence to their core missions and the appropriate application of NHSC contract requirements and covered benefits/protections of NDMS employment. I have also introduced legislation with Senator Blackburn (S.924, Rural America Health Corps Act), to increase recruitment and retention of NHSC clinicians in rural areas, given the fact that only 5 percent of incoming medical students hail from rural areas and one-third of placements are in rural communities. This legislation would test a pilot program to explore whether an elongated service commitment and increased loan repayment award—5 years and \$200,000—could enhance recruitment and retention in rural America.

Secretary Becerra, your budget proposes a \$47 million increase to the National Health Service Corps. Do you support using appropriations for certain pilot program approaches that test and evaluate new strategies to address specific nuances and acute gaps in our country's health workforce needs, including in health preparedness, health disparities, and in rural America?

Answer. HRSA will implement the programs that Congress enacts. The aim of National Health Service Corps (NHSC) is to address the primary care needs of underserved populations and to provide them with access to quality healthcare. The \$47 million request for the NHSC will be dedicated to bolstering the health workforce in rural and underserved communities where there is an existing shortage of primary care providers. Similar, in part, to the goals of the Rural America Health Corps Act, the proposed funding will expand access to primary care services to vulnerable populations, specifically those areas facing barriers to obtaining evidence-based substance use disorder (SUD) treatment services. The NHSC Rural Community Loan Repayment Program (LRP), SUD Workforce LRP, and the traditional NHSC LRP will serve as the mechanisms for distributing this requested funding, as these programs have proven their effectiveness in mobilizing and retaining providers in the areas where they are needed most. A total of 28,405 clinicians in the NHSC and Nurse Corps completed their service between 2012 and 2019; of these, 80 percent continue to serve in Health Professional Shortage Areas (HPSAs) after their service obligation is completed. One out of three of those NHSC alumni work in rural communities. Over the same timeframe, 78 percent of the NHSC participants who completed their service obligation at a site in a rural area continue to work in a rural area, with over 50 percent continuing to work in a HPSA in the same county where they completed their NHSC service.

The Hospital Preparedness Program (HPP) supports efforts to strengthen healthcare sector readiness to provide coordinated, life-saving care in the face of emergencies and disasters. The HPP portfolio supports a comprehensive, national network for healthcare preparedness and response. The programs and activities within the HPP portfolio are coordinated to address the many, complex facets of the nation's healthcare system, creating mechanisms and infrastructure to improve coordination between localities, states, and regions, as well as developing new capabilities (e.g., telemedicine, specialty healthcare, etc.) specific to key challenges with-

in the modern threat landscape (e.g., highly pathogenic disease; biological/chemical incidents, etc.).

As the primary source of Federal funding for healthcare system preparedness and response, HPP promotes a consistent national focus to improve patient outcomes during emergencies and to enable rapid healthcare service resilience and recovery. Since 2002, investments administered through HPP have improved individual healthcare entities' preparedness and have built a system for coordinated healthcare system readiness and response through healthcare coalitions (HCCs) and other partnerships, such as the Regional Disaster Health Response System (RDHRS) demonstration project. With respect to infrastructure needs, recipients of funding are expected to consider how to provide and plan for uninterrupted care when faced with damaged or disabled healthcare infrastructure during an emergency response; however, the HPP cooperative agreement does not allow for construction or major renovation costs.

HPP provides cooperative agreement funding to states to support healthcare system preparedness efforts. Specific to Colorado, if appropriated at the requested level in fiscal year 2022, it is estimated that Colorado will receive \$3,584,461 via the HPP cooperative agreement. Colorado will delegate this funding within the state to support such efforts, including enhancing rural capabilities.

—Additional ASPR Programs and Tools Concerning Colorado and Rural Health:

—The Denver Health and Hospital Authority was also recently awarded the Partnership for Disaster Health Response System Cooperative Agreement to establish the Region 8 Mountain Plains RDHRS demonstration site. To address gaps in regional healthcare delivery during disasters, ASPR developed the RDHRS: a tiered system that builds upon and unifies existing healthcare and ASPR assets within states and across regions that supports a more coherent, comprehensive, and capable healthcare disaster response system able to respond to health security threats. The RDHRS helps improve disaster readiness capabilities and capacity, increase medical surge capacity, and extend provision specialty care—including trauma, burn and infectious disease, among others—during large-scale disasters or public health emergencies.

—Additionally, the Rural Health Care Surge Readiness Portal was established in 2020 to provide the most up-to-date and critical resources for rural healthcare systems preparing for and responding to a COVID-19 surge. The resources span a wide range of healthcare settings (including EMS, inpatient and hospital care, ambulatory care, and long-term care) and cover a broad array of topics ranging from behavioral health to healthcare operations to telehealth. This portal was developed by the COVID-19 Healthcare Resilience Working Group, a partnership with the U.S. Department of Health & Human Services, the U.S. Department of Homeland Security, and other Federal agencies, to provide support and guidance for healthcare delivery and workforce capacity and protection.

QUESTIONS SUBMITTED BY SENATOR JACK REED

Question. My colleague on the LHHS Subcommittee, Sen. Capito, and I authored the Childhood Cancer Survivorship, Treatment, Access, and Research (STAR) Act—the most comprehensive childhood cancer bill in history—which was signed into law on June 5, 2018 (Public Law No: 115–180). Every year since becoming law, Congress has provided full funding (\$30 million) to support the programs created by the STAR Act. However, two provisions remain to be implemented: Title 2, Section 201(a), which requires the Secretary of Health and Human Services to make awards to establish pilot programs to develop, study, or evaluate model systems for monitoring and caring for childhood cancer survivors throughout their lifespan, including evaluation of models for transition to adult care and care coordination; and Title 2, Section 201(b), which requires the Secretary to conduct a review of HHS activities related to workforce development for healthcare providers who treat pediatric cancer patients and survivors and to report the findings within 2 years of the enactment of the STAR Act.

Could you provide a status update on the implementation of these two key provisions of the STAR Act?

Answer. Senator Reed, first, thank your sponsorship of the Childhood, Cancer Survivorship, Treatment, and Research Act (STAR Act). The STAR Act enhances the research on the late effects of childhood cancers and is a critical step toward improving the quality of life for survivors of childhood cancer. The Agency for Healthcare Research and Quality (AHRQ) has partnered with the National Cancer Institute

(NCI) to commission three evidence reports as part of the Department's response to the two provisions of the Act that you reference: Section 201(a) and 201(b).

—Disparities and Barriers to Pediatric Cancer Survivorship Care (<https://effectivehealthcare.ahrq.gov/products/pediatric-cancer-survivorship/research>).

The report was posted on the AHRQ for public comment in October 2020, with simultaneous peer review and the final report was published March 1, 2021.

—Findings from the report were presented on April 20, 2021 on a free NCI-sponsored webinar. The recording can be found at <https://cancercontrol.cancer.gov/ocs/events/disparities-and-barriers>.

—A manuscript titled "Interventions to address disparities and barriers to pediatric cancer survivorship care: a scoping review" derived from the report was published in the Journal of Cancer Survivorship on June 16, 2021.

—Findings from the technical brief were presented at University of Cincinnati Hematology-Oncology Grand Rounds (5/28/2021); MD Anderson Cancer Survivorship Grand Rounds (6/18/2021); Cancer Support Community Seminar (7/27/2021); and the University of Kentucky Markey Cancer Center Affiliate Network's 15th Annual Cancer Care Conference (9/30/2021).

The NCI used the findings of the report to provide administrative supplements for the "NCI P30 Cancer Center Support Grants" to support research to understand and address organizational factors that contribute to disparities in outcomes among childhood cancer survivors. Additionally, this report has already begun to inform the broader cancer survivorship research community and survivorship care providers based on dissemination of the review findings.

—Models of Care That Include Primary Care for Adult Survivors of Childhood Cancer (<https://effectivehealthcare.ahrq.gov/products/pediatric-adolescent-cancer-survivorship/protocol>). This report was posted on the AHRQ website for four weeks of public comment in June 2021, with simultaneous peer review. The report is now being finalized. The final report is expected to be shared with NCI and publicly posted by the end of 2021.

AHRQ and NCI expect to widely disseminate this report to the research community and the general public once it can be publicly posted to raise awareness of the role that primary care providers can play in the care of adult survivors of childhood cancer. The NCI also plans to use the findings of this report to evaluate its current grant portfolio, to identify and assess potential gaps and opportunities for additional research on this topic.

Transitions of Care from Pediatric to Adult Services for Children with Special Healthcare Needs (<https://effectivehealthcare.ahrq.gov/products/transitions-care-pediatric-adult/protocol>). The draft report was posted on AHRQ's website in September 2021 for four weeks of public comment and simultaneously underwent peer review. A final report will be shared with NCI and posted publicly in 2022. Similar to the Models of Care report, AHRQ and NCI expect to widely disseminate this report to the research community and the general public once it can be publicly posted to raise awareness of challenges in transitioning care from pediatric to adult services for children with special healthcare needs. This report is expected to serve as a resource for those with interests related to a number of serious healthcare diseases and conditions including cancer. The NCI also plans to use the findings of this report to evaluate its current grant portfolio, to identify and assess potential gaps and opportunities for additional research on this topic.

QUESTIONS SUBMITTED BY SENATOR JEANNE SHAHEEN

Question. While I am pleased that we've made so much progress on vaccinations and getting through this pandemic, I continue to hear from hospitals and nursing homes in New Hampshire that are running on tight budgets after significant financial losses due to the pandemic. In particular, many of these hospitals and nursing homes are located in southern New Hampshire counties that were left behind in previous rounds of the Provider Relief Fund. These providers did not qualify for previous rural-focused rounds of the grants, despite treating significant portions of patients from surrounding counties that are rural. To help address that, we worked to give HHS more flexibility to make these types of hospitals and nursing homes eligible for the \$8.5 billion in Provider Relief Fund grants from the American Rescue Plan Act of 2021.

Do you have an update that you can share on the plans that HHS has for the remaining Provider Relief Fund grants that have not yet been awarded?

Answer. HHS is committed to distributing the remaining provider relief payments as quickly, transparently, and equitably as possible while utilizing effective safe-

guards to protect taxpayer dollars. HHS is planning for future Provider Relief Fund (PRF) allocations, including the \$8.5 billion from American Rescue Plan Act and Phase 4 of the General Distribution.

HHS is actively considering feedback from stakeholders, as well as operational lessons learned from prior PRF payments, as part of the planning process. The feedback from Members of Congress and other stakeholders informs HHS' ability to administer the PRF in a manner that bolsters the healthcare system and helps providers experiencing COVID-related financial hardships during this crisis. HHS will publish additional information on future distributions on the Health Resources and Services Administration's PRF webpage, at www.hrsa.gov/provider-relief, as soon as it becomes available.

Question. I am pleased that the President has announced his intention to resettle 62,500 refugees in the second half of this fiscal year. However, the enormous cuts to refugee resettlement over the past 4 years under the previous Administration have severely decimated the U.S. Refugee Admissions Program's capacity to provide local support for newly arrived refugees. Local resettlement agencies face substantial challenges as they work to restore their staffing and the services they provide, and they need timely support in order to hire and train the new staff necessary to meet the needs of increased numbers of newly-arrived refugees.

What specific measures are you taking to help resettlement agencies bolster capacity and prepare for the increased rate of refugee arrivals in the second half of this fiscal year?

Answer. The President's fiscal year 2022 budget request includes an increase of \$515 million over the fiscal year 2021 enacted level for Refugee and Entrant Assistance programs to accommodate the expected increase in arrivals through the end of this calendar year and beyond. This request would support a total of up to approximately 214,000 arrivals in fiscal year 2022, including up to 125,000 refugees as well as other entrants, such as asylees, Cuban and Haitian entrants, and Special Immigrant Visa holders.

This includes more than doubling the Refugee Support Services program, from \$207 million in fiscal year 2021 to \$450 million in the fiscal year 2022 Budget. This is one of the major sources of funding for resettlement agencies to bolster their capacity.

In addition to the potential budgetary support, ORR has taken several programmatic steps to ensure that the resettlement network is prepared for an increase in refugee and other ORR-eligible arrivals. ORR conducted listening sessions in the spring of 2021 to better understand current state and local capacity to resettle refugees, plans to increase resettlement capacity, and barriers to such growth. ORR and the Department of State/PRM conducted a joint training for State Refugee Coordinators to ensure understanding of their role in local capacity planning.

ORR and PRM are exploring options to strengthen policy and practice for the required community consultations, as well as private sponsorship. ORR staff are conducting coordinated outreach with other Federal agencies to ensure access to mainstream benefits and services. We are also planning for enhancements to existing services such as mental health, employer engagement, youth and family literacy, Preferred Communities and Matching Grant in anticipation of increased arrivals.

Question. Does ORR anticipate being able to provide forward funding to refugee resettlement agencies, so they have the advance funding necessary to build capacity in anticipation of the increased rate of refugee arrivals?

Answer. ORR continues to provide support and guidance to its partners and anticipates being able to provide sufficient forward funding through the President's fiscal year 2022 budget request.

QUESTIONS SUBMITTED BY SENATOR BRIAN SCHATZ

Question. In the hearing, you agreed that Congress should move forward with legislation to expand telehealth coverage in Medicare and committed that you would work with Congress to provide the necessary data and technical assistance to enact telehealth legislation this year. You also stated that you need "greater accountability" and "better authority."

What authority to ensure accountability and put safeguards into place for telehealth services does HHS need that it does not already have?

What measures to ensure accountability does HHS plan to put into place when Congress expands coverage of telehealth services?

What has the HHS Office of Inspector General determined about concerns related to fraud, waste, and abuse associated with expanded utilization of telehealth during the COVID-19 pandemic?

Last July, ASPE released early data on Medicare beneficiary use of telehealth. Is HHS planning to release additional data on the use of telehealth in Medicare during the pandemic?

What is the expected timeframe on the study that CMS has commissioned on the telehealth flexibilities during the COVID-19 pandemic?

What Center for Medicare and Medicaid Innovation (CMMI) models include telehealth waivers, and what are those waivers for? For each waiver, please specify how many model participants have elected the waiver and how many beneficiaries have used telehealth services under the waiver.

In which CMMI models have waivers enabled healthcare professionals other than physicians and practitioners to furnish telehealth services, and how many participants have used those waivers?

A 2018 OIG report recommended that CMS offer education and training sessions to practitioners on Medicare telehealth requirements. How has CMS addressed this recommendation?

Answer. Telehealth is an important tool to improve health equity and improve access to healthcare. Healthcare should be accessible, no matter where you live. HHS continues to examine the telehealth flexibilities developed for the current public health emergency and determine how we can build on this work to improve health equity and improve access to healthcare. An HHS study released by ASPE has shown that massive increases in the use of telehealth helped maintain some healthcare access for Medicare beneficiaries during the pandemic. CMS also released a data snapshot showing increases in Medicare telemedicine utilization during the pandemic. Lessons learned from CMS Innovation Center models also provide valuable insight into how providers furnish high-value care and innovate in care delivery, including the use of telehealth. In addition to looking at which flexibilities HHS can and should continue administratively, I look forward to working with Congress to address changes that may need to be done through legislation.

HHS is also dedicated to making sure providers are aware of the telehealth options available to them as they treat their patients. CMS routinely educates practitioners through various channels, including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. CMS will continue to use channels such as these to educate and provide training sessions for practitioners on Medicare telehealth requirements and related resources.

ASPE/HHS is currently preparing a follow-up issue brief on Medicare FFS beneficiary use of telehealth compared with in-person visit trends in 2020 which will examine telehealth use by beneficiary characteristics including race/ethnicity, urban/rural geography, state, visit type (primary care, specialist, mental health). The brief will also examine various telehealth modalities, including audio-only visits, telecommunications in addition to two-way interactive video-based telehealth visits and whether the beneficiary was located at home or in a health-care setting for the telehealth visit. This issue brief is anticipated to be published later this fall.

OIG is conducting significant oversight work (8 ongoing audits and studies) assessing telehealth services during the public health emergency. Once complete, these reviews will provide objective, independent findings and recommendations to policymakers and other stakeholders regarding the effect that the public health emergency flexibilities had on telehealth. This work will help HHS ensure the potential benefits of telehealth are realized for patients, providers, and HHS programs without being compromised by fraud, abuse, or misuse. OIG anticipates the first telehealth work products to be published this fall.

Question. The Bipartisan Budget Act of 2018 authorized Medicare Advantage plans to offer additional telehealth benefits in their annual bid amount beyond eligible telehealth services under Medicare fee-for-service.

What percentage of plans have offered additional telehealth benefits?

What type of additional telehealth benefits have been offered (i.e., types of services, types of healthcare professionals, etc.)?

Has HHS determined if there are any concerns related to fraud, waste, and abuse associated with additional telehealth benefits in Medicare Advantage plans?

Answer. Beginning in plan year 2020, Medicare Advantage plans have been permitted, but not required, to offer additional telehealth benefits as part of the basic benefit package beyond what is allowable under the original Medicare telehealth benefit. These benefits can be available in a variety of places, and people with Medicare Advantage plans can use them at home instead of going to a healthcare facility. For plan year 2021, over 94 percent of Medicare Advantage plans offered additional telehealth benefits reaching 20.7 million beneficiaries.

Medicare Advantage plans have the flexibility to determine which services are clinically appropriate to furnish through additional telehealth benefits on an annual

basis, consistent with the limits in statute and regulations. For example, a Medicare Advantage plan may offer a dermatology exam using store-and-forward technology.

All Medicare Advantage plans are required to have an effective program to prevent, detect, and correct Medicare Advantage noncompliance and fraud, waste, and abuse. HHS is committed to oversight of plan compliance with this requirement while ensuring access to care for Medicare Advantage enrollees through additional telehealth benefits.

Question. In January, HHS said that the COVID-19 public health emergency declaration would likely be in place for all of 2021.

As we are now halfway through 2021, does HHS have an updated expectation for how long the public health emergency will last?

What are the factors you are considering for when the public health emergency could be declared over (i.e., vaccination rates, daily cases, etc.)?

Answer. The Secretary of Health and Human Services may, under section 319 of the Public Health Service (PHS) Act, determine that: (a) a disease or disorder presents a public health emergency (PHE); or (b) that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. If and when declared, a PHE lasts until the Secretary declares that the emergency no longer exists or for 90 days, whichever comes first, but it may be extended for additional 90-day periods as needed and as determined by the Secretary.

HHS will continue to evaluate the infection rate of COVID-19 and will modify the PHE, as needed, when cases decrease and the authorities under a PHE are no longer needed to support response operations.

Question. In the hearing, you agreed that it would be helpful for Federal response agencies, such as CDC, FDA, and NIH to be able to respond proactively to public health emergencies before they get out of control.

Would automatic funding to the Public Health Emergency Fund upon the declaration of certain public health emergencies—including infectious disease outbreaks—modeled after FEMA's Disaster Relief Fund, be helpful to ensure a quick and effective response to public health emergencies?

Answer. A key lesson learned during the ongoing COVID-19 pandemic is that having available funding in the Public Health Emergency Fund would ensure that HHS can immediately respond while working in partnership with Congress on broader supplemental needs. For example, during the initial days of the COVID-19 pandemic, the Biomedical Advanced Research and Development Authority (BARDA) shifted program funds and redirected contracts from some of its investments in emerging infectious diseases (Zika and Ebola contracts) and leveraged pandemic influenza preparedness contracts to support vaccine and therapeutic development efforts. The funds were used to start a few critical programs early on; however, there were insufficient funds available to start the multi-pronged approach that led to success in both the vaccine and therapeutic development efforts. Using funds planned for other programs impacted the long-term investments that were in place for other identified threats, and there is no guarantee in a future public health emergency, that it would be possible to similarly shift program funds.

If funded, the Public Health Emergency Fund would ensure that HHS could take immediate action to respond to a public health emergency before Congress enacts supplemental funding legislation. Immediate action can reduce the overall societal and economic impact of the public health emergency, reduce the lead time for development of supporting resources (e.g., medical countermeasure development if needed), and ultimately result in less overall expenditures if potential threats are quickly contained.

Question. The pandemic has illustrated that Native communities often do not have access to the same resources that other communities do. For example, IHS-funded Tribal epidemiology centers are public health authorities, but do not have access to CDC public health authority data. And HHS agencies do not often work with states and other public health authorities to improve data collection to allow for disaggregation of American Indian/Alaska Native/Native Hawaiian information.

How will you ensure that Native health systems, especially Native public health systems, have parity access to HHS resources going forward?

What steps is HHS taking to include Native Hawaiians, who are too often overlooked and left out, in HHS programs and initiatives?

Answer. Regarding your question about Native health systems, the HRSA funding opportunities for which tribes and tribal organizations were eligible to compete, as well as awards to tribes and tribal organizations have expanded.

HRSA's Office of Intergovernmental and External Affairs leads the agency's Tribal Affairs, participates in HHS Tribal Consultations, and collaborates with IHS and other Federal and community stakeholders to address tribal issues. In response to tribal requests, the HRSA Tribal Advisory Council is being established to provide

advice on how HRSA programs can better address tribal needs. HRSA IEA regional offices regularly communicate with tribal leaders to respond to issues and ensure they are aware of HRSA funding opportunities, program updates, and technical assistance.

In fiscal year 2020, tribes and tribal organizations were awarded more than \$16 million from Rural Tribal COVID-19 Response Program. The awards were distributed to 57 recipients across 22 states.

Additionally, in fiscal year 2020, the Health Center Program awarded grant funding as further described below for Tribal/Urban Indian health center organizations.

- Awarded nearly \$88 million in annual operational grant funding to 35 health center organizations operating over 250 service delivery sites serving Native communities across the U.S.
- Awarded over \$2.3 million to Tribal/Urban Indian health centers to support infrastructure needs related to disaster response and recovery efforts.
- Awarded \$31 million in Health Center Program supplemental funding to Tribal/Urban Indian health centers to support efforts to address the impact of the COVID-19 pandemic.

Below are fiscal year 2021 Health Center Program actions related to health centers that are tribes or tribal organizations providing health services within Native American communities:

- Continued annual health center operating grants, totaling approximately \$88 million for 35 health center organizations.
- Awarded \$60 million to 35 Tribal/Urban Indian health centers, as part of the American Rescue Plan Act awards. Health centers use the funds to support and expand COVID-19 vaccination, testing, and treatment for vulnerable populations; deliver needed preventive and primary healthcare services to those at higher risk for COVID-19; and expand health centers' operational capacity during the pandemic and beyond, including modifying and improving physical infrastructure and adding mobile units. This investment will help increase access to vaccinations among hard-hit populations, and increase confidence in the vaccine by empowering local, trusted health professionals in their efforts to expand vaccinations.
- In fiscal year 2021, HRSA and the Centers for Disease Control and Prevention launched the Health Center COVID-19 Vaccine Program to allocate COVID-19 vaccines to HRSA-supported health centers directly. The program ensures our nation's underserved communities and those disproportionately affected by COVID-19 are equitably vaccinated against COVID-19. HRSA invited all HRSA funded health centers to participate in the program, including the 35 Tribal/Urban Indian health centers. Eight tribal organizations have set up accounts to participate in the Health Center COVID-19 Vaccine Program. Six of the eight tribal organizations have placed at least one order through the program.
- In late September 2021, HRSA expects to announce approximately \$1 billion in awards supporting health center construction, expansion, alteration, renovation, and other capital improvements to modify, enhance, and expand healthcare infrastructure.

HRSA projects that 32 grants totaling approximately \$18 million will be awarded to Tribal/Urban Indian health centers through this funding opportunity.

NATIVE HAWAIIAN HEALTH CARE SYSTEMS

In fiscal year 2021, HRSA provided \$20.5 million in grants and scholarship awards to Native Hawaiian Health Care Systems to improve the provision of comprehensive disease prevention, health promotion, and primary care services to Native Hawaiians.

Additionally, in fiscal year 2021, HRSA provided \$20 million under the American Rescue Plan Act to Native Hawaiian Health Care Systems to aid their response to COVID-19. The awards provided six Native Hawaiian Health Care Improvement Act (NHHCIA) recipients resources to strengthen vaccination efforts, respond to and mitigate the spread of COVID-19, and enhance healthcare services and infrastructure in their communities.

TECHNICAL ASSISTANCE—HEALTH CENTERS LOCATED IN HAWAII

HRSA continues to make technical assistance available for Hawaii health centers to identify and address the primary healthcare needs of their target communities and populations, and to aid in identifying Federal programs to support those efforts. HRSA IEA Region 9 Office can assist Hawaii stakeholders with technical assistance and other HRSA resources.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN, III

Question. Secretary Becerra, as you may be aware, Federal data shows that more than 1.5 million students experienced homelessness in the 2017–2018 school year, and in my home state of West Virginia, we had well over 10,000 students identified as homeless during the 2019–2020 school year alone. Unfortunately, identification and reporting challenges have existed for years, and when you couple those existing challenges with the COVID–19 pandemic- we can only expect these numbers will be far greater than pre-pandemic levels. The Administration of Children and Families (ACF) is tasked with promoting the economic and social well-being of families and children, including those experiencing homelessness. That is why, in the height of the pandemic, I worked alongside Senator Murkowski and others to introduce the Emergency Family Stabilization Act; that would have created a dedicated funding stream through ACF to assist children, youth, and families experiencing homelessness during the COVID–19 pandemic. While I was able to work with my colleagues to secure dedicated funding through the Department of Education for identifying and assisting children and youth experiencing homelessness, it is not a permanent solution and does not incorporate all the needed resources to address the issue.

In recognizing the pandemic has greatly increased the need for better access to services for children, youth, and families experiencing homelessness; how does the President's budget further improve resources for those charged with identifying and connecting our children and youth experiencing homelessness with the services provided by ACF?

Answer. The Administration for Children and Families receives funding, through the Runaway and Homeless Youth Act (RHYA), to provide services and resources to youth experiencing homelessness. Through the Family and Youth Services Bureau (FYSB), ACF funds a National Communications System (NCS), which is a national, toll-free, runaway and homeless youth crisis hotline to assist runaway and homeless youth, and those at risk of running away, in communicating with their families and with service providers. The NCS includes telephone, Internet, mobile applications, and any technology-driven services used for runaway and homeless youth or youth who are at risk of running away. The NCS provides crisis intervention, referral services, information, and prevention resources to youth at risk of separation from their families, runaway and homeless youth, their families, legal guardians, and service providers.

The RHYA also authorizes the Runaway and Homeless Youth Training & Technical Assistance Center (RHYTTAC) to provide training and technical assistance to RHY program-funded grantees and allied professionals. RHYTTAC assists these organizations in developing effective approaches for serving runaway and homeless youth, accessing new resources to enhance their ability to serve these youth, and establishing linkages with other programs with similar interests and concerns. RHYTTAC also helps to ensure that grantees have effective interventions in place to build skills and capacities that contribute to the healthy, positive, and productive functioning of children and their successful transition from youth into adulthood.

The President's fiscal year 2022 Budget proposed to fund RHY programs at a level of \$144,987,000, which would be an increase of \$8.2M from the fiscal year 2021 appropriation level. With the proposed increase, ACF/FYSB will seek to increase the number of RHY grantees and continue to support training and technical assistance. ACF commits to working with other Federal youth-serving agencies to increase awareness of resources available through RHY Programs, and to further develop coordinated efforts to support prevention, outreach, engagement, and timely referral to ACF services as well as services available from other Federal agencies. Additionally, Head Start and Child Care Development Fund (CCDF) Block Grants also serve families with young children experiencing homelessness.

Question. During the COVID–19 pandemic, rural health providers have been hit hard. Last year alone, West Virginia had three hospitals close, putting patients at risk of accessing care. In response Congress passed \$8.5 billion in the American Rescue Plan aimed at supporting rural health providers. Since this was signed into law, HHS has made no announcements on the plan to distribute this funding, yet rural health providers remain at risk.

When will this funding begin to be allocated to our rural communities?

Answer. HHS is working to finalize the \$8.5 billion in American Rescue Plan Act of 2021 funding for rural Medicare and Medicaid providers and suppliers. HHS is considering operational lessons learned from prior Provider Relief Fund (PRF) payments, as well as feedback from Members of Congress and other stakeholders.

Question. During the previous Administration, determining the status of the Provider Relief Fund was nearly impossible to do. Will you commit to ensuring transparency when distributing this \$8.5 billion for rural providers?

Answer. HHS is committed to an equitable, transparent, and responsive approach when distributing future provider relief payments. HHS has listened to stakeholder input and feedback and is committed to ensuring equity in future PRF distributions, better support to providers applying for funds, and transparency in communication to providers. Furthermore, the Administration is committed to building a strong working relationship with Congress going forward and plans to provide periodic updates on the distribution of \$8.5 billion for rural providers.

Question. The COVID-19 pandemic had significant impacts on rural communities in West Virginia, who were already at a disadvantage when it comes to accessing healthcare services. We have seen exponential growth in telehealth adoption across Americans of all ages, locations, and conditions to help address these disparities. Telehealth is a lifeline to countless patients and their doctors in my state of West Virginia. Telehealth among Medicare beneficiaries has been made possible by temporary flexibilities in place for the duration of the public health emergency. You have previously committed to work to expand certain telehealth policies after the end of the public health emergency. And we have learned and seen in practice that telehealth has saved lives throughout this pandemic.

Secretary Becerra, how do we ensure that there is equitable access to telehealth services, particularly for individuals who lack a connection to broadband and rely on audio-only methods to communicate with their doctors?

Answer. Telehealth is an important tool to improve health equity and improve access to healthcare. Healthcare should be accessible, no matter where you live. HHS continues to examine the telehealth flexibilities developed for the current public health emergency and determine how we can build on this work to improve health equity and improve access to healthcare.

There are a number of efforts underway to help underserved communities and individuals, particularly rural and tribal communities, 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, established through a memorandum of understanding with HHS, the Federal Communications Commission, and the

U.S. Department of Agriculture, to increase access to affordable broadband services, which is the foundation for improving access to telehealth services. 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 Center Programs.

Question. What steps is the Department of Health and Human Services taking to ensure that Americans who have come to rely on telehealth services don't lose access when the public health emergency ends?

Answer. Telehealth services are an important tool to improve health equity and access to healthcare. Throughout the pandemic, telehealth services have filled an urgent need to maintain access to care while social distancing was necessary. For example, federally Qualified Health Centers and Rural Health Clinics were able to be paid by Medicare as distant site telehealth service providers, which had not been permitted outside of the COVID-19 public health emergency. After the pandemic, HHS will continue to support telehealth services. HHS is currently reviewing the telehealth flexibilities developed for the current public health emergency to determine which can and should continue after the public health emergency has ended. HHS plans to continue to support telehealth after the pandemic through resources like the Telehealth.HHS.gov website and the Telehealth Resource Centers so patients and providers have access to telehealth technical assistance.

Question. The 340B program is essential for providing access to safe and affordable medications for low-income West Virginians. Recently HHS determined that six pharmaceutical companies have violated the program, by restricting access to contract pharmacies. The undermining of the 340B program by pharmaceutical companies and pharmacy benefit managers has taken its toll on West Virginia's hospitals, community health centers and their contract pharmacy partners.

What are the next steps HHS will be doing to ensure the integrity of the 340B program?

Answer. On May 17, 2021, HRSA sent letters to six pharmaceutical manufacturers stating that HRSA has determined that their policies placing restrictions on 340B Program pricing to covered entities that dispense medications through pharmacies under contract have resulted in overcharges and are in direct violation of the 340B statute. In addition, the letters explain that the 340B Program Ceiling

Price and Civil Monetary Penalties final rule (CMP final rule) states that any manufacturer participating in the 340B Program that knowingly and intentionally charges a covered entity more than the ceiling price for a covered outpatient drug may be subject to a Civil Monetary Penalty (CMP) not to exceed \$5,000 for each instance of overcharging. Any assessed CMPs would be in addition to repayment for each instance of overcharging.

In its letters, HRSA informed the pharmaceutical manufacturers that continued failure to provide the 340B price to covered entities utilizing contract pharmacies, and the resultant charges to covered entities of more than the 340B ceiling price, may result in CMPs as described in the CMP final rule. While there is ongoing litigation on these matters, HRSA is actively reviewing each manufacturer's response to its May 17, 2021, letter to determine whether subsequent action, such as referral to the HHS Office of the Inspector General for the imposition of CMPs is warranted.

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

COVID-19 BOOSTERS

Question. Mr. Secretary, at our last two hearings—one with the CDC Director and one with the NIH Director—the issue of whether we need vaccine boosters was raised. Even from our own officials, there seems to be a divide as to whether they'll be necessary. In early May, BARDA notified the Subcommittee that they intend to purchase 400 million vaccine doses for boosters for \$7.9 billion. Does that notification mean that you believe boosters are necessary? Even though neither the Directors of CDC or NIH have officially said the same? My concern is that it could be very dangerous if vaccine companies, rather than public health experts, are setting the public's expectations around COVID-19 boosters.

Answer. Throughout the COVID-19 pandemic, BARDA has worked to develop and ensure that once authorized and/or approved by the FDA medical countermeasures (including vaccines) would be available to the American public immediately or with minimal delay. This has meant, contracting with companies to purchase millions of doses of vaccines prior to FDA authorization based on the lead time for vaccine manufacturing to ensure doses are available. Further, many manufacturers require orders to be placed several months ahead of the expected delivery date. Placing the order after a need is identified would result in a lapse/gap in production and ultimate delivery.

Supporting the early manufacturing of countermeasures ensures that once the FDA issues an EUA, vaccine doses are immediately available. It has also meant that, if a vaccine we invested in failed, the USG would have realized the financial risk associated with the aggressive development strategy underlying Operation Warp Speed which is now called the Countermeasures Acceleration Group or CAG. BARDA is taking the same approach to purchasing additional vaccine doses to be available immediately if/when the FDA authorizes/approves boosters.

COVID-19 VACCINES DONATED INTERNATIONALLY

Question. Secretary Becerra, on June 3, 2021, the Administration announced it would donate 80 million vaccines to the international community by the end of June. Did the Department of Health and Human Services fund the vaccines that are being donated?

Specifically, which vaccines are being donated? Please provide estimates based on vaccine producer and number of doses.

Answer. All vaccine doses the Department of Health and Human Services has purchased to date were ordered for domestic use. However, international donations have been made available from amounts that have been in excess of demand once vaccines were available for use.

BARDA MISUSED FUNDS

Question. In January, the Office of Special Counsel investigated the misuse of funds appropriated to BARDA. The Special Counsel found that at least since fiscal year 2010, the Office of Assistant Secretary for Preparedness and Response misused funds appropriated for BARDA and failed to accurately report this mismanagement to Congress. In fact, the practice of using BARDA funding by ASPR for non-BARDA purposes was so common that it was referred to in the agency as the "Bank of BARDA." Mr. Secretary, has the Department determined whether these actions violated the Anti-deficiency Act and what steps has HHS taken to address this issue?

Answer. HHS/ASPR is committed to ensuring taxpayers dollars are used in the most judicious manner and in accordance with statutory obligations. In response to

the HHS Inspector General's report, HHS's Office of Finance is undertaking an internal review of the HHS Assistant

Secretary for Preparedness and Response (ASPR)'s use of advanced research and development funding from the Public Health and Social Services Emergency Fund for fiscal years 2015 through 2019 to identify any potential Anti-deficiency Act violations. HHS also hired an outside accounting firm which is auditing ASPR's use of these funds. Both reviews are estimated to be completed in 2021.

DISEASE X

Question. The COVID-19 pandemic has highlighted the need for the Federal government to respond rapidly to the next fast-moving, novel infectious disease. The fiscal year 2021 LHHS bill included language that encouraged the Department of Health and Human Services to work with the Department of Defense to implement a program focused on developing flexible vaccines and antiviral treatments to address emerging and previously unidentified infectious disease threats, referred to as Disease X. Mr. Secretary, what progress has the Department made in implementing such a program and how is the Department planning to develop countermeasures for previously unidentified viral threats?

Answer. While no specific Disease X program has been established, BARDA does have processes and capabilities to prepare to respond to various disease threats. While BARDA has a mandate to develop medical countermeasures against emerging infectious disease threats, these efforts cross over and could support a robust and effective response to any rapidly emerging infectious disease event, subsequent to funding availability. One example is BARDA's support of platform technologies to develop vaccines and therapeutics for Ebola Zaire virus (Merck, Janssen, Regeneron) and Zika (Moderna). When COVID-19 outbreaks began, BARDA was able to pivot these efforts to develop medical countermeasures to aid the response to the emerging threat.

UNACCOMPANIED CHILDREN

Question. Mr. Secretary, while your Department has no role in setting border policy or enforcing border security, HHS is responsible, by law, for the safety and well-being of the unaccompanied children referred to its care. And this fiscal year, HHS is on track to have the highest number of referrals of unaccompanied children on record, with almost 69,000 referrals already. Instead of working to open multiple Influx facilities that provide an equivalent standard of care for children as the shelters in the permanent network, HHS created a new concept of Emergency Intake Sites that do not have the same accountability requirements as Influx facilities and provide children with only a minimal level of care. Why, months after this crisis began, have you not opened additional Influx facilities or transitioned some of these Emergency Intake Sites into Influx facilities?

Answer. ORR's preference is to place unaccompanied children into state-licensed care provider facilities, including transitional foster homes while their sponsorship suitability determinations or immigration cases are adjudicated (in cases when a child has no viable sponsor). ORR has prioritized increasing its network of state licensed beds by: (1) safely bringing back online beds that were impacted by COVID-19 restrictions, (2) partnering with current providers to provide additional bed capacity through recipient-initiated supplements, and (3) engaging non-governmental organizations and governmental jurisdictions to identify ways to expand bed capacity. However, during a time of sustained high referrals, ORR activates and operates Influx Care Facilities and Emergency Intakes Facilities (EIS) to meet its statutory obligations to care for unaccompanied children (UC) transferred from the Department of Homeland Security (DHS) and ensure that children are not waiting in CBP custody for longer than 72 hours. Since March 2021, ORR has activated a total of 14 EISs, and to date, ORR operates only one ICF and three EIS. At a minimum, these EISs provide lifesaving services, consistent with best practices in humanitarian and disaster response efforts. In addition, ORR has been working diligently to ramp up services including wrap-around services, where possible, to ensure the safety and well-being of the children in ORR care and custody.

Question. When do you expect to ensure that every unaccompanied child in the care of HHS receives the required standard of care?

Answer. ORR recognizes that children who enter ORR care may have experienced significant trauma not only in their home countries but also during their journey to the United States, and ensures that ORR's continuum of care remains rooted in trauma-informed care, and prioritizes the best interest of each child across its network of care provider facilities, including Carrizo ICF and the EISs.

Question. HHS has transferred or reprogramed almost \$3 billion to cover the costs of the influx of unaccompanied children crossing at the southern border. Do you expect that the transferred amount will cover the costs of the UC program for the remainder of the fiscal year?

Answer. Yes. HHS anticipates that the allocated amount will cover the costs of the UC program through the end of the fiscal year.

Question. Do you anticipate that your request of \$3.3 billion for the program in fiscal year 2022 accurately reflects the amount needed for the next fiscal year?

Answer. HHS strongly supports the President's budget request. However, given the ever-evolving situation at the southern border, it can be challenging to predict medium-to-long term funding needs with any degree of certainty. HHS continues to gather data and employ rigorous evaluation methods to inform its budgetary requests and decisionmaking, and will continue to update the Office of Management and Budget (OMB) and both the House and Senate Appropriations Committees on the dynamic situation at the southern border and the resultant resource requirements. HHS remains committed to working with Congress to ensure all relevant funding needs are communicated in a timely manner.

Question. What are the key assumptions behind both of those cost estimates?

Answer. To arrive at its cost estimates, ORR considers a variety of factors such as external political events, natural disasters, and other issues that may impact the number of referrals from DHS.

Additionally, cost estimates for fiscal year 2022 includes expanding the scope of post-release services and the number of children who receive them, as well as other critical programmatic reforms such as improving case management and implementing policies and procedures intended to reduce the time it takes to unify children with their sponsors.

ORGAN TRANSPLANTATION

Question. Mr. Secretary, I was pleased to see the Administration move forward with finalizing the Centers for Medicare and Medicaid Services' (CMS) rule to improve oversight and accountability of organ procurement organizations (OPOs) (CMS-3380-F2).

Related, a government contractor, the United Network for Organ Sharing (UNOS), has great influence over the protocols and processes for organ procurement and allocation. UNOS has held the government contract to run the Organ Procurement and Transplantation Network (OPTN) for roughly 35 years and appears to operate with little to no oversight by HHS. Over the course of the last few years, UNOS policies have had the effect of redistributing donated organs from the Midwest and South to more urban and coastal areas. In addition to the CMS OPO accountability rule, what more can the Department do to bring accountability and oversight to the organ procurement process and to hold the OPTN contractor accountable to actually improve the organ transplantation system in the U.S.?

Answer. HRSA provides oversight of the OPTN and the OPTN contractor. HRSA exercises its oversight according to statutory requirements, regulatory requirements, and through the OPTN contract. The OPTN Board of Directors develops organ allocation policies with the advice of the OPTN membership and other interested parties. The OPTN contractor neither develops nor approves OPTN policies. HRSA staff are ex-officio members of OPTN committees and the OPTN Board of Directors and attend all OPTN business meetings.

HRSA currently works closely with CMS on CMS' regulation of organ procurement and transplantation services. Additionally, HRSA and CMS collaborated to establish a new Affinity Group on Organ Procurement and Transplantation to improve oversight by the two agencies.

Question. The fiscal year 2021 Appropriations Joint Explanatory Statement encouraged CMS to consider removing the disincentive for Medicare Certified Transplant Centers to transfer patients suffering from complete loss of brain function to organ recovery centers operated by organ procurement organizations. What is the status of this work at CMS?

Answer. CMS published a final rule¹ on December 2, 2020 that updates the OPO Conditions for Coverage to change the way OPOs are held accountable for their performance. The final rule improves the current measures by using objective and reliable data, incentivizes OPOs to ensure all viable organs are transplanted, and holds OPOs to greater oversight while driving higher OPO performance. Under new outcome measures introduced in this final rule, except for pancreas procured for re-

¹ <https://www.Federalregister.gov/documents/2020/12/02/2020-26329/medicare-and-medicaid-programs-organ-procurement-organizations-conditions-for-coverage-revisions-to>.

search (which is required by law to be counted), an OPO will not receive credit for procuring an organ if the organ is not transplanted, creating greater incentive for OPOs to place all organs for transplant that they procure. Following review, the final rule went into effect March 30, 2021 (except for amendment 3).²

MENTAL HEALTH

Question. The pandemic has exacerbated the children's mental health crisis across the country and we are seeing alarming increases in children presenting in emergency rooms in severe crisis. Could you comment on how your budget addresses this crisis and ensures that children can get access to mental and behavioral health services earlier, closer to home, and in their communities?

What are your thoughts on further efforts we should consider to direct funding to address this crisis, such as Children's Hospital Graduate Medical Education which helps train frontline professionals focused on treating children's mental and behavioral health?

Answer. HHS is committed to improving access to mental and behavioral healthcare services for children and families. The fiscal year 2022 President's Budget requests includes an additional \$756 million for SAMHSA to increase access to children's behavioral health services, which includes \$473 million for mental health, \$281 million for substance use treatment, and \$2 million for substance use prevention related services and activities.

Within HRSA, the Budget provides \$10 million for pediatric mental healthcare access to increase access to behavioral health. This investment promotes behavioral health integration in pediatric primary care by supporting the development of new, or the improvement of existing, statewide or regional pediatric mental healthcare telehealth access programs.

The Children's Hospitals Graduate Medical Education (CHGME) Program is a formula based payment program that helps eligible hospitals maintain Graduate Medical Education (GME) programs to support graduate training for physicians to provide quality care to children. As such, the program supports the training of pediatric psychiatrists and other pediatric physician behavioral subspecialists. In Academic Year 2019–2020, 199 Child and Adolescent Psychiatry fellows received training through the CHGME Program. In addition, CHGME-funded hospitals served as sponsoring institutions for 42 residency programs and 252 fellowship programs, and also served as major participating rotation sites for 628 additional residency and fellowship programs. The CHGME Program also supported the training of 5,433 Pediatric residents that included General Pediatrics residents, as well as residents from seven types of combined pediatrics programs (e.g., Internal Medicine/Pediatrics). In total, 3,055 Pediatric Medical Subspecialists, including 199 Child and Adolescent Psychiatry fellows, received training.

HYDE AMENDMENT

Question. Mr. Secretary, for more than forty years, Democrat and Republican-led Administrations, as well as Democrat and Republican-led Congresses have supported the principle that taxpayer dollars should not fund elective abortions. As members of Congress, President Biden, Vice President Harris, and you, Mr. Secretary, all voted in favor of funding bills year after year that included this prohibition. It remains unclear why this radical change in public policy is suddenly an imperative for the Biden Administration to fund elective abortions with taxpayer dollars. Further, your request does not detail the cost this change will have on the U.S. taxpayer. Can you please provide an estimate of how many abortions would receive Federal funding, and what amount of Federal expenditures would be incurred to pay for abortions, relative to current law for this fiscal year and the next ten?

Answer. The Hyde Amendment disproportionately impacts the growing number of low-income, women of color who are enrolled in Medicaid, and is a barrier to expanding access to healthcare. That is why the President's first budget calls for Congress to remove the restriction from government spending bills.

²The January 20, 2021 memorandum from the Assistant to the President and Chief of Staff, entitled "Regulatory Freeze Pending Review," instructed Federal agencies to delay the effective date of rules published in the Federal Register, but which have not yet taken effect, for a period of 60 days. The effective date of the final rule, except for amendment number 3, which would have been February 1, 2021, became March 30, 2021. CMS also included a 30-day public comment period on the rule to allow interested parties to provide comments about issues of fact, law and policy raised by the rule. The 60-day delay in effective date was necessary to give Department officials the opportunity for further review of the issues of fact, law, and policy raised by this rule.

The Department of Health & Human Services implements the laws that Congress passes. Implementation of any changes in coverage related to the President's Budget would depend on the final language Congress passes. After passage of any legislation, agency staff and counsel review the language to determine the agency's authority and options for implementation action, such as initiating notice and comment rulemaking or issuing guidance documents.

Question. HHS issued a proposed rule in April that would allow Title X grantees to promote abortion as a form of family planning. The preamble of the proposed rule cites "that Planned Parenthood conducted a major fundraising campaign with the 2019 Title X regulatory changes as its key motivating message. If funds are more efficiently gathered and distributed via a program such as Title X than through such private campaigns, the efficiency would represent a cost savings attributable to the proposed rule." It is widely known that Planned Parenthood walked away from the Title X program in 2019, so I am troubled by the fact that HHS' proposal implies that Planned Parenthood is somehow entitled to taxpayer funding. This notion and the rush to finalize the proposed rule also raises questions about your agency's ability to be impartial in awarding of future Title X grants. How is this proposed rule not a kickback to Planned Parenthood?

Answer. On January 28, 2021, President Biden issued a "Memorandum on Protecting Women's Health at Home and Abroad" directing the Department to review the 2019 Title X Final Rule and "consider, as soon as practicable, whether to suspend, revise, or rescind, or publish for notice and comment proposed rules suspending, revising, or rescinding, those regulations, consistent with applicable law, including the Administrative Procedure Act." The memorandum stated that undue restrictions on the use of Federal funds have made it harder for women to access medical information.

After conducting an extensive review and consideration of the 2019 Title X Final Rule (84 Fed. Reg. 7714) pursuant to the Presidential memorandum, the Department published a Notice of Proposed Rulemaking (NPRM) entitled "Ensuring access to equitable, affordable, client-centered, quality family planning services" in the Federal Register that was open for public comment from April 15, 2021 to May 17, 2021.

As outlined by the Title X statute and reinforced in its regulations, "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." Consistent with the program's statute and regulations, any public or private nonprofit organizations, including faith-based organizations, state, county, local, and tribal governments, school districts, and public and state higher education institutions are eligible to apply for Title X grant funds. Title X's regulations, in the NPRM, also clearly define the criteria the Department uses to decide which family planning services projects to fund and in what amount.

PSYCHOLOGICAL CLINICAL SCIENCE ACCREDITATION SYSTEM

Question. The fiscal year 2021 Appropriations Joint Explanatory Statement encouraged HHS to "review the accreditation and eligibility requirements for the Public Health Service Corps and behavioral health workforce programs to allow access to the best qualified applicants, including those who graduate from Psychological Clinical Science Accreditation System (PCSAS) programs." Currently, there are more than 40 PCSAS University accredited doctoral programs in psychological clinical science, including Washington University in St. Louis, but the Department's guidance and regulations were adopted prior to the establishment of PCSAS and do not permit the graduates of PCSAS programs to be eligible to compete for these funding opportunities. What is the status of this review and updates at the Department and within the Health Resources and Services Administration, as it relates to the behavioral health workforce programs?

If this process has not yet started, please provide an explanation, an estimated start date, and any additional information that may be necessary to proceed.

Answer. HRSA is currently exploring options to include PCSAS doctoral programs as eligible entities in the upcoming fiscal year 2022 Graduate Psychology Education competition. HRSA will continue to explore options to include such programs in other future competitions, including, but not limited to, the Behavioral Health Workforce Education and Training program, and the Geriatric Academic Career Awards. HRSA currently anticipates posting the Notice of Funding Opportunity for the Graduate Psychology Education program in November 2021.

PROVIDER RELIEF FUND (PRF)

Question. Mr. Secretary, Congress provided \$178 billion over the course of the last year for the Provider Relief Fund, and the American Rescue Plan included an addi-

tional \$8.5 billion for rural providers. How is HHS planning to distribute the approximately \$50 billion remaining, and when can we expect to see the distribution?

Answer. HHS is committed to distributing the remaining provider relief payments as quickly, transparently, and equitably as possible while utilizing effective safeguards to protect taxpayer dollars.

HHS is planning for future Provider Relief Fund (PRF) allocations, including the \$8.5 billion from American Rescue Plan Act and Phase 4 of the General Distribution.

HHS is actively considering feedback from stakeholders, as well as operational lessons learned from prior PRF payments, as part of the planning process. The feedback from Members of Congress and other stakeholders informs HHS' ability to administer the PRF in a manner that bolsters the healthcare system and helps providers experiencing COVID-related financial hardships during this crisis. HHS will publish additional information on future distributions on the Health Resources and Services Administration's PRF webpage, at www.hrsa.gov/provider-relief, as soon as it becomes available.

Question. How are you planning to account for the ongoing needs of rural hospitals and rural healthcare providers in the distribution of the \$8.5 billion?

Answer. HHS is working to finalize the \$8.5 billion in American Rescue Plan Act of 2021 funding for rural Medicare and Medicaid providers and suppliers. HHS will publish additional information on future distributions on the Health Resources and Services Administration's PRF webpage, at www.hrsa.gov/provider-relief, as soon as it becomes available.

OPIOIDS

Question. There is no question that the pandemic has been challenging for many people and the data shows an unprecedented rise in opioid overdose deaths in 2020. What can you say about the latest trends in opioid overdoses and what we need to do to build on the investments of the last 6 years to combat the opioid epidemic?

Answer. The overdose crisis has certainly worsened in the face of the COVID-19 public health emergency. Estimates from the CDC find that more than 90,000 drug overdose deaths have occurred in the 12 months ending in September 2020. That represents a year-over-year increase of close to 29 percent. For the last few years, this increase in lives lost is principally driven by synthetic opioids like fentanyl, but increasingly, we are seeing stimulants, including methamphetamine and cocaine also involved. HHS is investing \$11.2 billion in programs responding to the overdose crisis, an increase of \$3.9 billion over fiscal year 2021 Enacted, with the goal of ending the crisis of opioids and other substance use by increasing funding for States and Tribes for medication-assisted treatment, and by expanding the behavioral health provider workforce. Of the \$11.2 billion, \$6.6 billion is from SAMHSA's prevention and treatment activities that address the substance use and opioid crisis, an increase of \$2.6 billion over Fiscal year 2021 enacted. HHS is committed to investments in the Substance Abuse Prevention and Treatment Block grant to expand implementation of evidence-based prevention, treatment and recovery support services for individuals, families, and communities across the nation. The budget includes a new 10 percent set-aside to direct funds to states for recovery support services, which can be provided prior to, during, after, and in lieu of treatment. This funding will allow SAMHSA to serve 2.1 million people in fiscal year 2022 and to significantly strengthen the Nation's recovery support services infrastructure. The fiscal year 2022 President's Budget also makes significant investments in First Responder Training programs to train first responders to respond to and prevent opioid overdose deaths, as well as expanding treatment for SUD for pregnant and post-partum women.

HHS is committed to continued support for efforts to increase access to SUD and broader behavioral healthcare services through the Rural Communities Opioid Response Program (RCORP). The budget includes a total of \$165 million to support prevention, treatment, and recovery services for opioids and other SUDs in the highest-risk rural communities. Through RCORP, more than 23,000 individuals received medication-assisted treatment; and the number of DATA-waivered providers serving rural communities was increased. In fiscal year 2019 and 2020, the National Health Service Corps Rural Community Loan Repayment Program (NHSC RC LRP) also served to further increase access to behavioral healthcare workforce services in rural communities with 651 providers working in rural communities, and 118 of those working specifically at RCORP service sites.

Other considerations to address the overdose epidemic include:

Treatment Capacity: The SAMHSA-HRSA Workforce projections report indicates a shortage of over 10,000 full time equivalents for child psychiatrists and master's

level mental and SUD counselors by the year 2025. The report also highlights the need for peer specialists in a wide variety of integrated and specialty care settings. Peers, as members of integrated healthcare teams, support all team members in working at the top of their scope of practice, improving efficiency and maximizing skill utilization.

Decreasing Barriers: Research reveals geographic and sociodemographic barriers to receiving treatment.³ Indeed, many treatment facilities are found in urban and suburban areas, and there is disparity in access to buprenorphine providers and Opioid Treatment Programs (OTPs).⁴ Recent policy changes, such as The Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder, remove perceived barriers to obtaining a DATA-2000 Waiver and expand access to this treatment.. New flexibilities enable more OTPs to establish mobile medication units (e.g., vans), which can improve geographic access and expand the provision of opioid use disorder treatment to disparate populations. Grants such as the State Opioid Response (SOR), Medicated Assisted Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA), Targeted Capacity Expansion-Special Projects (TCE-SP), and Screening, Brief Intervention and Referral to Treatment (SBIRT) will be used to address this need. The fiscal year 2022 President's Budget Request proposes increases for each of these programs.

Wrap Around Services Addressing Social Determinants of Health: These services not only improve the treatment experience, but also provide support to clients during their recovery. For example, research demonstrates that women's SUD treatment outcomes are improved when women-specific needs are addressed through wraparound services, such as the provision of childcare, employment assistance, or mental health counseling.⁵ Additionally, the receipt of basic needs, child care, educational, family, and medical services is associated with improvements in several outcomes.⁶ These services represent an important opportunity to support clients and to ameliorate many of those social determinants of health that precipitate substance misuse. That is why the fiscal year 2022 President's Budget Request proposes increase for programs such as the Pregnant & Postpartum Women, Treatment, Recovery, and Workforce Support, Adult and Family Treatment Drug Courts.

Telehealth: The recent pandemic has demonstrated the utility of telehealth in reaching disparate populations. Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied in the mental health space for over 20 years.⁷ Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management⁸ across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. The increase requested under SAMHSA's SOR grants can be used to address this need.

Evidence Based Practice: There is a need for combining leadership development with organizational strategies to support a climate conducive to evidence based practice implementation.⁹ This represents an opportunity to promulgate the evidence and best practices through SAMHSA publications, reports, and announcements. Beyond this, SAMHSA will work with grantees to consider implementation science strategies that support program sustainability and fidelity to the evidence

³Sharma RN, Casas RN, Crawford NM, Mills LN. Geographic distribution of California mental health professionals in relation to sociodemographic characteristics. *Cultur Divers Ethnic Minor Psychol*. 2017 Oct;23(4):595–600.

⁴Goedel WC, Shapiro A, Cerdá M, Tsai JW, Hadland SE, Marshall BDL. Association of Racial/Ethnic Segregation With Treatment Capacity for Opioid Use Disorder in Counties in the United States. *JAMA Netw Open*. 2020;3(4):e203711. Published 2020 Apr 1. doi:10.1001/jamanetworkopen.2020.3711.

⁵Oser C, Knudsen H, Staton-Tindall M, Leukefeld C. The adoption of wraparound services among substance abuse treatment organizations serving criminal offenders: The role of a women-specific program. *Drug Alcohol Depend*. 2009;103 Suppl 1(Suppl 1):S82–S90. doi:10.1016/j.drugalcdep.2008.12.008.

⁶Pringle, J, et al. The Role of Wrap Around Services in Retention and Outcome in Substance Abuse Treatment: Findings From the Wrap Around Services Impact Study. *Addict Disord Their Treatment* 2002;1:109–118.

⁷Bashshur, R. L., Shannon, G. W., Bashshur, N., & Yellowlees, P. M. (2016). The empirical evidence for telemedicine interventions in mental disorders. *Telemedicine and e-Health*, 22(2), 87–113.

⁸Substance Abuse and Mental Health Services Administration. (2015). Using technology-based therapeutic tools in behavioral health services. *Treatment Improvement Protocol (TIP) Series* 60.

⁹Aarons GA, Ehrhart MG, Moullin JC, Torres EM, Green AE. Testing the leadership and organizational change for implementation (LOCI) intervention in substance abuse treatment: a cluster randomized trial study protocol. *Implement Sci*. 2017 Mar 3;12(1):29.

base. The Evidence-Based Practice Center and Technical Assistance Grants will be used to address this need. Additionally, the Prevention Technology Transfer Center Network and the Addiction Technology Transfer Network will continue to help states develop capacity through training, consultation, and technical assistance and SAMHSA's new Peer Recovery Center of Excellence, authorized under Section 7152 of the SUPPORT Act for Patients and Communities, will continue to provide training and technical assistance to support integration of peer support workers into non-traditional settings, build and strengthen recovery community organizations, a key component of recovery support services infrastructure. It will also enhance the professionalization of peers through workforce development, providing evidence-based and practice-based toolkits and resources to diverse stakeholders.

Harm Reduction Activities: The promotion and distribution of naloxone and fentanyl test strips, similar to the existing syringe services programs, represents an opportunity to not only promote life-saving interventions, but to also provide education on drug potency and mortality.¹⁰ This might be achieved in partnership with public safety agencies, providers, community organizations and the public. Additionally, syringe services programs reduce transmission of HIV and viral hepatitis within the community. A comprehensive and coordinated approach must incorporate innovative and established prevention and response strategies, including those focused on polysubstance use. Among the programs that can support these efforts are the Treatment Systems for Homeless and Minority AIDS program, both of which request an increase in funding.

Education: Medical school graduates play a pivotal role in educating their patients and colleagues; screening, diagnosing, and treating patients; and modeling positive attitudes to reduce the stigma attached to SUDs. Research demonstrates that SUD educational interventions, using various approaches and durations, produce a positive impact on medical students' knowledge, skills, and attitudes.¹¹ Studies also reveal that simply increasing exposure to patients with addiction does not provide the formative knowledge required to identify, treat or even prevent SUDs without the presence of a concurrent, comprehensive didactic curriculum.¹² Even as the overdose crisis deepens, there remains wide heterogeneity in SUD curricula across medical schools.¹³ This adversely impacts patient care—a lack of preparedness has been identified as a barrier in the provision of buprenorphine to patients with opioid use disorder by early career family physicians.¹⁴ Moreover, a lack of appropriate education has also been shown to foster negative attitudes towards the treatment of SUD with buprenorphine.¹⁵ Such negative attitudes adversely impact patient-physician dialogues and contribute to the under treatment of SUDs by primary care and specialty providers.¹⁶ Comprehensive and uniform medical school teaching on SUDs, addiction, and treatment modalities has the potential to overcome these deficits and to positively impact all graduates and their patients. It also represents an important area of engagement with academic institutions. The Provider's Clinical Support System—Universities (PCSS-Universities) grant will be used to address this need and would be further supported by the increase proposed in the fiscal year 2022 President's Budget Request.

Reducing Stigma: Stigma can reduce willingness of policymakers to allocate resources, reduce willingness of providers in non-specialty settings to screen for and address substance misuse, and may limit willingness of individuals with SUDs to seek treatment.¹⁷ Negative attitudes toward patients with substance use disorder are common among health professionals, who generally lack adequate education, training and support structures to effectively serve patients with SUD. Health professionals' negative attitudes reduced patients' feelings of empowerment and dimin-

¹⁰ Han JK, Hill LG, Koenig ME, Das N. Naloxone Counseling for Harm Reduction and Patient Engagement. *Fam Med*. 2017 Oct;49(9):730–733.

¹¹ Muzyk A, Smothers ZPW, Akrobetu D, Ruiz Veve J, MacEachern M, Tetrault JM, Gruppen L. Substance Use Disorder Education in Medical Schools: A Scoping Review. *Acad Med*. 2019 Nov;94(11):1825–1834. doi: 10.1097/ACM.0000000000002883. PMID: 31663960.

¹² Tetrault, J. Improving Health Professions Education to Treat Addiction: The Time Has Come. The Josiah Macy Jr Foundation, News and Commentary. May 2018.

¹³ Blanco, C., Wiley, T.R.A., Lloyd, J.J. et al. America's opioid crisis: the need for an integrated public health approach. *Transl Psychiatry* 10, 167 (2020). <https://doi.org/10.1038/s41398-020-0847-1>.

¹⁴ DeFlavio JR, Rolin SA, Nordstrom BR, Kazal LA Jr. Analysis of barriers to adoption of buprenorphine maintenance therapy by family physicians. *Rural Remote Health*. 2015;15:3019.

¹⁵ Tong ST, Hochheimer CJ, Peterson LE, Krist AH. Buprenorphine Provision by Early Career Family Physicians. *Ann Fam Med*. 2018;16(5):443–446. doi:10.1370/afm.2261

¹⁶ Kennedy-Hendricks A, Busch SH, McGinty EE, et al. Primary care physicians' perspectives on the prescription opioid epidemic. *Drug Alcohol Depend*. 2016;165:61–70.

¹⁷ Yang LH, Wong LY, Grivel MM, Hasin DS. Stigma and substance use disorders: an international phenomenon. *Curr Opin Psychiatry*. 2017;30(5):378–388.

ished treatment outcomes. These attitudes resulted in less provider engagement, a more task-oriented approach to care delivery, and diminished empathy.¹⁸ All of these factors may help explain why so few individuals with SUDs receive treatment. Public education that reduces stigma and provides information about treatment is needed. This represents an opportunity to engage across multiple disciplines and modalities. Among others, PCSS-U and SOR grants seek to overcome stigma. The fiscal year 2022 President's Budget requested increases for both programs.

Partnering With Public Safety Officials And Community Organizations: Working with law enforcement, community groups, patients, and treatment teams to address the growing overdose epidemic has the potential to channel new ideas, data sources, and efforts towards reducing mortality and use of illicit substances. Such engagement promotes cross collaboration and encourages the creation of innovative and community focused interventions, such as pre- and post-arrest deflection to treatment. Increases proposed to SAMHSA grants such as the First Responder Training/Rural Emergency Medical Services can help address this need.

Question. This Subcommittee has worked in a bipartisan fashion to provide \$4 billion in fiscal year 2021 to address the opioid epidemic, including \$1.5 billion for State Opioid Response grants. This is a flexible grant provided directly to states to use funds as they see fit. Unfortunately, we continue to hear that states are not spending those funds in a timely manner. Does HHS know why this is the case?

Answer. The State Opioid Response (SOR) grants give states flexibility in providing a range of prevention, treatment, and recovery support services for opioid and stimulant use disorders. The grants also support infrastructure development to enhance/expand systems of care. One of the most common reasons grantees attribute spending challenges to is state procurement processes. Procurement challenges include state legislative timelines that do not align with Federal appropriation cycles; reluctance from contract bidders because of the short duration of the grant (i.e., 2 years); and delays that result from contract negotiations. Grantees have also cited challenges related workforce shortages. Additionally, the COVID-19 pandemic has also impacted states' ability to spend funds.

Question. How does this trend align with the 50 percent budget increase for SOR?

Answer. The fiscal year 2022 President's Budget increased the State Opioid Response grant program to allow grantees to enhance and expand evidence-based opioid and stimulant use disorder prevention, treatment and recovery support activities currently underway. Additionally, grantees will have the ability to increase their focus and efforts on continued areas of need such as workforce development, harm reduction and public education and training. This will also increase access to opioid and stimulant use disorder treatment services in states, territories, and tribes. Within this total, SAMHSA will direct \$75 million to the Tribal Opioid Response grant program to specifically address the opioid substance use needs in tribal communities. This critical investment will drive funding to States and Tribes to increase community-level response to the opioid crisis, expand access to evidence-based treatment and recovery services, and provide targeted investment to crisis services and recovery support services. HHS is committed to working to ensure that the SOR program supports states in addressing and investing in evidence-based treatment and recovery services for the ongoing opioid and substance use epidemic. SAMHSA is committed to providing technical assistance to ensure states understand how they can utilize these funds, as well as oversight to ensure funds are spent appropriately in a timely manner.

Question. What can be done to increase the spending rates by states?

Answer. Currently, SAMHSA monitors grantees' program implementation activities and provides feedback to states when benchmarks are not being met. SAMHSA also has a wealth of general and targeted technical assistance resources that SOR grantees may access. For example, the Addiction Technology Transfer Center (ATTC) Network is a multidisciplinary resource for professionals in the addiction treatment and recovery services field. The ATTC Network's mission and vision are to: accelerate the adoption and implementation of evidence-based and promising addiction treatment and recovery-oriented practices and services; heighten the awareness, knowledge, and skills of the workforce that addresses the needs of people with substance use or other behavioral health disorders; and foster regional and national alliances among culturally diverse practitioners, researchers, policy makers, funders, and the recovery community. SAMHSA also funds the Opioid Response Network (ORN) which was designed to provide training and other resources in efforts to address the opioid crisis. The ORN has local consultants in all 50 states and

¹⁸ van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence*. 2013;131(1):23–35.

nine territories to respond to local needs by providing free educational resources and training to states, communities and individuals in the prevention, treatment and recovery of opioid use disorders and stimulant use. SAMHSA has also extended flexibilities to grantees considering the COVID-19 pandemic including granting no-cost extensions to give grantees up to an additional 12 months to use any unexpended funds from the official grant period.

Question. To respond to the changing nature of the opioid epidemic, the fiscal year 2020 LHHS bill expanded the State Opioid Response grant authority to allow states to use funds on stimulants, like cocaine and methamphetamine. Mr. Secretary, how is the rising use of stimulants impacting the ability for state and local communities to provide effective treatment for opioid use disorders?

Answer. The Department has no evidence to suggest that the rise in use of stimulants is impacting states' ability to provide effective treatment for opioid use disorders.

It is important to consider stimulant misuse in the context of polysubstance misuse—increasingly, substances are not used in isolation. Individuals with polysubstance misuse involving alcohol, marijuana, opioids, and/or stimulants receive care in a variety of settings, and often require withdrawal management, psychological and FDA-approved pharmacological treatment, and monitoring as part of their care plan.

SAMHSA recently created an Evidence-Based Practice Guide to address polysubstance misuse. Through a literature review and consensus from technical experts, SAMHSA identified three effective practices used to treat polysubstance misuse in adults. These are (1) FDA-approved pharmacotherapy with counseling; (2) Contingency management (CM) with FDA-approved pharmacotherapy and counseling, and (3) Twelve-step facilitation (TSF) therapy with FDA-approved pharmacotherapy. These treatments should be delivered in a patient-centered and integrated manner in order to achieve the best outcomes. Many facilities offer such treatments, and they demonstrate a high level of success.

There currently are no Food and Drug Administration-approved medications specific for stimulant use disorders, making it important that behavioral health and healthcare service providers understand and offer (or offer referrals for) CM or other psychosocial treatments. Despite an increase in research into psychosocial treatments for people with stimulant use disorders, currently the only treatment with significant evidence of effectiveness is CM. Other psychosocial treatments that have some support (especially if used in combination with CM) are cognitive-behavioral therapy/relapse prevention, community reinforcement, and motivational interviewing. These interventions demonstrate efficacy in treating stimulant use disorder across age ranges. SAMHSA's State Opioid Response grants allow the use of Federal funds to provide CM. In treating stimulant use disorder, clinicians also are recommended to promote harm reduction (especially because of the high level of contamination of the drug supply with fentanyl and analogs) through educating about needle exchange programs, offering naloxone, and encouraging the use of fentanyl test strips, as these strategies can help save lives.

“ENDING HIV” INITIATIVE

Question. I was pleased to see the fiscal year 2022 budget increase of \$267 million for the Ending the HIV Epidemic initiative, started by this Subcommittee in fiscal year 2020. The Trump Administration, however, was notably more aggressive in their funding requests to address the HIV epidemic, requesting \$716 million in the second year of the initiative. After the challenging year of the pandemic, where do we stand as a nation in combatting new HIV infections?

Answer. Although it is too early to assess quantitatively the full impact of COVID-19 on HIV research, based on listening sessions conducted by the NIH OAR across the United States, the COVID-19 pandemic has placed a tremendous strain on sustaining research in general. Basic and translational research unrelated to COVID-19 in academic settings was suspended for months, severely delaying progress for trainees and principal investigators. Healthcare workers and clinical researchers were diverted to the care of COVID-19 patients, while clinical research resources had to be redirected to COVID-19.¹⁹ Recruitment and staffing for HIV and other clinical trials was halted due to distancing, travel restrictions and “lockdown” measures. Broadly, public health measures required to control the spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) have led to societal restrictions that have negatively impacted the economy and limited access to routine non-emergency healthcare. Specifically, the COVID-19 pandemic has

¹⁹ [nature.com/articles/s41581-020-00336-9](https://www.nature.com/articles/s41581-020-00336-9).

had a negative effect on HIV testing, linkage to care, and access to treatment and HIV research laboratories and investigation sites.

Preliminary reports suggest that COVID-19 is likely to affect key HIV study outcomes. For example, adverse events may be caused by SARS-CoV-2 infection or by deferral of care for other health issues due to fear of contracting SARS-CoV-2 infection. Research study participants likely changed their lifestyles to minimize contact with others, which may affect research outcomes. SARS-CoV-2 infection could worsen HIV comorbidities, such as glycemic control in persons with diabetes, blood pressure control in those with hypertension, or accelerate progression of chronic kidney disease.²⁰

The impact of COVID-19 on HIV research has been bidirectional. Contributions by the HIV researchers and community to COVID-related efforts are significant: from the successful mRNA vaccine platform, to clinical trials networks for testing candidate vaccines, to rapid testing and molecular epidemiology for tracking—the HIV research footprint is widely recognized in the response to COVID-19. In addition, there have been some positive aspects related to the COVID-19 response, such as the accelerated innovations that have advanced the way we conduct clinical research overall. These include new approaches to conduct remote visits by telehealth, use home-based testing or monitoring technologies. The NIH OAR HIV and COVID-19 Taskforce is meeting to discuss further impacts of the COVID-19 pandemic on HIV research progress and investigator retention within the NIH extramural community.

Question. What factors were considered for the fiscal year 2022 funding request? Please provide an updated cost estimate of resources needed over the next 5-years, by fiscal year and Operating Division for the Ending the HIV Epidemic initiative.

Answer. The Centers for Disease Control and Prevention (CDC) developed a methodology to estimate the number of people who need to be tested, diagnosed, and provided HIV medical care and treatment or PrEP. The CDC's methodology then informed the initial EHE budget for HRSA, which was developed to meet the EHE goal of enrolling newly diagnosed and people with HIV no longer in care into EHE-funded medical, treatment, and support services.

CDC provided data to HRSA on the number of diagnosed people with HIV in each Eligible Metropolitan Area, Transitional Grant Area, or State (not just the county of interest). HRSA then used CDC estimates for the percent of people with HIV who are undiagnosed in each state to calculate estimated undiagnosed. Using this data, overall cost estimates were then developed using the average RWHAP costs per person served.

The HRSA cost estimates for the EHE initiative are outlined in the table below. The Health Center fiscal year 2022 budget request for the EHE Initiative was developed in the context of increasing participation in the Phase I targeted areas. The estimated number of clients served (reflected below) through the EHE were adjusted from the initial estimates for the EHE initiative to align with appropriated funds.

Projections for fiscal year 2023 and beyond are under development.

[Dollars in millions]

	Fiscal Year	
	2021 Enacted	2022 Budget
Health Centers	\$102.25	\$152.25
HAB EHE	\$105.00	\$190.00
Total	\$207.25	\$342.25
Estimated Clients:		
Budget Health Centers (PrEP)	285,000	425,000
HAB EHE	27,000	50,000

Question. The jurisdictions involved in the Ending the HIV Epidemic program have invested significant resources. Do you anticipate any changes to the geographic distribution of the funding?

How does the initiative account for new HIV outbreaks, such as what's happening in West Virginia, which wasn't one of the seven targeted states?

Answer. No, HRSA does not anticipate any changes to the geographic distribution of funding in fiscal year 2022.

²⁰ academic.oup.com/jid/advance-article/doi/10.1093/infdis/jiab114/6167835.

HRSA health centers continue to make HIV prevention technical assistance and training available nationwide, including those centers with increasing HIV prevalence in their communities. In total for fiscal year 2020, health centers across the U.S. reported providing approximately 2.5 million HIV tests and PrEP related services to 389,000 health center patients.

HRSA also responds to HIV outbreaks through the RWHAP's established care, treatment and support systems in partnership with the CDC. Since 2015, HRSA's RWHAP has worked closely with CDC to address HIV outbreaks that have resulted from injection drug use, such as what is happening in West Virginia. This collaboration has been crucial in helping states and local communities identify those at risk for HIV due to injection drug use, getting at-risk individuals tested for HIV and hepatitis C, and getting people linked to and engaged in services for HIV and hepatitis care or for pre-exposure prophylaxis, substance use disorder treatment and other needed services.

SUPPLEMENTAL AND RECONCILIATION FUNDING

Question. In response to the COVID-19 pandemic, states have received billions of dollars in aid, with the intent of giving them maximum flexibility to respond to their unique needs and challenges. It is my understanding there is a sizable portion of unobligated funds remaining from the bipartisan emergency supplemental bills. And now there is even more funding provided for similar activities as part of the partisan reconciliation bill. While it is important to know how fast HHS is getting this funding into the hands of the frontline responders on the state level, it is just as important to know if the states are actually spending the money. What are the spend rates that HHS is seeing at the state level?

Answer. HHS has awarded over \$146 billion to states across six supplemental appropriations. In many cases, funds were directed to states by Congress in the COVID supplemental appropriations. As of early November, award recipients have drawn down \$29.5 billion, or twenty percent, of the total funding awarded. When examining the first four supplementals, state recipients have drawn down at least 50 percent or significantly higher percentages for resources appropriated at the earliest stages of the pandemic. Evaluating how the funds are being used cannot be achieved by examining draw down data alone since it is not a good indicator of how much jurisdictions have spent. States and jurisdictions are able to bill again their awards through the end of the established period of performance for that specific award. Funding recipients will typically draw down funds as expenses are incurred or after activities are executed and invoices are reconciled to confirm reimbursement totals. Drawdowns may occur monthly, quarterly, or at another frequency depending on the awardee. As a result there can be a significant time lag in the draw down data since actual state and jurisdiction expenditures are usually greater than the amount reflected in our draw down data. HHS grants policies and regulations require monitoring and award recipient reporting and HHS agencies closely monitor award recipient performance, activities, and progress through regular engagement.

Question. What accountability do the states have to tell the Department how they used the funds?

Answer. With respect to Centers for Disease Control and Prevention (CDC) grant awards, HHS awarding agencies adhere to HHS Grant Policies and Regulations, which detail required monitoring and reporting for award recipients. These may differ in frequency by type of award or program.

CDC for example continuously and closely monitors recipient/jurisdiction performance, activities, and progress through regular engagement. Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient reporting (including work plans, performance, and financial reporting). Monitoring includes tracking recipient progress in achieving the desired outcomes, ensuring the adequacy of recipient systems that underlie and generate data reports, and creating an environment that fosters integrity in program performance and results.

Monitoring may also include the following activities deemed necessary to monitor an award.

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with recipients on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

CDC complies with HHS requirements to implement internal tracking methods for issued Federal awards. Award recipients report expenditures into HHS' Payment Management System (PMS) quarterly and submit a Final Financial Report 90 days after the end of the budget period. All awards have assigned budget activity codes that are used to track and monitor funding

Question. Given the unprecedented amount of funding going out from HHS as a result of the partisan reconciliation bill, can you explain HHS' decisionmaking process and planning mechanisms for deploying such large sums of money in such a short period of time?

How does HHS plan for states and the public health infrastructure to sustain these advancements when the funding runs out?

Answer. The American Rescue Plan provided over \$160 billion for activities across HHS agencies. The legislation identified specific purposes for the resources appropriated to HHS agencies and many were intended to support states public health. In many cases, HHS was able to leverage existing program mechanisms to efficiently and quickly execute funding. For example, the American Rescue Plan appropriated substantial resources for existing block grants within ACF for child care development, and for mental health and to prevent substance abuse within SAMHSA. HHS was able to leverage existing program mechanisms to rapidly award funds when they were needed most by the population served by these critical programs. These large infusions of funds are supporting state implemented programs to meet both demands and other challenges presented during the COVID pandemic. Looking forward, HHS will work within the Administration to identify future investments in public health programs through the annual budget process taking into consideration experiences from the COVID response.

Question. The Administration has placed an emphasis on addressing health equity, especially as it relates to the pandemic response efforts. What trends are you seeing in rural communities right now with regard to the pandemic?

How does the HHS' health equity work account for the needs of rural communities?

Answer. COVID had a disproportionate impact in rural areas given limited clinical infrastructure (for example, fewer number of beds, workforce staffing issues already a challenge pre-pandemic, challenges accessing PPE). Rural communities suffered with high case rates and high mortality rates, often worse than in urban areas.

HHS has been intentional about targeting COVID relief to rural communities (and those populations with at higher risk within rural)—for example HRSA provided funding to grantees in the Mississippi Delta Region to promote the vaccine, supported regional trainings for community health workers in that region as well as the region along the U.S.—Mexico border, programs that have been proven effective in populations of racial and ethnic minorities that often face even higher health disparities than the broader rural populations.

Programs this year targeted Rural Health Clinics and small rural hospitals to support testing and mitigation activities for these key providers of the rural health safety net. Additionally, funding to support vaccine distribution and confidence was distributed to Rural Health Clinics—getting funding to trusted community providers.

We are enhancing our focus on the need to look at rural health issues through the lens of health equity; expanding the use of our research centers to gather more data to inform future work in this area; and providing targeted outreach to key underserved communities and populations to help them leverage our funding.

Question. Throughout the pandemic, and to date, we have heard concerns about the impact to the NIH research community. For example, scientists who had to close their labs and cull their animals lost valuable research data and post-doctoral candidates couldn't finish their research in time to get jobs in September. What is the strategy for using fiscal year 2021 or fiscal year 2022 dollars for COVID-19 related expenses and how much of non-emergency supplemental funding has been used by agencies to address these concerns?

Answer. As noted in the question, research on many NIH grants was impacted by the pandemic, causing delays in research activities and outcomes. NIH is considering various strategies to address these coronavirus disease 2019 (COVID-19) related expenses to support our recipients, such as:

- Providing extensions, both funded and un-funded, for recipients of NIH Fellowship (F) and NIH Career Development (K) awards who have been impacted by COVID-19²¹
- Supporting administrative supplements, competitive revisions, and extensions to existing grants
- Allowing extensions to one’s early-stage investigator status due to effects related to pandemic shutdowns²²
- Temporary extensions of eligibility for select NIH programs, including the NIH K99/R00 Pathway to Independence Award²³
- Flexibilities for NIH-funded clinical trials and human subjects for the duration of the declared public health emergency²⁴
- Flexibilities for assured institutions for activities of institutional animal care and use committees²⁵

The budgetary impact of these flexibilities and additional funding on new grants funded is not yet fully known. NIH will continue to analyze the data on the impact of COVID-19 on the biomedical research community, and its potential impact on our budget and grant activities.

NIH received the authority in Section 152 of the Continuing Resolution signed into law in September 2020 to extend multi-year funded grants awarded in fiscal year 2015, specifically for those active when the COVID-19 public health emergency was declared.²⁶ The project period end dates for those limited number of awards were extended through August 31, 2021. NIH is also requesting a similar extended disbursement authority for certain amounts available for obligation through fiscal year 2016 that were obligated for multi-year research grants, such that those amounts would continue to be available through fiscal year 2022.

INFLUENZA

Question. Influenza occurs seasonally each year, and has on occasion caused devastating pandemics in the past. Reports are already speculating that the next flu season may be bad after a year of hardly any flu cases. The budget requests an increase of \$25 million for CDC Influenza Planning and Response and an increase of \$48 million for ASPR’s Pandemic Flu program. Are these resources sufficient to meet the needs outlined in the U.S. National Influenza Vaccine Modernization Strategy, which projected far greater needs over 10 years?

How will the budget request advance the National Strategy?

Answer. The budget request aligns with and supports the pandemic influenza strategy. The key investments you note are also critical down payments to incorporate what we are learning in the ongoing COVID-19 response. Specifically, the budget provides \$335 million, an increase of \$48 million above fiscal year 2021 enacted, for pandemic influenza preparedness activities carried out by ASPR and the Office of Global Affairs (OGA). ASPR will continue to support priorities in the 2019 Executive Order, “Modernizing Influenza Vaccines in the United States to Promote National Security and Public Health,” and apply lessons learned from the COVID-19 response to improve pandemic influenza response capabilities. Through established public-private partnerships, ASPR will advance non-egg-based vaccine platforms, including more flexible manufacturing technologies (e.g., cell-based and recombinant technologies) that can produce influenza vaccine more quickly in the event of a pandemic. The budget also supports the development of alternative devices for vaccine administration to allow for rapid, large-scale vaccinations. The COVID-19 pandemic response has demonstrated the importance of therapeutics that can prevent progression to severe disease and treat severely ill individuals.

ASPR will continue to support the advanced development of new influenza therapeutics and diagnostic platforms to allow for earlier detection and, subsequently, faster treatment of influenza infections. OGA will continue to enhance international

²¹ grants.nih.gov/grants/guide/notice-files/NOT-OD-21-052.html.

²² nexus.od.nih.gov/all/2020/04/09/can-esi-status-be-extended-due-to-disruptions-from-covid-19/.

²³ NOT-OD-21-158 and NOT-OD-21-106, and those listed on grants.nih.gov/policy/natural-disasters/corona-virus.htm under Temporary Extension of Eligibility.

²⁴ NOT-OD-20-087 and grants.nih.gov/sites/default/files/Considerations-New-Ongoing-Human-Subjects-Research-During-the-COVID-19-Public-Health-Emergency.docx.

²⁵ NOT-OD-20-088.

²⁶ Section 152. (a) Funds made available in Public Law 113–235 to the accounts of the National Institutes of Health that were available for obligation through fiscal year 2015 and were obligated for multi-year research grants shall be available through fiscal year 2021 for the liquidation of valid obligations incurred in fiscal year 2015 if the Director of the National Institutes of Health determines the project suffered an interruption of activities attributable to SARS-CoV-2. (b)(1) This section shall become effective immediately upon enactment of this Act.

influenza preparedness by providing strategic coordination and technical expertise on health policy development and diplomacy to global partners, including nearly 200 Ministries of Health.

In addition, CDC provides technical expertise, resources, and leadership to support diagnosis, prevention, and control of influenza domestically and to address the threat posed by seasonal and pandemic influenza. The fiscal year 2022 Centers for Disease Control and Prevention budget request invests an additional \$25 million to continue supporting implementation of the influenza planning and response activities outlined in the 2020–2030 National Influenza Vaccination Modernization Strategy. These activities include expanding vaccine effectiveness monitoring and evaluation, enhancing virus characterization, and expanding vaccine virus development for use by industry, increasing genomic testing of influenza viruses, and increasing influenza vaccine use.

QUESTIONS SUBMITTED BY SENATOR RICHARD C. SHELBY

Question. On August 2, 2019, the Centers for Medicare and Medicaid Services (CMS) finalized the Inpatient Prospective Payment System (IPPS) payment rule, which updated Medicare payment policies for hospitals in states with a low Area Wage Index (AWI). CMS's AWI calculation has plagued states like Alabama since its inception. Prior to the IPPS rule being finalized in August 2019, Alabama had the lowest AWI floor and ceiling of any state in the country, around .66 and .8 respectively. The IPPS rule made formula changes to Medicare's AWI for fiscal years 2020–2024, which have benefitted several states to this point, including Alabama, by boosting annual hospital revenue for Alabama hospitals collectively by \$35–\$40 million annually, which saved many rural hospitals from closing their doors prior to the COVID–19 pandemic.

This is an important issue to all residents of Alabama. The ability to deliver healthcare in small towns maintains their ability to recruit businesses to the area. What are your thoughts on the AWI changes that were made in the fiscal year 2020 IPPS final rule?

Answer. The Inpatient Prospective Payment System (IPPS) pays hospitals for services provided to Medicare beneficiaries using a national base payment rate, adjusted for a number of factors that affect hospitals' costs, including the cost of hospital labor in the hospital's geographic area. This adjustment, or Area Wage Index, is updated by CMS annually.

In the fiscal year 2020 IPPS Final Rule,²⁷ to help mitigate wage index disparities between high wage and low hospitals, CMS adopted a policy to increase the wage index values for certain hospitals with low wage index values (the low wage index hospital policy). This policy was adopted in a budget neutral manner through an adjustment applied to the standardized amounts for all hospitals. CMS also indicated that this policy would be effective for at least 4 years, beginning in fiscal year 2020, in order to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation. For fiscal year 2022, CMS is continuing the low wage index hospital policy.

Question. I understand that the pending fiscal year 2022 IPPS rule includes some significant policy changes regarding organ transplantation, which could yield a significant negative impact to transplant centers. Constituents have told me that the rule was written without input from stakeholders in the transplant community, without adequate analysis of the impact to patients' access to transplantation, and without consideration of budgetary impact, if any, on state Medicaid/CHIP programs. I am concerned about unintended consequences if this rule were to go into effect, including to access to care, especially for the children.

Will you ensure that my concerns will be addressed before this rule is finalized? Will you also engage with all stakeholders on the issues I've raised?

Answer. The Medicare Program supports organ transplantation by providing an equitable means of payment for the variety of organ acquisition services. I can assure you that CMS will take all comments and concerns into consideration before issuing a final decision on the proposed Medicare usable organ counting policy.

Question. The overall budget requests \$10.7 billion to fight the opioid epidemic. Previous Administrations have spent billions of dollars on all aspects of the epidemic including prevention, research, education, and treatment and there are still severe issues.

²⁷ Final Rule (CMS–1716–F) and Correction Notice (CMS–1716–CN2) available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/fiscalyear2020-IPPS-Final-Rule-Home-Page-Items/fiscalyear2020-IPPS-Final-Rule-Regulations>.

Please provide details as to how the Department plans to spend this money and how it will have a different impact than the money spent before.

Answer. The budget takes action to address the epidemic of opioids and other substance use, investing \$11.2 billion, including \$10.7 billion in discretionary funding, across HHS, \$3.9 billion more than in fiscal year 2021. The impact of this epidemic is felt in our communities, and the budget will direct funding to states and Tribes to increase community-level response. The budget will also increase access to medications for opioid use disorder and expand the behavioral health provider workforce, particularly in underserved areas. HHS will continue to build on the investments the American Rescue Plan provided to the Substance Abuse Prevention and Treatment Block Grant, Community Mental Health Services Block Grant, and Certified Community Behavioral Health Centers. This crisis is evolving—overdose deaths involving substances other than opioids are also increasing. HHS will ensure our work is responsive to the needs of communities across the country.

Specifically, the \$3.9 billion increase in funding includes:

- FDA*: +\$38 million above fiscal year 2021, for a total of \$113 million, to develop opioid overdose reversal treatments and treatments for opioid use disorder and continue to support opioid research efforts.
- HRSA*: +\$190 million above fiscal year 2021, for a total of \$1.1 billion to increase behavioral health workforce grant programs and expand response to the opioid crisis in rural communities.
- IHS*: +\$27 million above fiscal year 2021, for a total of \$42 million to expand activities that increase access to culturally appropriate opioid use interventions, including medication-assisted treatment, for American Indians and Alaska Natives (\$15 million) and improve prevention and treatment of Hepatitis C and HIV in tribal communities (\$27 million). The prevalence of Hepatitis C and HIV in Indian Country is closely linked to rates of injection drug use.
- CDC*: +\$244 million above fiscal year 2021, for a total of \$733 million to address infectious diseases associated with injection drug use and expand opioid overdose prevention programs to communities heavily impacted by the overdose crisis. The additional resources will support collection and reporting of real-time, robust mortality data and investments in prevention for people put at highest risk as well as for testing, diagnosis, linkage to care, and treatment for infectious diseases related to injection drug use.
- NIH*: +\$627 million above fiscal year 2021, for a total of \$2.2 billion to increase opioid, stimulant, and substance use research. Within this total, \$811 million supports the Helping to End Addiction Long-term (HEAL) Initiative, NIH's aggressive, trans-agency effort to provide scientific solutions to the opioid crisis. Over \$1.4 billion supports ongoing research in this critical area.
- SAMHSA*: +\$2.7 billion above fiscal year 2021, for a total of \$6.8 billion to increase funding for SAMHSA block grants and grant programs directing funding to local public health response to the substance use and opioid crisis, including Certified Community Behavioral Health Clinics. This increase also will expand access to treatment for pregnant and post-partum women, access to medication-assisted treatment, access to recovery support services, and access to drug treatment activities.
- AHRQ*: +\$7 million above fiscal year 2021, for a total of \$10 million for new research grants to increase equity in substance use disorder (SUD) treatment access and outcomes, accelerate the implementation of effective evidence-based care in primary and ambulatory care, and develop whole person models of care that address the social factors that shape SUD treatment adherence and long-term recovery.
- CMS*: +\$12.9 million above fiscal year 2021, for a total of \$16.3 million, to increase opioid activities, including funding certain SUPPORT Act provisions. The funding requested will be used for data and information technology needs, provider education, monitoring and auditing, performance measurement, and claims analysis. CMS will continue to provide technical assistance to states on behavioral health, developing an updated opioid and SUD Action Plan, working with the Office of National Drug Control Policy on the National Drug Control Strategy, and collaborate with other HHS operating divisions on opioid and SUD actions, behavioral health, and pain initiatives.
- ACF*: +\$40 million above fiscal year 2021, for a total of \$140 million to increase state child abuse prevention grant funding focusing on developing infant safe care plans and expansion of kinship navigator and regional partnership grants which assist families at risk due to substance use of a family member.
- ACL*: +\$1 million above fiscal year 2021, for a total of \$3 million to increase grants for adult protective services and opioid-related activities to maximize the impact on direct services to the most affected clients.

The fiscal year 2022 President's Budget provides \$713 million for CDC's opioid overdose prevention and surveillance activities, which is an increase of \$239 million from fiscal year 2021. With the support of Congress and increases in appropriations in previous years, CDC has scaled its overdose surveillance and prevention program from 5 states in 2014 to 47 states, 16 localities, and two territories today.

With the fiscal year 2022 increased funding request, CDC would continue improving the timeliness and comprehensiveness of drug overdose data and scaling overdose prevention strategies, evaluation, and applied research. Because successful response strategies must be tailored to local communities, CDC would also use the increased funding to scale local investments so more local communities can quickly identify changes in local drug supply and prevent overdoses. The increased funding would also support states and communities that require additional resources to respond to an increase in overdoses due to the COVID-19 pandemic.

Question. After significant investment over the past several years, state Prescription Drug Monitoring Programs (PDMPs) are still not real-time, not interoperable, and are not incorporated into a provider's workflow, yet the technology exists to fix all these issues. How does your budget support improvements to PDMPs and will any funds specifically support upgrading these systems to address the concerns I've outlined?

Answer. CDC's goal is to maximize interconnectivity of all resources within this space. CDC's Overdose Data to Action (OD2A) program expanded previous Prescription Drug Monitoring Program (PDMP) investments and has worked to make PDMPs easier to use and more accessible to both clinicians and under-resourced communities. Under OD2A, required activities related to PDMPs include:

- Universal use among providers within a state
- Inclusion of more timely or real-time data contained within a PDMP
- Actively managing the PDMP in part by sending proactive or unsolicited reports to providers to inform prescribing
- Ensuring that PDMPs are easy to use and access by providers
- Propose activities to enhance and maximize the use of PDMPs, such as moving towards real-time data collection

In addition to the base OD2A funding provided to recipients to implement required PDMP activities, states were provided with the option to apply for additional funds to make PDMP data more actionable both within and across state borders. Activities under this supplemental funding include integrating state PDMPs with other health systems data and integrating the PDMP across state lines/interstate operability.

With Federal funding and substantial technical assistance provided by CDC, the Bureau of Justice Administration (BJA), the Centers for Medicaid & Medicare Services (CMS), SAMHSA, and the Office of the National Coordinator for Health Information Technology (ONC), states have made significant strides in reporting data faster and achieving interstate and intrastate PDMP operability, most commonly via the RxCheck hub or PMP Interconnect. As of May 2021, there are 46 jurisdictions that are live on the RxCheck hub and actively able to share data across state lines. PMP Interconnect, from the National Association of Boards of Pharmacy, currently includes 51 participating jurisdictions. In addition to those jurisdictions sharing data across states, 45 states and territories are also engaged in intrastate integration with electronic health records (EHRs), Health Information Exchanges (HIEs), and Pharmacy Dispensing Systems. CDC collaborated with other Federal partners to support PDMP/EHR integration in states through several different projects, including OD2A. CDC also collaborated with Office of the National Coordinator for Health Information Technology to select three states (Kentucky, Utah, and Illinois) as pilots to demonstrate how to integrate PDMP data with EHR information through the RxCheck Hub.

Currently, only the Oklahoma PDMP has real-time data reporting. However, 49 state, district, and territory PDMPs have daily or next day reporting. CDC and BJA funds continue to help states report data faster. For example, Maine is moving towards real-time PDMP reporting by using CDC funds to support reporting dispensed controlled substances no later than the next business day. With fiscal year 2022 funds, CDC's OD2A program will continue supporting states to improve PDMPs and maximize interconnectivity. CDC will also support states to increase data sharing within states, particularly increasing PDMP data within EHRs and HIEs.

Question. What are your thoughts on continuing the CMS issued flexibilities around telehealth once the Public Health Emergency has ended?

Answer. Telehealth is an important tool to improve health equity and improve access to healthcare. Healthcare should be accessible, no matter where you live. HHS continues to examine the telehealth flexibilities developed for the current public

health emergency and determine how we can build on this work to improve health equity and improve access to healthcare. In addition to looking at which flexibilities HHS can and should continue administratively, I look forward to working with Congress to address changes that may need to be done through legislation.

QUESTIONS SUBMITTED BY SENATOR JERRY MORAN

Question. Before turning to the fiscal year 2022 budget request, I would like to discuss the remaining money in the Provider Relief Fund. According to May data from the Health Resources and Services Agency, there is around \$24 billion left in the PRF plus the additional \$8.5 billion allocated to rural healthcare providers in the American Rescue Plan. While HHS has rolled out programs using some of the remaining PRF funding, I want to ensure the PRF is still serving its original purpose of protecting healthcare facilities.

Are you considering allocating any of the remaining PRF funds to assist rural hospitals who may still be struggling in the aftermath of the pandemic?

Answer. HHS is committed to distributing the remaining provider relief payments as quickly, transparently, and equitably as possible while utilizing effective safeguards to protect taxpayer dollars. HHS is planning for future Provider Relief Fund (PRF) allocations, including the \$8.5 billion from American Rescue Plan Act and Phase 4 of the General Distribution.

HHS is actively considering feedback from stakeholders, as well as operational lessons learned from prior PRF payments, as part of the planning process. The feedback from Members of Congress and other stakeholders informs HHS' ability to administer the PRF in a manner that bolsters the healthcare system and helps providers experiencing COVID-related financial hardships during this crisis. HHS will publish additional information on future distributions on the Health Resources and Services Administration's PRF webpage, at www.hrsa.gov/provider-relief, as soon as it becomes available.

Question. The CARES Act established the PRF to prevent hospitals from closing during the most severe pandemic mitigation measures and rural hospitals in particular needed this financial assistance. While the PRF was largely successful, hospitals that opened in late 2019 did not receive enough relief and are now strapped for cash. Rock Regional in Derby, Kansas, which opened just months before the pandemic in 2019, is one such hospital that deserves more PRF funding under the guidelines of the Consolidated Appropriations Act of 2021.

Would you consider reopening Phase 3 PRF applications to accept updated documentation consistent with guidelines of the Consolidated Appropriations Act?

Answer. In processing PRF applications, HHS has sought to make payments as quickly and equitably as possible while taking appropriate precautions to safeguard taxpayer dollars. HHS recognizes that providers may have questions regarding the accuracy of their PRF payments. HHS will provide any updates on Phase 3 payments on the Health Resources and Services Administration's PRF webpage, at www.hrsa.gov/providerrelief, as soon as they becomes available.

Question. Given the purpose of the PRF, if hospitals are still struggling, that ought to lead to consideration of a Tranche 4 targeting such healthcare facilities, especially those that opened in 2019.

Is this something you will consider as you look at allocating the remaining PRF funding?

Answer. As HHS plans for future Provider Relief Fund (PRF) allocations, including the \$8.5 billion from American Rescue Plan Act and Phase 4 of the General Distribution, we are cognizant that hospitals that began operating in 2019 and 2020 are facing unique financial burdens related to the pandemic. Under the previous PRF distribution payment methodology, HHS paid new providers based on the average lost revenues and increased expenses for their provider type to avoid disadvantaging these entities.

As we move forward, HHS is actively considering feedback from stakeholders, as well as operational lessons learned from prior PRF payments, as part of the planning process for future funding. The feedback from Members of Congress and other stakeholders informs HHS' ability to administer the PRF in a manner that bolsters the healthcare system and helps providers experiencing COVID-related financial hardships during this crisis.

HHS will publish additional information on future distributions on the Health Resources and Services Administration's PRF webpage, at www.hrsa.gov/provider-relief, as soon as it is available.

Question. I have been concerned with the challenges that the senior living community has faced throughout the duration of the pandemic. Long-term care and as-

sisted living facilities were tasked with caring for the population most vulnerable to COVID-19. In caring for the over two million seniors across the country, these facilities faced increasing costs in protecting residents and their staff. As you have heard me mention before, these senior living facilities have not been receiving enough support from HHS and are in need of assistance.

Can you confirm that senior and assisted living facilities will actually see meaningful financial support from the remaining Provider Relief Fund money in a timely manner?

Answer. As of June 4, 2021, over 10 percent of the total PRF payments made and kept by providers were directed to nursing homes, assisted living facilities, and skilled nursing facilities, including more than \$9 billion in PRF Targeted Distribution payments and over \$3 billion in PRF General Distribution payments to provider organizations with at least one nursing home, skilled nursing facility, assisted living facility, or long term care facility.

HHS appreciates the care being given to seniors across the nation and recognizes that some assisted living facilities are still experiencing financial burdens related to the pandemic. HHS is committed to distributing the remaining provider relief payments as quickly and equitably as possible while utilizing effective safeguards to protect taxpayer dollars. At present, HHS is planning a Phase 4 of the General Distribution. Congress also appropriated an additional \$8.5 billion, which has not yet been obligated, in the American Rescue Plan Act for Medicare and Medicaid providers and suppliers in rural areas or who serve rural patients.

HHS is actively considering feedback from stakeholders, as well as operational lessons learned from prior PRF payments, as part of the planning process. The feedback from Members of Congress and other stakeholders informs HHS' ability to administer the PRF in a manner that bolsters the healthcare system and helps providers experiencing COVID-related financial hardships during this crisis. HHS will publish additional information on future distributions on the Health Resources and Services Administration's PRF webpage, at www.hrsa.gov/provider-relief, as soon as it becomes available.

Question. I would like to ask about your approach to Community Health Centers. Health Centers in Kansas have been among the leaders in responding to the COVID-19 pandemic. Since the beginning of the year, Kansas Health Centers have tested nearly 20,000 patients and administered vaccines for over 48,000 patients. The fiscal year 2022 budget request mentions the Administration looks forward to working with Congress to advance the President's goal of doubling the Federal investment in community health centers. However, the budget also included a \$45 million cut to the overall program due to budget sequestration.

Could you please discuss HHS' support for greater health center funding and how you intend to work with Congress to double Federal investments in community health centers?

Answer. HRSA supports the President's goal to double the Federal investment in community health centers and looks forward to working with Congress to expand the Health Center Program to: (1) increase access to primary medical care services in the high need communities; (2) ensure that health center patients receive a full range of comprehensive primary healthcare services; (3) improve health outcomes and reduce health disparities through new, evidence-based and innovative approaches to care; and (4) invest in local healthcare infrastructure and expand employment opportunities in medically underserved communities.

Question. As I'm sure you're aware, the Children's Hospital Graduate Medical Education (CHGME) program supports the specialized training that occurs in many children's hospitals. For example, Children's Mercy in Kansas City trains the majority of pediatricians that serve the state of Kansas, instructing nearly 230 pediatric residents and fellows annually. The fiscal year 2022 budget request included \$350 million for CHGME, marking the first time since fiscal year 2021 the budget request included a separate request for CHGME.

Could you expand on HHS' goals for the separate funding request and fiscal year 2022 increase for the CHGME?

Answer. The budget requests \$350 million for CHGME to provide continued support for the pediatric workforce. The funding amount of \$350 million aligns with the fiscal year 2021 enacted funding level and is expected to support approximately 7,700 resident full-time equivalents (FTEs). CHGME payments are for direct and indirect medical expenses for medical residency training programs. The funding will also support contracts to meet legislative requirements such as the FTE reconciliation which ensures correct reporting and that residents are not funded by other Federal programs to prevent duplicate payments.

QUESTIONS SUBMITTED BY SENATOR JOHN KENNEDY

Question. A recent report indicated that HHS has approximately \$24 billion in unspent CARES funding. Many healthcare providers are still working their way through the financial effects of the COVID-19 pandemic, and this funding is crucial.

Can you indicate if healthcare providers, including air ambulances, can expect to see this funding made available, or will you be returning unspent CARES funding so that we can reduce the overall financial impact of spending related to the pandemic response?

Answer. HHS is committed to distributing the remaining provider relief payments as quickly, transparently, and equitably as possible while utilizing effective safeguards to protect taxpayer dollars. HHS is planning for future Provider Relief Fund (PRF) allocations.

HHS is actively considering feedback from stakeholders, as well as operational lessons learned from prior PRF payments, as part of the planning process. The feedback from Members of Congress and other stakeholders informs HHS' ability to administer the PRF in a manner that bolsters the healthcare system and helps providers experiencing COVID-related financial hardships during this crisis. HHS will publish additional information on future distributions on the Health Resources and Services Administration's PRF webpage, at www.hrsa.gov/provider-relief, as soon as it becomes available.

Question. If HHS is going to retain unspent CARES Act funds, can it be used to waive recoupment of Medicare Advanced Payments?

Answer. HHS is committed to distributing the remaining provider relief payments as quickly, transparently, and equitably as possible while utilizing effective safeguards to protect taxpayer dollars. HHS is planning for future Provider Relief Fund (PRF) allocations.

As we move forward, HHS is actively considering feedback from stakeholders, as well as operational lessons learned from prior PRF payments, as part of the planning process for future funding. The feedback from Members of Congress and other stakeholders informs HHS' ability to administer the PRF in a manner that bolsters the healthcare system and helps providers experiencing COVID-related financial hardships during this crisis.

HHS will publish additional information on future distributions on the Health Resources and Services Administration's PRF webpage, at www.hrsa.gov/provider-relief, as soon as it is available.

QUESTIONS SUBMITTED BY SENATOR CINDY HYDE-SMITH

Question. Secretary Becerra, new data has just been released by NORC at the University of Chicago finding that nearly two-thirds of assisted living facilities reported no deaths from COVID-19 in 2020. Despite this positive data, some have expressed concerns assisted living providers caring for nearly 2 million elderly individuals have received less than 1 percent of all provider relief funding to date. It is my understanding that assisted living providers expended a great deal of capital in order to ensure COVID-19 safety in their facilities, as well as to compete for staffing in a tight nursing labor market. I have been informed that assisted living caregivers will suffer \$30 billion in losses through June 2021 due to these efforts and that over half of assisted living facilities nation-wide are operating at a loss currently.

How can HHS help support these assisted living providers, through the PRF and otherwise?

Answer. As of June 4, 2021, over 10 percent of the total PRF payments made and kept by providers were directed to nursing homes, assisted living facilities, and skilled nursing facilities, including more than \$9 billion in PRF Targeted Distribution payments and over \$3 billion in PRF General Distribution payments to provider organizations with at least one nursing home, skilled nursing facility, assisted living facility, or long term care facility.

HHS appreciates the care being given to seniors across the nation and recognizes that some assisted living facilities are still experiencing financial burdens related to the pandemic. HHS is committed to distributing the remaining provider relief payments as quickly and equitably as possible while utilizing effective safeguards to protect taxpayer dollars.

HHS is actively considering feedback from stakeholders, as well as operational lessons learned from prior PRF payments, as part of the planning process. The feedback from Members of Congress and other stakeholders informs HHS' ability to administer the PRF in a manner that bolsters the healthcare system and helps providers experiencing COVID-related financial hardships during this crisis. HHS will

publish additional information on future distributions on the Health Resources and Services Administration's PRF webpage, at www.hrsa.gov/provider-relief, as soon as it becomes available.

Question. Your budget calls for the elimination of the Hyde Amendment to allow taxpayer funding of abortion through Medicaid, Medicare, and other programs under Labor/HHS appropriations.

Why is this Administration insistent on reversing four decades of bipartisan precedent and ignoring the will of most Americans who object to their tax dollars funding the destruction of human life?

Answer. The Hyde Amendment disproportionately impacts the growing number of low-income, women of color who are enrolled in Medicaid, and is a barrier to expanding access to healthcare. That is why the President's first budget calls for Congress to remove the restriction from government spending bills.

The Department of Health & Human Services implements the laws that Congress passes. Implementation of any changes in coverage related to the President's Budget would depend on the final language Congress passes. After passage of any legislation, agency staff and counsel review the language to determine the agency's authority and options for implementation action, such as initiating notice and comment rulemaking or issuing guidance documents.

Question. Your budget proposes a 19 percent increase in funding for the Title X family planning program by \$53.521 million to \$340 million from \$286.479 million. I am concerned that Title X will be a slush fund for Planned Parenthood and the abortion industry.

Can you ensure that these new funds will not be used to bolster abortion giant Planned Parenthood and its cohorts?

Answer. The Title X program does not provide abortion services. Section 1008 of the Public Health Service Act specifically states that "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." Consistent with the program's statute and regulations, any public or private nonprofit organizations, including faith-based organizations, state, county, local, and tribal governments, school districts, and public and state higher education institutions are eligible to apply for Title X grant funds. Title X's regulations, in the NPRM, also clearly define the criteria the Department uses to decide which family planning services projects to fund and in what amount.

Question. As you know, the previous administration disallowed \$200 million in Medicaid funds from California because it was literally forcing nuns to buy abortion insurance in violation of conscience protection laws.

Will you commit to not reversing the findings made by career professionals supporting the disallowance and not otherwise restoring the money to California?

Answer. In my ethics agreement signed on January 17, 2021, and the subsequent authorization issued on March 31, 2021, I have agreed not to participate in any litigation involving the State of California that was pending during my tenure as Attorney General. I understand that there has been no litigation on this matter, however, as Attorney General I did issue a public statement on the matter. After consulting with the HHS Acting Designated Agency Ethics Official, I have determined that it is prudent for me to recuse myself from this Medicaid financing matter to avoid even an appearance of impropriety. I trust that the very talented employees of the Department who, at the working level, handle the vast amounts of work, including specific enforcement and program financing matters, will resolve this matter in a manner that is consistent with the Department's obligations and in the best interest of the American people. If leadership input is required, the Chief of Staff will either handle the case without any input from me or will refer the case to the appropriate person for decision.

Question. Your budget asks for a \$9 million increase for the Office for Civil Rights (OCR), yet OCR inherited over \$60 million in enforcement settlement funds that you are free to use right now to support the bulk of OCR operations.

Do you think it is appropriate for you to ask Congress for more taxpayer money for an Office that is sitting on such a huge sum of money?

Answer. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) law requires the Office for Civil Rights (OCR) to spend any money that it collects in HIPAA settlements on HIPAA enforcement only. This means that these funds are limited in their use as directed by Congress.

The proposed increase in OCR's budget would support civil rights authorities and operations, specifically working on improving overall enforcement stemming from OCR's authority over healthcare.

Question. Will you commit to preserving the Conscience and Religious Freedom Division as a Division within OCR?

Answer. HHS will continue to protect the religious, civil, and constitutional rights of all Americans. This means that we will continue to enforce conscience and religious freedom protections, including receiving complaints, investigating cases, and making findings consistent with the law.

Question. A few weeks ago you announced that HHS will interpret prohibitions on sex discrimination in healthcare to include “sexual orientation and gender identity.”

As I read your announcement, male or female are no longer to be understood as being based on biology. What does it mean to be a man or a woman going forward under these laws?

Under your announcement, do doctors, who receive HHS funding, have a right to decline to perform procedures that violate their religious beliefs or conscience?

Do you favor HHS funds being available for sex-reassignment surgeries in minors? If so, please explain your justification under current Federal law.

Do you favor HHS funds being available for puberty blockers and cross-sex hormones for young children? If so, please explain your justification under current Federal law.

Answer. HHS will continue to protect the religious, civil, constitutional rights of all Americans.

Question. As of this week over 60 percent of Americans have received at least one dose of the COVID-19 vaccine. This extraordinary milestone was made possible by the unprecedented speed of developing a vaccine less than 1 year after the start of the COVID-19 pandemic. However, when the next pandemic hits, the U.S. will need to move even faster. With the frequency of epidemics and pandemics increasing, the next fast-moving, novel infectious disease pandemic could occur within the next 10 years. In addition to naturally occurring threats, rapid advances in biotechnology increase the chance that novel pathogens could be created with the potential to start major outbreaks. Given the uncertainty about how the next pandemic will arise, we must harness innovative technologies, outside the box thinking, and game changing science to develop countermeasures that are pathogen-agnostic. In the fiscal year 2021 House and Senate Committee Reports we included language that encouraged the Department to work with the Department of Defense to implement a dedicated medical countermeasures program focused on developing flexible vaccines and antiviral treatments to address emerging and previously unidentified infectious disease threats, referred to as Disease X.

Mr. Secretary, what progress has the Department made in implementing such a program?

How is the Department planning to develop countermeasures for previously unidentified viral threats?

Answer. The U.S. Department of Health and Human Services recognizes the importance of developing flexible, broadly applicable technologies for the development of medical countermeasures, especially vaccines, to be able to respond quickly to emerging infectious diseases. The development of highly adaptable vaccine platforms and structural biology tools enabling the design of novel and improved immunogens have helped usher in a new era of vaccinology. In addition, the development of broadly acting antivirals and other therapeutics will be critical as we prepare to respond to a future Disease X.

The National Institute of Allergy and Infectious Diseases (NIAID) at the National Institutes of Health (NIH) supports and conducts research to both identify previously unidentified viral threats and to develop medical countermeasures that can be used to respond to them. On August 27, 2020, NIAID established the Centers for Research in Emerging Infectious Diseases (CREID), a multidisciplinary global network that seeks to identify how and where viruses and other pathogens emerge from wildlife and spillover to cause disease in people. The CREID network, along with other U.S. Government funded global surveillance efforts, will enable early warnings of emerging diseases wherever they occur, facilitate a coordinated outbreak response to an emerging virus, and may be a crucial tool in early identification of a future Disease X with pandemic potential. This program will build upon prior U.S. Government efforts in global disease surveillance and complement important ongoing activities supported by Federal partners.

NIAID supports basic, translational, and clinical research to develop novel medical countermeasures, including novel vaccine platforms, adjuvants, and directly acting oral antivirals. These medical countermeasures are often developed for broad pathogen families and can be quickly modified for efficacy against related emerging pathogens with pandemic potential. NIAID also makes available to the broader research community a suite of preclinical services that can help lower the risk to developers and help to advance novel diagnostics, therapeutics, and vaccines. In addition, NIAID has leveraged and strengthened global and domestic clinical research

networks to facilitate preparedness for rapid launch of clinical trials in outbreak situations. These long-standing NIAID investments were crucial to the response to the emergence of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19. For example, the NIAID Vaccine Research Center played a key role in both the development of novel vaccine platforms and the design of the stabilized prefusion spike protein immunogen used in all three of the COVID-19 vaccines currently authorized under an Emergency Use Authorization from the FDA. The development—in record time—of these highly efficacious vaccines with the potential for saving millions of lives was only possible through an extraordinary multidisciplinary effort leveraging decades of basic, preclinical, and clinical science.

NIH- and NIAID-supported advances in medical countermeasure research and development, as well as other efforts across HHS to prepare for novel disease threats, were vital to the Federal response to COVID-19. Throughout the COVID-19 pandemic, NIH has supported HHS' efforts to leverage highly productive public-private partnerships with industry, academia, and the public-sector; utilize longstanding relationships with community partners to facilitate the biomedical research response; and engage existing domestic and international research infrastructure to respond to COVID-19. The whole-of-government approach that began under Operation Warp Speed and has continued under the current HHS and Department of Defense Countermeasure Acceleration Group partnership has efficiently supported the development of safe and effective COVID-19 medical countermeasures. This effort led to the rapid identification and clinical testing of candidate therapeutics for the treatment of COVID-19, as well as multiple COVID-19 vaccine candidates that progressed in record time from concept to FDA emergency use authorization. Lessons learned from the Federal response to COVID-19 will be used to inform future pandemic preparedness efforts at NIH and across HHS.

In addition to developing platforms that allow for the accelerated development of vaccines for emerging pathogens, there is a need to move beyond chasing the different viral strains or variants as they emerge. NIAID is leading efforts to develop “universal” influenza vaccines to protect against multiple strains of seasonal and pandemic influenza viruses that may emerge. NIAID also is conducting early-stage research on the development of pan-coronavirus vaccines designed to provide broadly protective immunity against multiple coronaviruses, especially SARS-CoV-2 and others with pandemic potential. New viral threats will continue to emerge, and the development of universal influenza vaccines and pan-coronavirus vaccines will help us be better prepared for future infectious disease threats.

Gaining a deeper understanding of the interplay between pathogens and the human immune system also could expedite the development of medical countermeasures against emerging pathogens. NIAID supports a number of research initiatives to define human immune mechanisms that provide protective anti-viral immunity or contribute to disease pathogenesis. For example, the NIAID Vaccine Research Center is establishing the Pandemic Response Repository through Microbial/Immune Surveillance and Epidemiology (PREMISE) program. This program will use data from T and B cell immune surveillance to inform diagnostic, prophylactic, and therapeutic countermeasures and accelerate the global response to pandemic threats. NIAID anticipates the research conducted by PREMISE, and other similar NIAID initiatives, will advance our knowledge of the immune response to vaccination and infection and help inform the response to future pandemic threats.

The COVID-19 pandemic is an important reminder of the value of sustained and robust support for the U.S. biomedical research enterprise, which continues to accelerate the development of medical countermeasures to protect against emerging and re-emerging infectious diseases. NIH remains committed to working with our partners across the Federal Government to continue advancing the research that will help us respond to future pandemic threats from Disease X. NIAID will continue to support the development of flexible vaccine platforms, novel adjuvants, and antiviral treatments to address emerging and previously unidentified infectious disease threats. NIAID also anticipates launching new initiatives focused on preparing for future pandemic threats from Disease X. These initiatives will continue to build on long-standing NIAID efforts in this area, as well as lessons learned from the research response to COVID-19.

Question. As you know from your previous role as a Member of the Ways and Means Committee, chronic kidney disease (CKD) is unique to Medicare in that individuals with irreversible kidney failure are eligible for Medicare regardless of age or other disability. Over its nearly 50-year existence, this unique coverage has saved tens of thousands of lives, including 750,000 Americans who currently are on dialysis or who have a functioning kidney transplant. Individuals with chronic kidney disease cost Medicare \$130 billion in fee-for-service spending per year, almost \$50 million of which is for patients with irreversible kidney failure. Kidney failure pa-

tients represent 1 percent of Medicare beneficiaries but 7 percent of FFS expenditures. Improving detection and care of early stage CKD can help reduce health expenditures and improve patients' lives, yet an estimated 90 percent of our nation's 37 million adults with CKD are unaware they have it.

How will you prioritize changes at your Department to expand the focus on awareness, early detection, and early treatment to help prolong kidney function and help ensure the solvency of Medicare?

Nearly 20 years ago, the CDC created the Chronic Kidney Disease Initiative to increase awareness of the disease and expand public health surveillance activities. Unfortunately, funding has been mostly stagnant throughout its history, and it currently receives only \$2.6 million, despite the tremendous cost of CKD to society, Medicare, and Medicaid. The previous Administration created the Advancing American Kidney Health Initiative, which was very favorably received by the kidney community. One of the most important goals of AAKH, correlating to the CDC kidney initiative, was to increase awareness and early detection of kidney disease via a national kidney disease awareness public health initiative.

Please comment on efforts to expand the Chronic Kidney Disease Initiative to meet this awareness and early detection need.

COVID-19 has disproportionately affected kidney patients, who have experienced some of the highest rates of hospitalization and mortality from the pandemic. Additionally, COVID-19 is linked to acute kidney injury (AKI) and to kidney disease in recovering COVID-19 patients who have no prior history of kidney disease. A March 2021 study from Yale University indicates that AKI occurred in up to 57 percent of COVID-19 hospitalizations and 78 percent of intensive care unit admissions. In addition, reports from early in the pandemic indicate that barely a third of patients who developed AKI had not yet recovered baseline kidney function at a median of 21 days after leaving the hospital. (<https://www.ajmc.com/view/study-illustrates-kidney-impact-after-covid-19-resolves>)

Without intervention, these patients could develop chronic kidney disease. What steps will HHS take to ensure COVID-19 patients have access to the kidney services and care they need going forward?

Answer. Many beneficiaries with end-stage renal disease (ESRD) suffer from poor health outcomes and face increased risk of complications with underlying diseases. For example, people with ESRD who get coronavirus disease 2019 (COVID-19) have higher rates of hospitalization. Last year, CMS established the End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model, a mandatory Medicare payment model tested under the authority of section 1115A of the Social Security Act. The ETC Model tests the use of payment adjustments to encourage greater utilization of home dialysis and kidney transplants, in order to preserve or enhance the quality of care furnished to Medicare beneficiaries while reducing Medicare expenditures. This payment model is expected to encourage participating healthcare providers to invest in and build their home dialysis programs, allowing patients to receive care in the comfort and safety of their home. Home dialysis gives patients the freedom to choose the therapy that works best with their lifestyles, without being tied to the dialysis facility's schedule. The ETC Model also includes financial incentives for participating ESRD facilities and clinicians to encourage transplantation based on their transplant rate, calculated as the sum of the transplant waitlist rate and the living donor transplant rate.

Increasing access to affordable coverage will increase access to care, including preventive services and treatments that prolong kidney function. The President's fiscal year 2022 Budget includes numerous provisions that would work together to give Americans additional, lower-cost coverage options. One provision would give people age 60 and older the option to enroll in the Medicare program with the same premiums and benefits as current beneficiaries, but with financing separate from the Medicare Trust Fund. In States that have not expanded Medicaid, the President has proposed extending coverage to millions of people by providing premium-free, Medicaid-like coverage through a Federal public option.

Question. Sec Becerra, as you know, influenza occurs seasonally each year and throughout history has caused devastating pandemics—including the 1918 pandemic that killed an estimated 675,000 Americans. While this year's flu season was extremely mild, next year's could be much worse. The U.S. National Influenza Vaccine Modernization Strategy was released 1 year ago, with an ambitious vision of a domestic influenza vaccine enterprise that is highly responsive, flexible, scalable, and more effective at reducing the impact of seasonal and pandemic influenza viruses. The HHS Budget included a \$25 million increase within CDC's Influenza Division and a \$48 million increase for ASPR Pan Flu.

Are these resources sufficient? The previous administration estimated \$1 billion over 10 years would be needed to sufficiently resource the Strategy.

Answer. ASPR/BARDA has a long and successful history of focused efforts to invest in increasing influenza vaccine production capacity in preparation for a pandemic influenza response. While these efforts benefit seasonal influenza (e.g., cell-based vaccine, recombinant protein vaccine), they are not specific for seasonal influenza. In 2020, ASPR/BARDA also worked with industry to develop respiratory panel diagnostics that test for influenza and SARS-CoV-2 infection simultaneously. ASPR/BARDA looks forward to continuing these efforts as part of the National Influenza Vaccine Modernization Strategy and working with our colleagues at NIAID supporting early development of a universal influenza vaccine.

Question. Sec Becerra, the Administration has requested \$30 billion over 4 years in mandatory funding to protect Americans from the next pandemic. According to the latest budget request, \$24 billion of that would be allocated to HHS for medical countermeasures manufacturing and other initiatives.

Please elaborate on the need for this \$30 billion investment.

Answer. The President's request for \$30 billion over 4 years would help protect Americans from future pandemics through major new investments in medical countermeasures manufacturing; research and development; and related biopreparedness and biosecurity. This includes investments to shore up our nation's strategic national stockpile; accelerate the timeline to research, develop and field tests and therapeutics for emerging and future outbreaks; accelerate response time by developing prototype vaccines through Phase I and II trials, test technologies for the rapid scaling of vaccine production, and ensure sufficient production capacity in an emergency; enhance U.S. infrastructure for biopreparedness and investments in biosafety and biosecurity; train personnel for epidemic and pandemic response; and on-shore active pharmaceutical ingredients. COVID-19 has claimed hundreds of thousands of American lives and cost trillions of dollars, demonstrating the devastating and increasing risk of pandemics and other biological threats. The American Rescue Plan serves as an initial investment of \$10 billion. With this new major investment in preventing future pandemics, the United States will build on the momentum from the American Rescue Plan, bolster scientific leadership, create jobs, markedly decrease the time from discovering a new threat to putting shots in arms, and prevent or mitigate future biological catastrophes.

Question. Will any of these funds be targeted at influenza, which has the potential for a pandemic even more devastating than Covid-19?

Answer. HHS will follow the requirements spelled out in statute and follow the latest science in directing resources toward current and future pandemics.

Question. Please also provide greater clarity into how those funds would be allocated within HHS.

Answer. HHS is thankful for the resources provided by Congress to address the COVID-19 pandemic. We will follow the statutory requirements for use of funds appropriated to HHS and take a broad approach to addressing COVID-19 by continuing to support research on prevention, therapeutics, and vaccines; supporting workforce expansion to ensure equitable distribution of vaccines and therapeutics; investing in testing and screening to allow our schools and businesses to remain open; addressing our supply chain and manufacturing challenges; as well as addressing the mental health of those affected by COVID-19 whether they lost a family member or friend, suffered COVID-19, or lost the ability to fully participate in significant life events over the past 18 months or more. We will invest in the science and follow the science during this unprecedented time and do our best to address the challenges it has brought to our public health infrastructure.

Question. One of the silver linings of this pandemic has been the wide-spread adoption of technology to bring people together, whether it be families scattered across the nation or patients and their providers. We have seen exponential growth in telehealth adoption across Americans of all ages, locations, and conditions. Telehealth among Medicare beneficiaries has been made possible by temporary flexibilities in place for the duration of the public health emergency.

These include allowing Medicare beneficiaries to have telehealth visits from their home, regardless of where they live across the country. This has also allowed new types of providers, such as physical therapists and speech pathologists to practice via telehealth.

Sec. Becerra, do you agree that access to telehealth has been critical to protecting patients and providers during the nation's response to COVID-19? b.Sec. Becerra, do you agree that providers and beneficiaries have seen immense value from expanded access to telehealth over the past year? Do you agree that Americans have been overwhelmingly satisfied with care received virtually during the pandemic?

Sec. Becerra, can you tell us where telehealth ranks in terms of your priorities? d.Sec. Becerra, how can Congress ensure that Medicare beneficiaries do not lose access to telehealth after the public health emergency expires?

Will you commit to working with Congress to ensure that the millions of Medicare beneficiaries enrolled in fee-for-service Medicare do not face a telehealth service coverage cliff when the public health emergency expires?

Sec. Becerra, as Congress considers permanent telehealth reform, we will need your support, including an evidence-based assessment of how many of the telehealth flexibilities extended in response to the pandemic impacted both the Medicare program and beneficiaries. With that said, do you believe that there are some telehealth regulatory restrictions that Congress and HHS can work together to address in the near term that do not require additional data?

About 46 million Americans, nearly 15 percent of the U.S. population live in rural areas. Those living in rural areas are more likely to die prematurely and face higher risks for chronic conditions like heart disease and diabetes. Americans living in rural communities face 17 percent higher prevalence of diabetes than those living in urban areas and may have to wait months before needing to travel great distances to see an endocrinologist to help manage their condition. This scenario is not uncommon and instead is the reality of rural Americans that routinely encounter not just a lack of specialty care, but in my cases, primary care. Digital health tools, including telehealth and remote monitoring, have the potential to relieve some of the key healthcare challenges facing rural America.

Sec. Becerra, can you speak to the promise and value of telehealth and digital health more broadly to rural communities?

Answer. Telehealth is an important tool to improve health equity and improve access to healthcare. Healthcare should be accessible, no matter where you live. HHS continues to examine the telehealth flexibilities developed for the current public health emergency and determine how we can build on this work to improve health equity and improve access to healthcare. In addition to looking at which flexibilities HHS can and should continue administratively, I look forward to working with Congress to address changes that may need to be done through legislation.

Throughout the pandemic, telehealth services have filled an urgent need to maintain access to care while social distancing was necessary. For example, federally Qualified Health Centers and Rural Health Clinics were able to be paid by Medicare as distant site telehealth service providers, which had not been permitted outside of the COVID-19 public health emergency. After the pandemic, HHS will continue to support telehealth services. HHS is currently reviewing the telehealth flexibilities developed for the current public health emergency to determine which can and should continue after the public health emergency has ended. HHS plans to continue to support telehealth after the pandemic through resources like the Telehealth.HHS.gov website and the Telehealth Resource Centers so patients and providers have access to telehealth technical assistance.

Question. More than 147 million Americans are living with chronic conditions. It's estimated that 180 million Americans are living with mental health challenges. According to a 2017 RAND Corporation Study, 90 percent of the US healthcare spend is on chronic conditions, this includes \$327 billion on diabetes and \$131 billion for the treatment of hypertension. These are staggering figures. I believe that technology has the potential to empower patients, improve access and allow those Americans already living with these chronic conditions a chance at a happier, healthier life. Unfortunately, Medicare has been slow to adopt innovative digital health tools, some of which has been limited by outdated statutory limitations.

Beyond telehealth, can you speak to the Administration's efforts to enable Medicare beneficiaries to leverage digital health tools for the prevention and treatment of disease?

Are their limitations in your ability to expand access to these valuable resources for those that want to use them within Medicare?

What do you see CMMI's role to be in facilitating the demonstration and evaluation of virtual care solutions and digital health tools?

Could you discuss how remote patient monitoring is used today in Medicare and Medicaid today, in addition to telehealth, to help in the care of those living with chronic conditions like diabetes, hypertension, asthma or kidney disease?

Remote patient or physiologic monitoring (RPM) has shown great value in facilitating the management of both acute and chronic conditions. Using connected devices, individuals can, in real time, have data shared back with their care team to allow for intervention and ultimately prevention of more severe health outcomes. While HHS has begun to allow for the reimbursement of RPM, use of the codes in Medicare fee-for-service remains rather low.

Do you see value in enabling adoption of additional virtual care technologies, such as remote monitoring, for Medicare beneficiaries?

From a health equity perspective, what more can be done to make resources like remote monitoring tools available to all Americans, especially those living with chronic conditions?

RPM solutions, which for someone with diabetes, may be leveraged for years, warrants a recurring monthly 20 percent copay. Is there value in revisiting copay structures for remote monitoring and chronic care management services?

Answer. Innovation is important to advancing goals in healthcare, including by learning how to better leverage digital health tools for the prevention and treatment of disease. Individuals with chronic disease benefit from access to comprehensive and coordinated care to manage and treat their chronic conditions and prevent the need for more costly care. Ensuring access to remote patient monitoring services, including through evaluating the adequacy of payments, will be important to beneficiaries who may benefit from these and other virtual services that allow their physicians to help manage and treat their health conditions outside of regular office visits. The CMS Innovation Center is integral to the Administration's efforts to promote high-value care and encourage healthcare provider innovation, including virtual and digital health innovation. I look forward to hearing from Congress on ideas to change coinsurance for Medicare covered services.

QUESTIONS SUBMITTED BY SENATOR MARCO RUBIO

Question. I am incredibly concerned about the Biden Administration's decision to upend decades of bipartisan agreement by failing to include the Hyde Amendment in the proposed budget.

Does the Administration support taxpayer-funded abortion?

When Congress likely rejects this radical proposal and includes the Hyde Amendment in future spending bills—will the Administration follow the law and ensure that Federal Medicaid dollars are not used to finance abortions?

Answer. The Hyde Amendment disproportionately impacts the growing number of low-income, women of color who are enrolled in Medicaid, and is a barrier to expanding access to healthcare. That is why the President's first budget calls for Congress to remove the restriction from government spending bills.

The Department of Health & Human Services implements the laws that Congress passes.

Question. Of additional concern, the NIH announced that it will end its Ethics Advisory Board for reviewing external research applications for Federal funding involving the use of human fetal tissue.

Why has the NIH moved to end the Ethics Advisory Board?

What plan does the NIH have in place to provide adequate oversight and ensure Federal laws are followed?

Answer. NIH's mission is to seek fundamental knowledge about the nature and behavior of living systems and apply that knowledge to enhance health, lengthen life, and reduce illness and disability. Under its broad research mission, and as authorized by the Public Health Service Act, NIH conducts and funds biomedical research involving the study, analysis, or use of human fetal tissue for a range of diseases and conditions. NIH also funds research to develop, demonstrate, and validate experimental models that are alternatives to the use of human fetal tissue.

Given the current administration taking a different position on the merit of this research, the U.S. Department of Health and Human Services decided to rescind the 2019 decision that all research applications for NIH grants and contracts proposing the use of human fetal tissue from elective abortions will be reviewed by an Ethics Advisory Board. So on April 16, 2021, NIH published an Update on Changes to NIH Requirements Regarding Proposed Human Fetal Tissue Research (NOT-OD-21-111),²⁸ stating that HHS was reversing its 2019 decision that all research applications for NIH grants and contracts proposing the use of human fetal tissue from elective abortions will be reviewed by an Ethics Advisory Board. Accordingly, HHS/NIH will not convene another NIH Human Fetal Tissue Research Ethics Advisory Board. Please note that all other requirements described in NOT-OD-19-128²⁹ and updated in NOT-OD-19-137³⁰ for extramural research remain unchanged. Furthermore, NIH reminded the scientific research community of expectations to obtain informed consent from the donor for any NIH-funded research using human fetal tissue, and of continued obligations to conduct such research only in accord with any applicable Federal, state, or local laws and regulations, including prohibitions on the

²⁸ grants.nih.gov/grants/guide/notice-files/NOT-OD-21-111.html.

²⁹ grants.nih.gov/grants/guide/notice-files/NOT-OD-19-128.html.

³⁰ grants.nih.gov/grants/guide/notice-files/NOT-OD-19-137.html.

payment of valuable consideration for such tissue.³¹ The same requirements apply to the NIH intramural research program.

All NIH-supported organizations certify that they will comply with the NIH Grants Policy Statement,³² which summarizes NIH policies regarding the use of human fetal tissue in research and incorporates Federal statutory requirements for research with human fetal tissue (sections 498A and 498B of the PHS Act, 42 U.S.C. 298g-1 and 298g-2).

Question. With much of the country finally moving to pre-pandemic operations, and as Americans are taking flights, riding trains, and generally living their lives, all without a Federal vaccine requirement, there is one industry that the CDC continues to treat differently.

The White House Press Secretary has stated: “The government is not now, nor will we be supporting a system that requires Americans to carry a credential. There will be no Federal vaccinations database and no Federal mandate requiring everyone to obtain a single vaccination credential Our interest is very simple from the Federal Government, which is American’s privacy and rights should be protected so that these systems are not used against people unfairly.”

Mr. Secretary, if this were true, then the CDC would not be restricting cruise activities, and would not be putting unfair guidance in place that essentially requires that a minimum number of cruise passengers be vaccinated.

If the Biden Administration wants to protect the rights of Americans and ensure that policies do not discriminate against certain Americans, then why does the Biden Administration support vaccine requirements for cruises that discriminate against families with young children?

Answer. The Conditional Sail Order (CSO) is a phased approach for the resumption of passenger operations on cruise ships in the U.S. The timing of these phases depends on cruise ship operators’ demonstrated ability to mitigate COVID-19 risk on board their ships with crew. Phases can also be adjusted based on lessons learned from the previous phases.

Under the CSO, cruise ships are not mandated to require cruise passengers to be vaccinated. CDC recommended that cruise operators incorporate COVID-19 vaccination strategies to maximally protect passengers and crew in the maritime environment, seaports, and land-based communities to further reduce spread of SARS-CoV-2.

CDC is committed to ensuring that cruise ship passenger operations are conducted in a way that protects crew members, passengers, and port personnel, particularly with emerging COVID-19 variants of concern.

Question. When does the Biden Administration plan to end discriminatory policies that make it more difficult for families with children to go on vacation?

Answer. CDC currently recommends people delay travel until they are fully vaccinated. Fully vaccinated travelers are less likely to get and spread COVID-19 and can now travel at low risk to themselves within the United States. If people are traveling with children who cannot get vaccinated at this time, CDC recommends choosing safer travel options.

Question. I assume the vaccine mandate is based on science? If so, can you elaborate on that science?

Answer. Under the CSO, cruise ships are not mandated to require cruise passengers to be vaccinated. CDC recommended that cruise operators incorporate COVID-19 vaccination strategies to maximally protect passengers and crew in the maritime environment, seaports, and land-based communities to further reduce spread of SARS-CoV-2. COVID-19 vaccinations significantly reduce the risk of severe illness, hospitalization, and death.

Question. Does this science also apply to airlines, busses, or trains?

Why or why not?

Answer. Yes, CDC’s science applies in all travel settings. CDC’s current domestic and international travel recommendations suggest people delay travel until they are fully vaccinated. Fully vaccinated travelers are less likely to get and spread COVID-19 and can travel at lower risk to themselves.

QUESTIONS SUBMITTED BY SENATOR PATRICK LEAHY

Question. The COVID-19 pandemic has disproportionately impacted rural hospitals and healthcare providers that were already operating on shrinking margins. The Department has proposed an increase of \$71 million for Rural Health programs

³¹ grants.nih.gov/grants/guide/notice-files/not-od-16-033.html.

³² grants.nih.gov/grants/policy/nihgps/HTML5/introduction.htm.

to ensure access to high-quality care that caters to the unique needs of rural communities. This funding is vital to ensure that our rural providers remain viable.

The COVID-19 pandemic has also exposed serious inequities in healthcare for BIPOC and underserved populations. Rural communities have been no exception to this issue. How can any funding proposed for rural health programs help improve outcomes for BIPOC patients in rural areas?

Answer. This is an important issue; one fifth of rural Americans are from a racial or ethnic minority group. The Federal Office of Rural Health Policy has added language in Notices of Funding Opportunity. Applicants for rural health grants will be expected to address issues of equity by targeting underserved communities and populations to ensure program dollars can reach the people most in need to improve their health outcomes.

While rural Americans face a range of disparities in terms of mortality, life expectancy and chronic disease burden, those gaps are even more pronounced for members of racial and ethnic groups who live in rural communities, and ensuring the data analysis disaggregates race and ethnicity, when possible, helps monitor progress toward eliminating disparities. We will continue to do all we can to make sure rural communities with populations adversely affected by persistent poverty or inequality are leveraging our grant programs.

SUBCOMMITTEE RECESS

Senator MURRAY. This committee will next meet in Dirksen 138 Wednesday, June 16 at 10 a.m. for a hearing on the Biden administration's budget request for the Department of Education. The hearing is adjourned.

[Whereupon, at 11:48 a.m., Wednesday, June 9, the subcommittee was recessed, to reconvene at 10 a.m., Wednesday, June 16.]